STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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STARKVILLE MANOR HEALTH CARE AND REHABILI1	1001 HOSPITAL ROAD STARKVILLE, MS 39759

(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey from 1/29/24 through 2/06/24. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500, M610, and M615. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 9/20/23 when Resident #269, who had an existing pressure ulcer to the coccyx, was seen by the Wound Nurse Practitioner (NP) and ordered an X-Ray of the coccyx. The X-Ray was not completed until 12/27/23. The wound worsened. The IJ and SQC existed at: 45.17.2 - Resident Rights - M500 - Scope/Severity -Level IV 45.21.3 - Pressure Sores - M615 - Scope/Severity - Level IV The facility Administrator was notified of the IJ and SQC on 1/31/24 at 4:50 PM. The facility provided an acceptable Removal Plan, in which they alleged all corrective actions to remove the IJ were completed on 2/01/24 and the IJ removed on 2/02/24. The SA validated the Removal Plan on 2/06/24 and determined the IJ was removed on 2/2/24. Therefore, the scope and severity (s/s) for 45.17.2 - Resident Rights - M500 and 45.21.3 - Pressure Sores - M615 - was lowered from a "Level IV" to a s/s of "Level II" while the facility develops a plan of correction to monitor the	M 000		

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M 000	Continued From page 1 effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy	M 500		3/8/24

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M 500	Continued From page 2 provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician	M 500		

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M 500	Continued From page 3	M 500		

assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

13. may meet with, and participate in activities of, social, religious and community groups at his

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M 500	Continued From page 4 discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level IV Based on observations, interviews, record review, and facility policy review, the facility failed to protect a resident's right to be free from neglect as evidenced by failure to implement physician orders for the treatment of wounds for three (3) of five (5) wound observations. Resident #52, Resident #103, and Resident #269. The facility's failure to implement and follow physician orders for wound care and treatments put Resident #52, Resident #103 and Resident #269 and all other residents who are at risk for	M 500	1.¿Root Cause Analysis was conducted by Quality Assurance Performance Improvement (QAPI) Committee on 1/31/2024 and based on findings the facility failed to protect a resident right to be free from neglect as evidenced by failure to implement physician orders for the treatment of wounds for three of five wound observations for residents #52, #103, and #269.¿ On 2/1/2024 at 1:00 pm wound nurse was suspended by Executive Director and terminated on 2/1/2024 at 6:43pm. Wound Nurse was reported to	

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M 500	Continued From page 5 skin breakdown at risk for serious harm, serious injury, serious impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 9/20/23 when Resident #269, who had an existing wound to the coccyx was seen by the Wound Nurse Practitioner (NP) and an X-ray was ordered of the coccyx to rule out Osteomyelitis. The X-Ray was not performed until 12/27/23. The resident's coccyx wound worsened. The facility Administrator was notified of the IJ and SQC and was presented with an IJ template on 1/31/24 at 4:50 PM. The facility provided an acceptable Removal Plan on 2/5/24, in which they alleged all corrective action to remove the IJ was completed on 2/01/24 and the IJ was removed as of 02/02/24. The Survey Agency (SA) validated the Removal Plan on 2/06/24 and determined the IJ and SQC was removed on 2/02/24. Therefore, the scope and severity for Rule 45.17.2 Resident Rights M 500was lowered from Level IV to a Level II, while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Record review of facility policy titled "Abuse, Neglect, Exploitation & Misappropriation" with a revision date of 11/16/22 revealed, "Policy: It is inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect .... The management of the facility	M 500	the Mississippi Board of Nursing on 2/1/2024 at 6:32pm related to not following professional standards of practice. 2.¿ All residents have the potential to be affected by this deficient practice. 3. On 1/31/2024 Assistant Director of Nurses initiated education with 5 Housekeeping employees, 6 Therapist, 4 Dietary employees, 8 Certified Nursing Assistants, 6 office staff, 5 Licensed Practical Nurses and 5 Registered Nurses on Abuse and Neglect with emphasis on following physician orders and timely implementation and documentation of medical treatments of wounds and diabetic ulcers. Employees will be educated prior to accepting assignment. New hires will be in-serviced on Abuse and Neglect during orientation. Employees will be educated prior to accepting assignment. 4.¿Quality Assurance Improvement QAPI) meeting was held on 1/31/2024 to ensure all staff understands the policy and procedures of abuse and neglect with emphasis on following physicians orders with the treatment of wounds and ensuring orders are accurate prior to treatment of wounds. On 1/31/2024 Director of Nurses and Assistant Director of Nurses initiated ongoing Quality Monitoring for all residents with treatment orders to ensure the orders are implemented and accurate as per policy 4 x weekly x 4 weeks, then 3 x weekly x 3 weeks, then weekly x 4, then monthly for 6 months to ensure all solutions are sustained. On 2/26/2024,	

