STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255311	A. BUILDING _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT OAKS REHABILITATION AND HEALTHCARE CENTER	111 CHASE STREET BYHALIA, MS 38611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and complaint investigations (CI) MS#23601 and CI MS#23551 at the facility from 01/02/24 through 01/04/24 . During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F578, F640, F656, F677, F658, F761, and F880. The SA found the facility to not be in compliance related to CI MS #23601 and cited deficiencies at F656 and F677. The SA found the facility to be in compliance related to CI MS#23551 and no deficiency was cited. The census at the time of the survey was 51 and the facility was licensed for 60 beds.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		2/2/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/25/2024

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F 578	Continued From page 1 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to ensure the resident's right to formulate an Advance Directive (Resident #15 & 50) or identify if a resident had an Advance Directive (Resident #34) for three (3) of 18 residents reviewed for Advance Directives. Findings Include: Review of the facility policy titled, "Advance Directives" with a revision date of 8/2023 revealed, "Policy Interpretation and Implementation ...1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical	F 578	Preparation and submission of this plan of correction by Great Oaks Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws. Facility failed ensure the resident□s rights to formulate an advance directive for resident #15 and #50 or identify if a resident had an advance directive on	

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F 578	Continued From page 2 treatment and to formulate an advance directive if he or she chooses to do so..." Record review of Resident #34's "Advance Directive Policy" that was electronically signed by the resident's representative revealed there was no indication if the resident had an Advance Directive. Record review of Resident's #15 and #50's "Advance Directive Policy" that was electronically signed by the resident for Resident #15 and Resident Representative for Resident #50 revealed that the residents did not have an Advance Directive and accepted assistance by the facility in obtaining one, but there was no documentation regarding the facilities assistance. An interview on 1/3/24 at 9:00 AM, with the Director of Business Development revealed she is responsible for going over the admission packs which include the "Advance Directive Policy" when the residents are admitted to the facility. She stated that on the "Advance Directive Policy" it indicated if they did not have an Advance Directive that the facility would offer assistance to obtain one. She stated that assistance would be things like calling the facilities legal department to help the resident develop an advance directive. When she reviewed the "Advance Directive Policy" for Resident #15, she confirmed that it was marked "No Advance Directive" and that the "Resident/Resident representative Accepted" was marked, indicating they accepted assistance in obtaining one. She stated that the facility does not help them develop one unless they come back and ask for that help. She stated she understood that to mean the facility would help them when they were ready, but they never came	F 578	resident #34. On 1/4/24, Director of Business Development (DBD), called resident #15, #50, and #34□s responsible party to clarify the Advance Directive form and corrections were made. DBD was in-serviced by Administrator 1/4/24 on the Advance Directive form and the correct way to complete form. All residents, 51, had the potential to be affected. Upon review of the residents on 1/3/24, there were 47 residents whose Advance Directive Form needed to be clarified. DBD and Administrator initiated calling families to get clarification on Advanced Directive requests on 1/8/24. DBD and Social Services Director were in-serviced by Administrator 1/4/24 on the Advanced Directive Policy and Regulation F578, Request/Refuse/Discontinue Treatment; Formulate Advanced Directive. Beginning 1/8/24 DBD or Administrator will review Advanced Directive Forms on all new admissions one time a week for four weeks, then one time a month thereafter until compliance is achieved. DBD will bring the results of the audits to the Quality Assurance Committee (QA) meeting monthly x 3 months beginning 1/30/2024. The QA Committee will review for further recommendations.	

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F 578	Continued From page 3	F 578		

back and asked for any help. She stated there are currently no residents in the facility that has received assistance in obtaining an "Advance Directive".

An interview on 1/3/24 at 10:30 AM, with the Administrator confirmed that the facility had understood that if the resident or representative marked "accepted" under "No Advance Directive" then the facility would help them when they were ready, but I can see how that could be misread. He stated that the purpose of an Advance Directive is to plan for the care of a resident in case they are not able to voice that for themselves or become incapacitated. He admitted that they have not helped assist residents in obtaining an Advance Directive since they misunderstood what the marked acceptance for assistance meant.

