STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255118	A. BUILDING _____ B. WING _____	01/25/2024

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DIVERSICARE OF MERIDIAN	4728 HIGHWAY 39 NORTH MERIDIAN, MS 39301

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 1/22/24 to 1/25/24. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550, F641, F656, F677, and F679. The census was 94 and the facility had a license for 120 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		2/28/24

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

Electronically Signed | 02/07/2024

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and facility policy review the facility failed to ensure residents' rights were respected as evidenced by staff members using their cell phones in the resident's rooms for two (2) of 34 sampled residents. Residents #30, 32, 35 and 61. Findings Include: Review of the facility's policy, "Resident's Rights and Quality of Life", with an effective date of 5/1/2012, revealed "Policy Statement ...It is the policy ...that all residents have the right to a dignified existence, self-determination, and communication with an access to people and services inside and outside the facility ..." Review of the facility's policy, "Personal Cell Phone and Portable Electronic Device Usage Policy", with an effective date of 7/1/2014, revealed "Purpose...we require that our employee follow the guidelines listed below for the safety of	F 550	This Plan of Correction constitutes Diversicare of Meridian□s credible allegations of compliance for the cited deficiencies. Nothing in this plan of correction should be construed as admission by the Center of any violation of State and Federal Statues, regulations, or standards of care. This Plan of Correction is to demonstrate compliance of the State and Federal requirements cited during the survey. 1. The Activity Director (AD) confirmed with Residents #30, 32, 35, 61, and 39 on 1/24/2024 that no staff members were current using their cell phones while in their rooms on 1/30/2024 and again on 2/7/2024. All Staff members were immediately in-serviced on the use of cell phones while in the center and informed to stop using cell phones in any resident care areas and only on break—this was	

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F 550	Continued From page 2 the residents, patients, our associates, and others ... Policy ...Usage in Work Areas During Work Time ...Personal cell phones and/or portable electronic devices may not be used in resident care areas or other work areas during work time. Usage may only take place during regular break and meal periods in non-work areas ..." An observation and interview on 1/23/24 at 3:30 PM, revealed Certified Nurse Aide (CNA) #1 standing in the corner of Resident #39's room talking on a cell phone with the resident lying in bed. When the State Agency (SA)entered the resident's room, the staff member stated, "Ok I've got to get off here". CNA #1 stated he should not have been in the resident's room talking on the phone. During a resident council meeting on 1/24/24 at 10:00 AM, there were four (4) residents (Residents #30, 32, 35 and 61) that complained the staff talked on their cell phone or those "ear things" while they were in resident rooms. Resident #30 stated that staff came into his room and went behind the curtain to his roommate's side and talked on their phones for personal conversations. He stated that his roommate was bed bound and did not talk much, but they both could hear. Resident #32 revealed he agreed with Resident #30, and he had also had staff come into his room talking on the phone and at times has thought they were talking to him, but they were talking to someone on those "ear things". Resident #35 agreed with Resident #30 and #32 and stated that she had complained about staff doing that to her and that several had come into her room and had about a 20-minute conversation. Resident #61 agreed with the other residents and admitted that staff had done that to	F 550	done by the Director of Clinical Education (DCE), Director of Nursing Services (DNS), the Assistant Director of Nursing Services (ADNS), and Human Resource Coordinator (HRC) on 1/24/2024. No staff member was allowed to work until this in-service was completed. 2. The center identified that all residents in the Center have the potential to be affected by the same deficient practice. 3. A resident Council was held on 2/7/2024 to discuss the center's expectation that no cell phone should be used during resident care. Each resident was encouraged to notify the NHA or any supervisor if a team member was using a cell phone for follow-up action. All team members were educated regarding no cell phones use during resident care by the DCC as of 1/30/2024. The cell phone policy will be educated during orientation for all new hires by the Human Resource Coordinator. 4. To monitor the performance of our corrective action, the Nursing Home Administrator (NHA), DNS, ANDS, Unit Managers (UM) will review patient care areas five (5) times a week for 12 weeks to ensure no cell phones are used in resident care areas, beginning 1/30/2024. Any negative findings will be brought to the QAPI (Quality Assurance Performance Improvement) meeting monthly beginning February 27, 2024 for a minimum of three months by the Nursing Home Administrator. The QAPI Committee will review the findings and determine if there is a need to alter our corrective action.	