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M 500	Continued From page 6 recognizes these rights and hereby establishes the following statements, policies, and procedures to protect these rights and to establish a disciplinary policy, which results in the fair and timely treatment of occurrences of resident abuse. Employees of the center are charged with a continuing obligation to treat residents, so they are free from abuse, neglect, mistreatment, and/or misappropriation of property. No employee may at any time commit an act of physical, psychological, or emotional abuse, neglect, mistreatment, and/or misappropriation of property against any resident....Neglect is the failure of the center, its employees ...to provide goods and services necessary to avoid physical harm ..." Resident #269 An observation and interview with the Wound Nurse Practitioner (NP) and the Wound Nurse on 01/31/24 at 12:00 PM of wound care for Resident #269 confirmed that the resident has a Stage 4 Pressure Ulcer to her Sacrum/Coccyx area. The NP removed the residents brief revealing that the resident was currently having a large bowel movement. After cleaning the resident, the wound care nurse removed a Duoderm from the resident's coccyx area. There was a large amount of fresh brown stool inside the residents wound. The Wound Nurse cleaned the wound with 1/4 strength Dakins solution, packed the wound with ¼ strength Dakins moistened gauze and covered with Duoderm. The Wound NP confirmed that the pressure ulcer is in an area that is very hard to keep a dressing on and to keep clean when the resident has a bowel movement. The dressing was not completely sealed across the bottom due to being in between the folds of the buttocks. She stated, "They check	M 500	conducted a QAPI meeting to review our findings from our Quality Monitoring.¿ We will review all finding from our Quality Monitoring on the last Tuesday of each month during the QAPI meeting by the QAPI Committee in the monthly meeting for 6 months to ensure our solutions are sustained.	

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M 500	Continued From page 7	M 500		

on her often to make sure that she has not had a bowel movement". The wound was measured by Wound Nurse Practitioner revealing measurements 5 centimeters (cm) x 5.4 cm x 2.2 cm. There is undermining of the wound at 10 to 2 (spreading from 10:00 to 2:00 on a clock face) with a maximum depth of 2.4 cm. Wound Nurse Practitioner was asked when the resident was first noted to have Osteomyelitis to the Sacrum/Coccyx pressure ulcer and she replied, " I don't really remember when it began," and replied, "I don't believe it will ever close completely, the goal is to keep infection out of the wound."

Record review of the Order Summary Report revealed that the current treatment order dated 1/16/24 was to cleanse stage 4 sacrum with ¼ strength Dakin's, pack with ¼ strength Dakin's moistened gauze and cover with foam bordered dressing every day shift and as needed.

Record review of documentation from the Wound Nurse Practitioner on 09/20/23 revealed that staff reported that the sacral wound began to have a prulent drainage and foul odor and the patient began to experience drowsiness, nausea and vomiting. The resident was less talkative and appeared to not feel well. The sacral wound is noted with moderate drainage as well as bone exposure and an x-ray was ordered with the visit to rule out Osteomyelitis.

Record review of the Wound Nurse Practitioner visit note on 09/27/23 revealed, "Nurse Practitioner to follow up with x-ray and final culture report". Wound Nurse Practitioner visit note on 10/04/23 revealed "an x-ray was ordered with a previous visit and is pending." Wound Nurse Practitioner visited again on 10/11/23,