An interview on 1/4/24 at 10:30 AM with the Director of Nurses (DON) stated that a resident not having an Advance Directive or the facility not assisting the resident in obtaining an Advance Directive could lead to a delay in treatment or care for the resident if an emergency occurred and the resident was incapacitated.

Record review of Resident #15's "Admission Record" revealed that Resident #15 was admitted to the facility on 10/12/23 with medical diagnoses that included Acute Respiratory Failure with Hypoxia.

Record review of Resident #15's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/1/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident is cognitively intact.

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F 578	Continued From page 4 Record review of Resident #34's Admission Record revealed was admitted on 7/27/23 with medical diagnoses that included Wedge Compression Fracture of Unspecified Lumbar Vertebra Subsequent Encounter for Fracture with Routine Healing. Record review of Resident #34's MDS with an ARD of 10/30/23 revealed in Section C a BIMS score of 15, which indicates the resident is cognitively intact. Record review of Resident #50's Admission Record revealed Resident #50 was admitted on 10/26/23 with medical diagnoses that included Metabolic Encephalopathy. Record review of Resident #50's MDS with an ARD of 11/2/23 revealed in Section C a BIMS score of 09, which indicates the resident is moderately cognitively impaired.	F 578		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there	F 640		2/2/24

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F 640	Continued From page 5 is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and Resident Assessment Instrument (RAI) Manual review, the facility failed to submit Minimum Data	F 640	Facility failed to submit Minimum Data Set (MDS) assessment within 14 days of the MDS completion date for resident #12,	

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F 640	Continued From page 6 Set (MDS) assessments within 14 days of the MDS Completion Date for three (3) of 18 MDS resident assessments reviewed, Resident #12, Resident #14, and Resident #32. Findings Include: An interview on 1/4/24 at 11:00 AM, with the Director of Nurses (DON) revealed the facility uses the RAI Manual as the MDS Policy for the facility. Review of the RAI Manual dated October 2023 revealed under "5.2 Timeliness Criteria ...facilities participating in the Medicare and Medicaid programs must meet the following conditions: ...Transmitting Data: Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument ...Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (VO200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days) ..." Record review of the MDS Assessments CMS Submission Report revealed the following MDS were submitted more than 14 days after the MDS Completion Date: Resident #12's Quarterly assessment with a target date of 7/27/23 was submitted late on 8/23/23. Resident #14's Discharge assessment with a target date of 7/21/23 was submitted late on 1/3/24.	F 640	#14, and #32. Resident #12's assessment with a target date of 7/27/23 as submitted on 8/23/23, Resident #14's Discharge Assessment with a target date of 7/21/23 was submitted on 1/3/24, Resident 32's Quarterly Assessment with a target date of 10/6/23 was submitted on 1/3/24 by MDS Nurse. Minimum Data Set (MDS) Nurse was inserviced on late reporting by Administrator on 1/4/24. All residents, 51, had the potential to be affected by deficient practice. On 1/4/24, Regional MDS Director reviewed assessment submissions. Any negative findings were corrected. On 1/4/24, Minimum Data Set (MDS) Nurse was in-serviced by Administrator on 1/4/24 on the requirement to submit data in accordance with CMS guidelines. Beginning 1/8/24 submissions will be reviewed by Regional MDS Director weekly times four weeks, then biweekly for four weeks and monthly thereafter to maintain compliance with CMS guidelines regarding submitting assessments. MDS Coordinator will review submission reports and report to QA Committee x three months beginning 1/30/2024. The QA Committee will make further recommendations after review, if needed.	

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F 640	Continued From page 7	F 640		

Resident #32's Quarterly assessment with a target date of 10/6/23 was submitted late on 1/3/24.