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F 550	Continued From page 3	F 550		

her in her room on their cell phones. All four residents stated they had complained about this to other staff members but could not remember anyone's name. Resident #35 stated she had told the head nurse on her hall, but nothing had changed. Resident #30 stated they did not need to be coming in our rooms and talking on their phone because that is our home.

An observation and interview on 1/24/24 at 10:55 AM, revealed CNA #2 standing in an unsampled resident's room, with the door closed and the resident not present in the room. This observation revealed she was looking at her cell phone and stated in the interview that she was on her cell phone checking messages. She admits that she should not have been in the resident's room doing that and the facility policy was that staff are not to use their cell phones in front of the residents and that they are supposed to use them in a break area. She revealed the reason they should not use their cell phones in resident areas is because it is disrespectful.

An interview on 1/24/24 at 11:22 AM, with the Director of Nursing (DON) confirmed that staff should not use their cell phones or earpiece phones while in the resident areas. She stated they are supposed to use those in break areas if needed. She revealed the reason they should not use them was because they would not be able to provide care. She confirmed the facility policy was that cell phone usage was not permitted in the resident care areas.

Resident #30

Record review of Resident #30's "Admission Record" revealed the resident was admitted to

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F 550	Continued From page 4	F 550		

the facility on 4/29/15 with medical diagnoses that included Anxiety disorder.

Record review of Resident #30's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/26/23 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident is cognitively intact.

Resident #32

Record review of Resident #32's "Admission Record" revealed the resident was admitted to the facility on 3/21/23 with diagnoses that included Heart Failure and Major Depressive Disorder.

Record review of Resident #32's MDS with an ARD of 12/22/23 revealed under Section C a BIMS score of 15, which indicates the resident is cognitively intact.

Resident #35

Record review of Resident #35's "Admission Record" revealed the resident was admitted to the facility on 8/9/22 with diagnoses that included Generalized Anxiety Disorder

Record review of Resident #35's MDS with an ARD of 10/31/23 revealed under Section C a BIMS score of 15, which indicates the resident is cognitively intact.

Resident #61

Record review of Resident #61's "Admission Record" revealed the resident was admitted to

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F 550	Continued From page 5 the facility on 2/10/20 with diagnoses that included Chronic Kidney Disease. Record review of Resident #61's MDS with an ARD of 11/7/23 revealed under Section C a BIMS score of 15, which indicates the resident is cognitively intact.	F 550		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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's Minimum Data Set (MDS) assessment was accurately coded for ordered medication for one (1) of 21 MDS assessments reviewed. Resident #63 Findings Include: Record review of facility policy titled, "RAI (Resident Assessment Instrument) Process Guideline ", dated September 2020, revealed, " Guideline Statement: The purpose of this guideline is to provide guidance and instruction on how to complete the RAI process. The RAI process consists of three components: The Minimum Data Set (MDS) Version 3.0, The Care Area Assessment (CAA) process, and the RAI utilization guideline ...Process ...The center will determine how the process is completed ensuring that the process includes direct observation and communication with the residents and direct care staff ..."	F 641	1. Resident #63's assessment was modified, corrected, and resubmitted to remove coding Ozempic as an insulin injection on the Minimum Data Set (MDS) for the assessment reference date (ARD) 1/11/2024, Section N. 2. The center identified that all residents in the Center that receive Ozempic injections have the potential to be affected by the same deficient practice. 3. The Director of Care Coordination (DCC) and The Registered Nurse Assessment Coordinators (2) reviewed all current residents with orders for Ozempic to ensure that proper coding of this medication was coded on their MDSs—correcting and resubmitting any MDSs that were not correct as of 1/30/2024. 4. In order to monitor the center's performance to assure performance is sustained, the DCE will review all MDSs prior to submission to ensure that no	2/28/24