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M 500	Continued From page 8 10/18/23, 10/25/23, 11/01/23, 11/08/23, 11/15/23,11/30/23, 12/06/23, 12/13/23, and 12/27/23 and continued to document that the Xray was pending. Wound Nurse Practitioner visit note on 01/03/24 revealed "a recent x-ray indicated Osteomyelitis and a midline was placed and the patient is currently receiving Meropenem with recommendations for IV course of antibiotics for a minimum of six weeks", and for patient to be started on probiotic for duration of antibiotic use. An interview, on 01/31/24 at 4:00 PM with Wound Nurse Practitioner confirmed that she was aware that the x-ray that she ordered on 09/20/23 to rule out Osteomyelitis was not acted upon and done until 12/27/23. Wound Nurse Practitioner was asked if she reported to the Director of Nursing or the Assistant Director of Nursing (ADON) that the x-ray had not been performed at any point between the order date of 09/20/23 and the x-ray date of 12/27/23 and the Wound Nurse Practitioner stated "No, I did not report it to them, I probably should have , but I didn't. I have to be careful what I say, we are a contracted business in this facility. I probably should have reported it to them, but I didn't." The NP was asked if the treatment for the Osteomyelitis was delayed because the x-ray was not obtained when it was ordered on 09/20/23, and she stated, "I would have started the IV whenever the x-ray was gotten if it had showed Osteomyelitis." The NP confirmed that the failure of the facility to treat an infection timely could have brought about sepsis or even death for this resident. An interview on 02/01/24 at 8:45 AM, with the Administrator confirmed that it is the expectation that the Wound Nurse Practitioner notify the Director of Nursing (DON) or Assistant Director of Nursing (ADON) if there is a problem with	M 500		

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M 500	Continued From page 9	M 500		

wounds and if she sees her orders are not being implemented.

An interview on 02/01/24 at 9:50 AM, with ADON confirmed that the Wound Nurse Practitioner did not make her aware that the x-ray she ordered on 09/20/23 had not been completed. The ADON stated that around that time in December that she was helping with the wound care because they had terminated the nurse prior for not doing her job and that she found the x-ray order on 12/27/23 had not been done on an audit that she had completed. The ADON confirmed that she immediately called the doctor and got the x-ray ordered and made both the Wound Nurse Practitioner and the Facility Nurse Practitioner aware that the x-ray order had not been completed. She confirmed that the Wound Nurse Practitioner should have reported that the x-ray was not followed through to her or the Director of Nursing immediately, but that she failed to do that.

An interview on 02/01/24 at 10:06 AM, with Licensed Practical Nurse (LPN) #5 confirmed that she is the primary nurse for Resident #269 and was unaware that the Wound Nurse Practitioner had ordered an x-ray on 09/20/23. LPN #5 stated, "She doesn't tell us anything about the wounds when she sees them."

An interview on 02/01/24 at 10:15 AM, with RN #3, Unit Manager confirmed that she was not aware that there was an order for an x-ray on Resident #269 on 09/20/23. RN #3 confirmed that new orders are reviewed each morning in their stand-up meeting and that she never saw an order come through for Resident #269 for an x-ray.

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M 500	Continued From page 10 Review of the Admission Record for Resident #269 revealed that the resident was admitted to the facility on 12/23/22 with a diagnosis of Heart Failure, Local Infection of the skin and subcutaneous tissue, Pressure Ulcer of Sacral Region Stage 4, Rhabdomyolysis, and chronic kidney disease. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/13/23 revealed a Brief Interview for Mental Status (BIMS) score of 07 which indicated Resident #269 was cognitively impaired. Resident # 52 An observation and interview on 01/29/24 at 12:04 PM, with Resident #52 revealed him sitting in a wheelchair in his room. The resident stated he had a wound on his bottom and his left heel. Record review of Resident #52's January 2024 Treatment Administration Record (TAR) revealed an order dated 12/29/23, "Wound Care: Cleanse stage 4 pressure ulcer to coccyx with normal saline, pat dry with gauze, apply Santyl to wound bed and cover with foam bordered dressing daily" with a D/C (discontinue) date of 1/12/24, which revealed there was not an active wound care physician's order for the pressure wound to the coccyx after 1/11/24. Record review of Resident #52's Order Summary Report revealed an order dated 1/18/24, "Wound Care: "Clean unstageable pressure ulcer of left heel with Dakins, pat dry, apply nickel thickness Santyl, apply hydrogel, cover with foam bordered dressing, wrap with kerlix, and secure with tape daily and as needed for soilage/dislodgement..."	M 500		