An interview on 1/3/24 at 3:50 PM with Registered Nurse/Minimum Data Set Nurse (RN/MDS Nurse) confirmed that Resident #12, ##14 and #32's MDS assessments were submitted late as revealed in the record review, but she does not know why. She stated we have had a lot of changes in MDS requirements and have lost the other MDS nurse a few weeks ago. She revealed that when she pulled Resident #32's validation report today, was when she realized that there had been an error on the residents MDS assessment, and she resubmitted it today. She stated that she usually pulls a validation report monthly but cannot find the reports that would have corresponded with these residents' late submission months. She revealed that she keeps a written calendar of any MDS assessment that is due and at the end of the month she reviews her calendar to make sure she has completed her task. She stated there is no other form of notification or reminder for her that she is aware of. She confirmed that the resident's deadline for submission of their MDS assessment is based on the last completed assessment, but she does not ever want to go past 92 days from the last assessment because it will be late, and she believes she has 15 days to submit a resident's discharge assessment. She revealed that the purpose of the MDS Quarterly assessment was to capture the needs of the residents for care plans and payment.

An interview on 1/3/24 at 4:10 PM, with the Administrator confirmed that the purpose of the MDS assessments was to capture the care needs

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F 640	Continued From page 8 of the residents and confirmed on record review of the validation and submission reports for Resident's #12, #14 and #32 that their assessments were submitted late. He admitted that he realized that they had an issue with MDS and had recently lost an MDS nurse. He stated he thought there was an issue with being able to submit to MDS in both July and October of 2023, but then after record review realized that two of the late MDS assessment submissions were completed on 1/3/24 after the facility was made aware during the survey. Record review of Resident #12's Admission Record revealed that Resident #12 was admitted to the facility on 5/12/23 with medical diagnoses that included Infection following a procedure, Superficial Incisional Surgical Site, Subsequent Encounter. Record review of the Admission Record revealed Resident #14 was admitted to the facility on 4/13/23 with medical diagnoses that included Nontraumatic Intracerebral Hemorrhage in Hemisphere, Subcortical. Record review of the Admission Record revealed Resident #32 was admitted on 4/25/22 with medical diagnoses that included Major Depressive Disorder, Recurrent, Unspecified.	F 640		
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	F 656		2/2/24

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F 656	Continued From page 9 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate 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-	F 656		

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F 656	Continued From page 10 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, record review and facility policy review the facility failed to implement a care plan for Activities of Daily Living (ADL) for one (1) of 18 residents care plans reviewed. Resident #6. Findings include: Review of the facility policy titled, "Care Plan, Comprehensive Person-Centered" with a reviewed date of 01/2023 revealed under "Policy Interpretation and Implementation ...1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive person-centered care plan for each resident". Record review of Resident #6's care plans revealed the resident had an ADL care plan had a deficit in self-performance related to her diagnosis of Metabolic Encephalopathy and required extensive assistance by 1 staff for toileting that was initiated on 11/22/23. On 01/02/24 at 1:59 PM, an interview and observation of Resident #6 revealed the resident was lying in bed with her eyes closed and a foul odor. An interview with the resident's son who was sitting at the bedside revealed he thought she had a bowel movement , so he called for someone to come change her, but it had been 10 minutes, and no one had come yet. On 1/2/24 at 3:40 PM, an interview and observation revealed Certified Nurse Assistant	F 656	Facility failed to implement a careplan for activity of daily living for resident #6. Resident #6 Activities of Daily Living (ADL) care completed 1/2/24 at 3:40 in accordance with the comprehensive care plan by Certified Nursing Assistant (CNA) #1 and CNA #2. Careplan was reviewed by Director of Nursing 1/4/24 to ensure accuracy. All residents, 51, had the potential to be affected by the deficient practice. On 1/4/24 Social Service Director (SSD) interviewed residents with a Brief Interview for Mental Status (BIMS) score of 12 and above to identify concerns regarding ADL care. No negative findings were noted. On 1/4/24 Staff Development Coordinator (SDC) initiated in-services with direct care staff on following careplans and answering call lights timely. Beginning 1/8/24 SDC, Director of Nursing, Assistant Director of Nursing, or Nurse Manager will observe ADL care and careplans three times week for four weeks then two times a week for four weeks, then one time monthly thereafter. DON will bring results of the observations to monthly QA Committee for review times three months beginning 1/30/2024. The QA Committee will make recommendations based on findings.	