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F 641	Continued From page 6 Record review of Resident #63's "Admission Record" revealed she was admitted to the facility on 10/1/20. She had a diagnosis of Type 2 Diabetes Mellitus with Hyperglycemia with an onset date of 10/30/23. Record review of the "Order Summary Report", with active orders as of 1/25/2024, revealed Resident #63 had a Physician's Order, dated 10/30/23, for "Ozempic ...Inject 0.25 milligrams (mg) subcutaneously weekly ...for Diabetes related to Type 2 Diabetes Mellitus." Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/11/24, Section N revealed Resident #63 received one (1) Insulin injection during the seven day look back period. Review of the medical record revealed there were no Physician's Orders or documentation recorded that Resident #63 received insulin in January of 2024. During an interview on 1/23/24 at 4:03 PM, the MDS Assistant Coordinator Registered Nurse (RN) revealed she was responsible for entering the information for the MDS, dated 1/11/24, for Resident #63. She stated she was new to the position and thought that since Ozempic was an injectable medication that lowered the blood sugar for diabetic residents and that it was categorized as Insulin. She stated the MDS assessment provides health information on each resident and confirmed she failed to accurately enter Resident #63's medication information. An interview with the Director of Nursing (DON)	F 641	residents with orders for Ozempic are coded on the MDS as insulin, beginning 1/30/24 for a period of 12 weeks. Any negative findings will be brought to the QAPI (Quality Assurance Performance Improvement) meeting monthly beginning 2/27/2024 for a minimum of three months by the DCC. The QAPI Committee will review the findings and determine if there is a need to alter our corrective action.	

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F 641	Continued From page 7 on 1/25/24 at 8:45 AM, revealed she thought Ozempic was classified as an insulin. She confirmed after researching this, she determined that it was not an insulin and coding it as an insulin was an MDS discrepancy.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		2/28/24

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F 656	Continued From page 8 (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 observation, staff interview, record review and facility policy review the facility failed to implement a care plan related to resident activities for one (1) of 21 resident care plans reviewed. Resident #39 Findings include: Review of the facility policy, "Comprehensive Care Plan", with an effective date of May 1, 2012, revealed "...Practice Guidelines ... 1. The interdisciplinary care plan is implemented to guide health care center staff in the provision of necessary care and services to obtain and maintain the highest practicable physical, mental, and psychosocial well-being of the resident and promotion of the resident and family in planning care ..." A record review of the Comprehensive Care Plan revealed "Focus (Proper Name) is (dependent on staff ...) for meeting emotional, intellectual, physical, and social needs r/t (related to) CVA	F 656	1. Resident # 39 was updated by the AD to reflect the current needs of the resident and in-room TV, radio, Alexa was provided at the resident's choice. 2. The Center identified that all residents in the Center that need assistance for Activities may have the potential to be affected by the same deficient practice. 3. All nursing staff was in-serviced by the DCE on implementing the activity care plans for every resident as of 1/30/2024. The AD audited all current activity care plans to ensure those needing assistance or in-room activities were documented in the care plan. The AD conducted an audit of all residents with vison/hearing impairment and their current activity likes/dislikes as of 1/30/2024. The AD established an Activity Calendar to meet the needs of these resident and will document daily on these residents beginning 1/30/2024. 4. To monitor the performance of the	

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F 656	Continued From page 9 (Cerebral Vascular Accident) affected left dominant side or vision deficits ... revised 6/2/2023 ...Interventions/Tasks ...Invite the resident to scheduled activities. The resident needs assistance/escort to activity functions." An interview and observation on 01/22/24 at 03:01 PM, revealed Resident #39 stated he does not usually go out of the room for activities, but would like to, and revealed that he cannot see. He stated he does not know when the activities are, and the staff had not asked or told him. An observation and interview on 1/23/24 at 10:40 AM, revealed a group activity of "Devotion" was taking place in the room while Resident #39 was sitting up in bed in his room. Resident #39 said that he was not asked if he wanted to attend the activity. During an interview on 1/23/23 at 11:00 AM, with Certified Nurse Aide (CNA) #3, she stated that Resident #39 had to be taken to Activities, because he could not get himself out of bed or self-propel his wheelchair. During an interview on 1/23/24 at 11:15 AM, the Activities Director confirmed that Resident #39 did not attend the group activity of Devotion this morning. She revealed that she does not document who all comes to her group activities and she depends on the staff to help her know when residents are not coming to activities so she can put them on "in room" activities. She stated that the resident was not documented as having received "in room" activities for the month of January. During an observation on 1/23/24 at 1:45 PM, a	F 656	corrective actions and to ensure sustainability, the AD will review five (5) residents per week for four (4) weeks and then three (3) residents per week for eight (8) weeks to ensure activities are provided for those residents with hearing/vision impairment and per the care plan, beginning 1/30/2024. The AD will bring the results of the monitoring monthly beginning 2/27/2024 to the Quality Assurance Performance Improvement (QAPI) Committee for three months for review and/or revision and to make recommendations as needed.	