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M 500	Continued From page 11 On 1/30/24 at 3:38 PM, an observation of Resident #52's wound care with the Wound Nurse revealed, there was not a wound dressing to the resident's coccyx upon initiating the wound care. The Wound Care nurse provided wound care to the coccyx using a discontinued order dated 1/12/24. An observation of the left heel pressure wound revealed the Wound Nurse failed to provide the correct wound care to the left heel per the current physician orders effective 1/19/24. An interview with the Wound Nurse on 1/30/24 at 3:45 PM, confirmed that the resident did not have a dressing to the coccyx area. She revealed that she did not apply the prescribed hydrogel to the left heel wound as ordered. Record review of Resident #52's January 2024 Treatment Administration Record (TAR) revealed an order for Santyl to the coccyx with a start date of 12/29/23 was initialed every day however, the order for wound care utilizing Santyl to the coccyx was discontinued on 1/12/24. The TAR was initialed as performed by the Wound Nurse for two (2) of the thirty-one days in January on 1/30/24 and 1/31/24. All the other days were initialed as performed by other facility nurses. Record review of Resident #52's January 2024 TAR revealed, an order dated 12/29/23, "Santyl External Ointment... Apply to left heel topically everyday shift for DTI (deep tissue injury)." This was initialed as performed by the Wound Nurse two (2) of the thirty-one days in January 1/30 and 1/31. All the other days were initialed as performed by other facility nurses. Record review of Resident #52's Order Summary Report revealed an order dated 1/15/24, "Obtain	M 500		

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M 500	Continued From page 12 Xray of left heel r/t (related to) increased pain and clinical symptoms of osteoporosis." Record review of the Radiology Report dated 1/20/24 for Resident #52 revealed under, "Conclusion: Subtle cortical bone loss at the dorsal lateral aspect of the calcaneus which may represent early osteomyelitis ...." There was a four (4) day delay in obtaining the ordered x-ray for Resident #52's left heel. Record review of Resident #52's Physician Order Details dated 1/24/24 revealed orders for "Wound #1 Left Heel and Wound #2 Coccyx..." These orders were not transcribed to the TAR to reflect the current orders for Resident #52. Record review of the Admission Record revealed Resident #52 was admitted to the facility on 3/8/22 with medical diagnoses that included Type 2 Diabetes Mellitus with Diabetic Peripheral Angiopathy without Gangrene, Peripheral Vascular Disease, Pain and Pressure Ulcer of Left Heel, Stage 2. Record review of Resident #52's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/30/23 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 11, which indicates the resident is moderately cognitively impaired. Resident #103 During an observation and interview on 01/30/24 at 8:19 AM, Resident #103 revealed him lying in bed, awake and alert. He stated he had a wound on his bottom and on his foot that caused him pain.	M 500		

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M 500	Continued From page 13 During an interview with the Wound Nurse on 1/30/24 at 3:50 PM, revealed Resident #103 was admitted to the facility with a pressure wound on the left heel that has not shown any progress with healing and the resident has also developed other areas on the left great toe and some areas of breakdown between the toes on the left foot. She revealed the left toe started out as a blood blister and had worsened over the past couple of weeks and now are eschar covered. She stated the left great toe had been debrided by the Wound Nurse Practitioner (NP), but necrotic tissue returned. She revealed an appointment had been made with a general surgeon due to the wounds not healing and the resident's history of previous amputation of the right great toe due to a necrotic wound. During an observation of wound care for Resident #103, with the Wound Nurse on 1/30/24 at 3:55 PM, revealed she removed the soiled dressing from the wounds on the left foot. A moderate amount of red serosanguinous drainage was observed around the toe portion of the dressing. The left great toe diabetic wound was covered in 100% adherent brown eschar with redness to the peri-wound with a slight odor observed. The wound nurse cleaned the wound to the left great toe and in between the areas of the toes with normal saline, patted dry, and applied xeroform gauze to all the areas and wrapped with a gauze wrap, secured with tape. Record review for the Physician Order Details for Resident #103 dated 1/24/24 revealed the xeroform to the left great toe was discontinued. New orders were given to apply enzymatic debriding agent (Santyl) to the left great toe wound bed only and wrap with kerlix gauze. Thread toes with xeroform on the left foot, secure	M 500		

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with tape daily and as needed.

Record review of the January 2024 Treatment Administration Record (TAR) for Resident #103 revealed there was not a wound care order for the diabetic ulcer on the left great toe or the breakdown between the inner toes.

Record review of the Order Summary Report with active orders as of 1/31/24 for Resident #103 revealed there was not a Physician Order for wound care to the left great toe or in between the toes on the left foot.

Record review of the Weekly Skin Integrity Review forms for Resident #103 dated 1/23/24 and 1/30/24 revealed the wounds in between the toes on the left foot were present and the treatment nurse was aware. The report did not address the left great toe.