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F 656	Continued From page 11 (CNA) #1 and CNA #2 were finishing incontinent care for Resident #6. CNA #1 stated that Resident #6's family came to her and told her about an hour and half ago that the resident needed changing because they thought she had a bowel movement, but she was busy, so she was just now getting to change her. On 1/3/24 at 1:10 PM, an interview with CNA #2 revealed that a care plan lets the staff know what care the resident needs. She stated the resident does need assistance with incontinent care and if she waited that long for assistance then her care plan for ADL's (Activities of Daily Living) was not implemented. On 1/3/24 at 1:18 PM, an interview with the Director of Nurse (DON) confirmed that the resident had a care plan for assistance with ADLS and if you are aware that the resident needs assistance prior to their two-hour check then it needs to be done, so in that way her care plan was not implemented. Record review of Residents #6's "Admission Record" revealed the resident was admitted to the facility on 11/22/23 with medical diagnoses that included Metabolic Encephalopathy. Record review of Resident #6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/29/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 11, which indicates the resident is moderately cognitively impaired and in Section GG that the resident needed substantial to maximal assistance with toileting hygiene.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards	F 658		2/2/24

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F 658	Continued From page 12 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review the facility failed to administer a medication as the physician ordered for (1) one of 28 medication administration opportunities. Findings include: Review of the facility policy titled, "Administering Medication, revised April 2019, revealed Policy heading: "Medications are administered in a safe and timely manner, and as prescribed." ... Policy Interpretation and Implementation: 4.) Medications are administered in accordance with prescriber's orders ... 10.) The individual administering the medication checks the label three times to verify the right resident, right medication, right dose, right time, and right method (route)of administration before giving the medication..." An observation of Licensed Practical Nurse (LPN) #1 on 1/03/24 at 8:35 AM, revealed she prepared medication for Resident #15, locked her cart and entered room to administer the medications. All liquid and crushed medications were administered via percutaneous endoscopic gastrostomy (peg) tube. A reconciliation of medications given by LPN #1	F 658	Facility failed to administer a medication as the physician ordered for Resident #15. 1/4/2024, LPN #1 was inserviced by Director of Nursing (DON) on Administering Medications in a safe and timely manner, and as prescribed per prescriber□s orders. DON called prescriber 1/4/24 and obtained a new order for the medication to be given in accordance with the prescriber□s orders. All residents, 51, had the potential to be affected by the deficient practice. DON reviewed orders for residents□ receiving medications by PEG for accuracy on 1/4/24. At the time of survey, three other residents were identified that receive medications by PEG. No negative findings were noted. 1/4/24, DON and Staff Development Coordinator (SDC) initiated inservices on administering medications per prescriber□s orders. DON and ADON will monitor medication administration and orders for accuracy three times per week for four weeks, then one time per week for two weeks, then monthly beginning 1/8/24. DON will bring	

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F 658	Continued From page 13 on 1/03/23 at 8:35 AM, with the medication record for Resident #15 revealed "Sacubitril-Valsartan oral tab 24-26 mg (milligram)-1 tablet by mouth twice daily by mouth." An interview with LPN #1 on 1/04/24 at 7:45 AM, she confirmed she gave all Resident #15's pill and liquid medications by peg tube and did not realize that the Sacubitril-Valsartan was ordered by mouth and revealed she should have held the medication and called the provider for a clarification order before administering the medication. She confirmed she should have caught the error when checking the 5 rights of medication. An interview with the Director of Nursing (DON) on 1/04/24 at 8:00 AM, she revealed after review of the physician's orders for Resident #15 the order for the Sacubitril-Valsartan should have been clarified by the provider because the resident is NPO (nothing by mouth). The DON also revealed that the nurse should have caught the incorrect route of the medication when checking the 5 rights of medication and not administered the medication until clarified. Record review of the Admission Record revealed that the facility admitted Resident #15 to the facility on 10/12/23 with diagnoses that included Chronic Obstructive Pulmonary disease.	F 658	results of the observations to monthly QA Committee for review times three months beginning 1/30/2024. The QA Committee will make recommendations based on findings.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		2/2/24