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F 656	Continued From page 10 facility staff member was going down the hallway where Resident #39 resides and asking residents if they wanted to go to activities. The staff member did not ask Resident #39 if he wanted to attend the activity. On interview on 1/23/24 at 2:15 PM, with the Director of Nurses (DON) and the Administrator, revealed that Resident #39 should be having one-on-one activities at a minimum. The DON revealed that the purpose of residents going to activities is for socialization and livelihood. During an interview on 1/23/24 at 3:04 PM, the Activities Director confirmed that activities are for residents to socialize with others. She revealed that if Resident #39 had a care plan that indicated the staff should be assisting the resident with his activities, then his care plan was not implemented. An interview with CNA #3 and record review of the Comprehensive Care Plan, on 1/24/24 at 8:30 AM, confirmed Resident #39 had a care plan intervention to invite the resident to scheduled activities #3 confirmed that by not inviting or taking Resident #39 to activities means the care plan was not implemented.	F 656		
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; This REQUIREMENT is not met as evidenced by: Based on observation, resident, staff and family	F 677	1. Resident # 52 was shaved on	2/28/24

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F 677	Continued From page 11 interview, record review, and facility policy review, the facility failed to shave a resident who required staff assistance for Activities of Daily Living (ADLs) for one (1) of 21 sampled residents. Resident # 52 Findings Include: A review of the facility policy, "ADL's", with an effective date of August 2021, revealed "Policy: Ensure ADL's are provided in accordance with accepted standards of practice, the care plan, and reasonable accommodation of the resident's choices and preferences ..." An observation and interview on 01/22/24 at 2:30 PM, with Resident #52 revealed he had facial hair that was approximately a quarter of an inch in length. The resident's mother was at the bedside and stated, "He needs to be shaved and I have told them that I can't do it anymore." The resident confirmed that he wanted to be shaved. An observation and interview on 01/23/24 at 1:30 PM, with the Director of Nursing (DON) confirmed that Resident #52 needed to be shaved. She stated that the resident should have been shaved when he received a bath or shower, and that if a resident refused, the Certified Nurse Aide (CNA) should have reported it to the nurse. She revealed that there was no documentation that Resident #52 refused to be shaved. An interview on 01/23/24 at 01:45 PM, with CNA #4 confirmed that she was responsible for caring for Resident #52 today and she had him every day. She revealed the resident received baths, which included shaving, on Mondays, Wednesdays, and Fridays. CNA #4 revealed that	F 677	1/23/2024. 2. The Center identified that all residents in the Center that have the potential to be affected by the same deficient practice. 3. The DCE in-serviced all nursing staff on proper Activities of Daily Living (ADLs) to all residents and to document properly on the completions of the ADLs, to include informing the nurse if any care is refused and for the nurse to communicate refusals to the family/resident representative as of 1/30/2024. The North and South Unit Managers and Weekend Supervisors will ensure all ADL care is provide and documented on a daily basis—to ensure any refusals are communicated to the resident's representative, beginning 1/30/2024. 4. To monitor the performance of the corrective action and to ensure sustainability, the DNS/ADNS/UMs will review two (2) residents per day Monday-Friday for four (4) weeks then five (5) residents per week for eight (8a) weeks to ensure ADL shaving are being given and documented correctly—to include refusals, beginning 1/30/2024. The DNS will bring the results of the monitoring monthly beginning 2/27/2024 to the Quality Assurance Performance Improvement (QAPI) Committee for three months for review and/or revision and to make recommendations as needed.	

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	255118	A. BUILDING _____ B. WING _____	01/25/2024

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F 677	Continued From page 12 Resident #52 was not shaved on Monday (1/22/24) because she did not think that he needed to be shaved and commented, "His facial hair may be long to you, but it is not to him." An observation and interview on 01/23/24 at 2:10 PM, with Resident #52 and the DON confirmed that the resident wanted to be shaved. Record review of Resident #52's "Admission Record" revealed he was initially admitted to the facility on 8/7/2019 with a medical diagnoses that included Type Two Diabetes Mellitus with Diabetic Neuropathy. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/30/23 revealed Resident #52 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated his cognition was moderately impaired. A review of Section GG revealed he required assistance with bathing.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by:	F 679		2/28/24

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F 679	Continued From page 13 Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to invite and assist a dependent resident to group activities for one (1) of 21 sampled residents. Resident #39 Findings Include: Review of the facility policy titled, "Activities", with an effective date of April 2022, revealed, "Policy ...It is the policy of this center to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Center-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction with the community ...Policy Explanation and Compliance Guidelines ...10. All staff will assist residents to and from activities when necessary ..." During an interview and observation on 01/22/24 at 03:01 PM, revealed Resident #39 sitting in bed in his room, staring out of the window. He stated he does not usually go out of the room for activities, but would like to, and revealed that he cannot see. He stated he does not know when the activities are, and the staff had not asked or told him. An interview on 1/22/24 at 3:12 PM, with Licensed Practical Nurse (LPN) #2, revealed most of the residents on the hall were at activities because they were having devotion. During an observation and interview on 1/23/24 at	F 679	1. Resident # 39 was provided a TV, an Alexa for music, and a radio on 1/23/24 and on 1/24/24. Resident # 39 was taken to activities on 1/24/2024 and 1/25/2024 by the AD. The AD will document the attendance of Resident #39 in group activities and if he does not attend, will ensure in-room activities are provided of his choice. 2. The Center identified that all residents in the Center that have vision/hearing impairment have the potential to be affected by the same deficient practice. 3. The NHA in-serviced the AD on 1/23/24 to ensure all residents with hearing/vision impairment that do not attend group activities are provided in-room activities of their choice and that all activity care plans must be followed as written. The AD conducted an audit of all residents with vison/hearing impairment and their current activity likes/dislikes as of 1/30/2024. The AD established an Activity Calendar to meet the needs of these resident and will document daily on these residents. 4. To monitor the performance of the corrective actions and to ensure sustainability, the AD will review five (5) residents per week for four (4) weeks and then three (3) residents per week for eight (8) weeks to ensure activities are provided for those residents with hearing/vision impairment, beginning 1/30/2024. The AD will bring the results of the monitoring monthly beginning 2/27/2024 to the Quality Assurance Performance Improvement (QAPI) Committee for three months for review and/or revision and to	

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F 679	Continued From page 14 10:40 AM, revealed that Resident #39 was sitting up in bed in his room and there was a group activity of "Devotion" in process in the dining room. An interview with the resident revealed he was not asked to go to Activities and that he had not done anything but sit there where he was. In an interview on 1/23/23 at 11:00 AM, with Certified Nurse Aide (CNA) #3, she stated that Resident #39 had to be taken to Activities, because he could not get himself out of bed or self-propel his wheelchair. An interview on 1/23/24 at 11:15 AM, with the Activities Director confirmed that Resident #39 did not attend the group activity of Devotion this morning. She revealed that she does not document who all comes to her group activities and she depends on the staff to help her know when residents are not coming to activities so she can put them on "in room" activities. She stated that the resident was not documented as having received "in room" activities for the month of January. An observation on 1/23/24 at 1:45 PM revealed a staff member going down the hallway where Resident #39 lives asking residents if they wanted to go to activities, but the staff member did not stop and ask Resident #39. An interview and observation on 1/23/24 at 1:50 PM, with CNA #3 revealed Resident #39 was sitting in bed with his eyes closed. She stated that the resident had diarrhea this morning, so she did not even ask him if he wanted to go to activities. She asked the resident at this time if he would like to go to activities and the resident stated, "Yes".	F 679	make recommendations as needed.	

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F 679	Continued From page 15 On interview on 1/23/24 at 2:15 PM, with the Director of Nurses (DON) and the Administrator, revealed that Resident #39 should be having one-on-one activities at a minimum. The DON revealed that the purpose of residents going to activities is for socialization. An interview on 1/23/24 at 3:04 PM, with the Activities Director confirmed that activities are for residents to have some socialization with other residents. An interview 1/24/24 at 8:30 AM, with CNA #3 confirmed that activities are important for the residents to have something to do and get out of their rooms. Record review of Resident #39's "Admission Record" revealed the resident was admitted to the facility on 2/11/20 with medical diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side. Record review of Resident #39's Minimum Data Set with an Assessment Reference Date of 11/16/23 revealed under Section C a Brief Interview for Mental Status score of 12, which indicates the resident's cognition is moderately impaired.	F 679		