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F 677	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interview and facility policy review the facility failed to provide timely incontinent care for a resident who had a bowel movement as evidenced by the resident waiting an hour and a half for incontinent care for one (1) of 18 Residents sampled. Resident #6 Findings include: Review of the facility policy titled, "Activities of Daily Living (ADL), Supporting" with a revision date of March 2018 revealed "Policy Statement ...Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene..." Review of the facility policy titled "Perineal Care" with a revision date of 7/21/18 revealed "Purpose ...The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition". An interview and observation of Resident #6 on 1/02/24 at 1:59 PM, revealed Resident #6 was lying in bed with eyes closed and a foul odor in the room. This observation revealed that the resident's son and daughter in law were sitting at the bedside and on interview stated they had called for someone to come change her, but it had been 10 minutes, and no one had come yet. The resident's son revealed they thought she had a bowel movement. An interview and observation on 1/2/24 at 3:40	F 677	Facility failed to provide timely incontinent care for resident #6 who had a bowel movement. On 1/02/2024 CNA #1 provided ADL care to resident #6. On 1/4/24 CNA #1 and #6 were inserviced by DON on answering the call lights timely and communicating with nursing staff if they are unable to answer the call light in a timely manner. All residents, 51, had the potential to be affected. 01/04/24 SSD interviewed residents with a BIMS of 12 and above to identify concerns regarding ADL care. No negative findings were noted. 1/4/24 SDC and DON initiated inservices with staff on ADL care and answering call lights timely. Beginning 1/8/24 SDC, Director of Nursing, Assistant Director of Nursing, or Nurse Manager will observe ADL care and answering call lights timely three times week for four weeks then two times a week for four weeks, then one time monthly thereafter until compliance is achieved. DON will bring results of the observations to monthly QA Committee for review times three months beginning 1/30/2024. The QA Committee will make recommendations based on findings.	

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F 677	Continued From page 15	F 677		

PM, revealed Certified Nurse Assistant (CNA) #1 and CNA #2 were finishing up incontinent care for Resident #6. CNA #1 confirmed that Resident #6's family came to her and told her about an hour and half ago that the resident needed changing because they thought she had a bowel movement, but she was busy with other residents, so she was just now getting to change Resident #6. CNA #1 stated there is another CNA on the hall but he was busy and she did not notify the nurse she needed help. CNA #2 revealed she came into work at 2 PM to help with Activities but she came and helped change Resident #6.

An interview on 1/3/24 at 1:10 PM, with CNA #2 revealed that she had come in at 2:00PM yesterday 1/2/24 and about 3:20 PM she noticed that Resident #6's call light was on so she went to answer it. She stated that when she did the family told her that the resident had a bowel movement. She stated the resident could have had skin breakdown from laying in the bowel movement for an hour and a half.

An interview on 1/3/24 at 1:18 PM with the Director of Nurses (DON) confirmed that CNA #1 had come to tell her about the incident with Resident #6 waiting so long to be changed yesterday. She stated that the CNA should have had better time management and notified her nurse that she needed help if she was not able to get to the resident in time. She stated that every resident has to be checked every 2 hours but if you are aware that the resident needs assistance prior to that two-hour check then it needs to be done. She confirmed that a resident lying in a bowel movement for too long could lead to skin breakdown for the resident.

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F 677	Continued From page 16 Record review of Resident #6's "Admission Record" revealed the resident was admitted to the facility on 11/22/23 with medical diagnoses that included Metabolic Encephalopathy. Record review of Resident #6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/29/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 11, which indicates the resident is moderately cognitively impaired and in Section GG that the resident needed substantial to maximal assistance with toileting hygiene.	F 677		
F 761 SS=D	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	F 761		2/2/24

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F 761	Continued From page 17 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, staff interview, record review, and policy review the facility failed to ensure medications were secured when a medication cart was left unlocked and unattended with medications left on top of the cart for (1) one of (5) five medication administration observations. Findings include: Review of the facility policy titled, "Storage of Medications, revised April 2019, revealed, Policy Statement: "The facility stores all drugs and biologicals in a safe, secure, and orderly manner." ... Policy Interpretation and Implementation: 9.) Unlocked carts are not left unattended..." An observation of Registered Nurse (RN) #1 during medication administration on 1/03/2024 at 8:00 AM, revealed RN #1 left the medication cart to go get supplies. She stated "I will be right back" and walked towards the nurse's station leaving the medication cart unlocked and a cup with an inhaler in it on the top of the cart. An interview with RN #1 on 1/03/24 at 8:04 AM she confirmed she left her medication cart unlocked and left the Albuterol inhaler for Resident #13 on the top of the cart unattended. A continued medication administration observation revealed RN #1 prepared medications for Resident #13 locked her cart and entered the resident's room and administered the	F 761	Facility failed to ensure medications were secured when a medication cart was unlocked and unattended with medications on top of the cart. On 1/3/24, Registered Nurse (RN) #1 was inserviced by DON on storing all drugs and biologicals in a safe, secure, and orderly manner. All carts must be locked and medications secured when leaving the cart unattended. All residents, 51, have the potential to be affected due to the deficient practice. On 1/3/24 observations were made by DON and Administrator that carts were locked and medications were stored correctly and no other negative findings were noted. On 1/8/24 Staffing Development Coordinator (SDC) and DON initiated inservices on proper medication storage with Licensed Practical Nurses (LPN) and RNs. Beginning 1/8/24 SDC, Director of Nursing, Assistant Director of Nursing, or Nurse Manager will observe proper medication storage and that carts are not left unattended and unlocked three times week for four weeks then two times a week for four weeks, then one time monthly thereafter until compliance is	

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F 761	Continued From page 18 medications with observation of Tiotropium inhaler box with inhalation powder capsules left on top of the medication cart in the hallway unattended. After completion of medication administration RN #1 left the room and confirmed she left the box of Tiotropium inhaler inhalation powder capsules with 16 capsules on the top of the medication cart unattended. She confirmed the medication should have been placed back in the cart before entering the room. RN #1 then confirmed that leaving the medication cart unsecure and medications on top of the cart unattended could have resulted in adverse reaction to a resident if taken. An interview with the Director of Nursing (DON) on 1/03/24 at 1:00 PM, confirmed medications should never be left on top of the medication cart and the cart should always be locked when left unattended and revealed that someone could have taken the medications off the cart and placed others at risk for harm or adverse reactions. Record review of the Admission Record revealed that the facility admitted Resident #13 to the facility on 04/04/22 with diagnoses that included Chronic Obstructive Pulmonary Disease and Emphysema.	F 761	achieved. DON will bring results of the observations to monthly QA Committee for review times three months beginning 1/30/2024. The QA Committee will make recommendations based on findings.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		2/2/24

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F 880	Continued From page 19 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880		

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F 880	Continued From page 20 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review the facility failed to prevent the potential spread of infection when staff failed to sanitize hands between a respiratory treatment and peg (percutaneous endoscopic gastrostomy) tube medication administration and failed to clean and properly store a respiratory mask and peg tube syringe for (1) one of (8) resident care observations. Resident #15 Findings include: Review of the facility policy titled, "Administering Medication, revised April 2019, revealed "Policy heading: Medications are administered in a safe and timely manner, and as prescribed... Policy Interpretation and Implementation: 25.) Staff	F 880	Facility failed to prevent the potential spread of infection by not sanitizing hands between a respiratory treatment and a PEG tube administration and failed to properly clean and store a respiratory mask and PEG tube syringe for Resident #15. Resident #15 was assessed by Director of Nursing (DON), 1/3/24, and no negative findings were noted. On 1/4/24 LPN #1 was inserviced by DON on following established facility infection control procedures when administering medications per PEG, respiratory treatments, storing respiratory masks, PEG tube syringes and sanitizing hands. All residents, 51, had the potential to be affected by the deficient practice.	

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F 880	Continued From page 21 follows established facility infection control procedures (e.g. (for example) handwashing, antiseptic technique, and gloves) for the administration of medications, as applicable..." Review of the facility policy titled, "Infection Prevention and Control Program," reviewed January 2023, revealed "Policy Statement: An infection prevention and control program is established and maintained to provide a safe, sanitary, and comfortable environment and help to prevent the development and transmission of communicable disease and infections..." A medication administration observation of Licensed Practical Nurse (LPN) #1 on 1/03/24 at 8:35 AM revealed she prepared medication for Resident #15, locked her cart and entered room to administer the medications. LPN #1 sanitized and donned gloves started the Brovana Nebulizer treatment via face mask and then began to administer peg tub medications. After giving half of the medications via the peg tube she stated, "The nebulizer is completed" and took the nebulizer mask off Resident #15 and placed it in the clean storage bag with no observation of doffing gloves, sanitizing hands prior to removing the nebulizer mask or sanitizing the mask before placing it in the clean bag. LPN #1 then began to finish the peg tube medications wearing the same gloves she applied upon entering the resident's room. Once the peg medications were finished LPN #1 placed the peg tube syringe in the clean storage bag with no observation of sanitizing the syringe. LPN #1 then took her gloves off sanitized hands at the door and left the room. During an interview with LPN #1 she confirmed she failed to remove her gloves and sanitize prior to taking the resident's nebulizer mask off and did	F 880	Staffing Development Coordinator (SDC) and DON initiated inservices 1/8/24 to LPNs and RNs on following established facility infection control procedures when administering medications per PEG, respiratory treatments, storing respiratory masks, PEG tube syringes, and sanitizing hands. DON, SDC, or Nurse Manager will observe medication administration and handwashing between respiratory treatments, cleaning and storage of respiratory masks and PEG tube syringes three nurses per week for four weeks, then two nurses per week for two weeks then one nurse monthly thereafter until compliance is achieved beginning 1/8/24. DON will bring results of the observations to monthly QA Committee for review times three months beginning 1/30/2024. The QA Committee will make recommendations based on findings.	

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F 880	Continued From page 22	F 880		

not sanitize the mask prior to putting it in the bag and then revealed she knew she should have done that and knew that could cause possible cross contamination of bacteria and lead to increased risk of infections. LPN #1 then confirmed she failed to clean the peg tube syringe after use and revealed she should have sanitized her hands, cleaned the syringe, dried, and stored in the bag to reduce the risk of bacteria growth.

An interview with the Director of Nursing (DON) on 1/03/24 at 1:00 PM, confirmed staff should have sanitized their hands between administering the peg tube medications and the nebulizer treatment and should always sanitize the nebulizer and peg tube syringe after each use. She stated that by failing to do so placed the resident at risk for cross contamination and increased risk of infection.

An interview with Registered Nurse (RN) #1 on 1/04/24 at 10:40 AM revealed that breathing treatment masks and peg syringes should be cleansed and stored in a clean dry bag after each use and confirmed if a staff failed to do so the oncoming nurse would assume the items were clean and may use them.

Record review of the Admission Record revealed that the facility admitted Resident #15 to the facility on 10/12/23 with diagnoses that included Chronic Obstructive Pulmonary disease.