Record review of the Progress Note Details dated 12/27/23 for Resident #103 revealed, "There is also a 0.8 × 1.5 × 0.0 bruised area on the left great toe that was noted at his most recent visit ...Will continue to monitor left great toe ..."

Record review of the Progress Note Details dated 1/03/24 for Resident #103 revealed under, "Wound Assessment(s) ... Wound #3 Left Toe blister and has received a status of Not Healed. Initial wound encounter measurements are 1 cm (centimeter) length x 1.2 cm (centimeter) width with no measurable depth, with an area of 1.2 sq (square) cm (centimeters)." ... Also revealed under," General Notes: Will continue to monitor left great toe. Staff to notify of any changes." ...

Record review of Resident #103's Treatment Administration Record (TAR) for January 2024

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revealed an order dated 12/28/23, for wound care to the left heel stage 3 pressure ulcer with a D/C (discontinue) date of 1/18/24. The order was not initialed as completed by the Wound Nurse any of the 18 days in January the order was active.

Record review of Resident #103's Treatment Administration Record (TAR) for January 2024 revealed an order dated 1/19/24 for wound care to the left heel stage 3 pressure ulcer. The wound care was not documented as administered on 1/22/24 and 1/28/24, which was a total of 2 missed wound treatments.

Record review of Resident #103's Treatment Administration Record (TAR) for January 2024 revealed an order dated, 12/28/23 for the right foot great toe amputation site revealed the TAR was initialed as completed by the Wound Care Nurse two (2) of the 31 days in January. The other dates were initialed as completed by other facility nurses. Also, the wound care was not documented as administered on 1/22/24 and 1/28/24, which was a total of 2 missed wound treatments.

Record review of Resident #103's TAR for January 2024 for sheering abrasion to the left buttocks revealed an order dated 12/15/23 was only initialed as completed by the Wound Care Nurse two (2) of the 31 days in January. The other dates were initialed as completed by other facility nurses. Also, the wound care was not documented as administered on 1/22/24 and 1/28/24, which was a total of 2 missed wound treatments.

Record review of the Admission Record for Resident #103 revealed he was admitted to the facility on 7/07/23 with medical diagnoses that

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included Encounter for Orthopedic Aftercare Following Surgical Amputation, acquired absence of Right Great Toe, End Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Pressure Ulcer of Left Heel, Stage 3, and Pain. ??????

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/05/23 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 13, which indicates Resident #103 is cognitively intact.

During an interview with the Wound Care Nurse on 1/31/24 at 9:45 AM, revealed she had been back in the Wound Nurse position since January 1, 2024. She revealed all the wound documentation was behind, and she had to catch things up when she transferred to the position. She stated all the wounds were seen in the facility by the Wound Nurse Practitioner (NP) once weekly on Wednesdays and the Wound NP did not give any orders the day she visited but tells her what she wants to be changed up or makes recommendations for the treatments, and she will send the facility the progress notes the following Friday or Monday. She revealed there were times she did not get the Wound NP's Progress Note until a week later. She confirmed that she had access to the site where the Wound NP uploads the documents, and she could pull the progress notes after it was uploaded. She revealed that Resident #52's left heel pressure wound developed in the facility and was initially a Stage 2 blister and was now unstageable. She stated she was unsure what interventions were put in place to prevent skin breakdown since she had only been in the wound position for a month. She revealed that she worked Monday-Friday and had

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been doing all the wound care in the facility on those days. She explained that on the weekends, she leaves a list of the residents with wounds so that the nurses will know whom to perform wound care on. She confirmed that her initials were not listed on Resident #52's Treatment Administration Record (TAR) for the month of January 2024 except for 1/30/24 and 1/31/24. She stated that she did do the treatments but did not sit down to initial them until the evenings and occasionally the other nurses had signed off on them already. She revealed that the Medication Cart Nurses did help her with holding certain residents, so they could have gone in and signed the TAR before she got to it. She revealed that she was not aware that Resident #52's treatment order for the coccyx pressure wound had been discontinued on 01/12/24. She explained that she had no idea who would have discontinued the treatment order out of the system and acknowledged that she did not follow the TAR for treatment orders, or she would have caught the error. She explained that Resident #103's left great toe wound developed as a dry piece of skin that has continued to worsen, with new ulcers that developed in between the toes. She revealed the Wound NP visited him last week to assess the wound and made the recommendation to apply xeroform gauze and start clindamycin for infection, but she did not enter the orders into the system. She confirmed that she would be the person responsible for implementing the orders and that she goes ahead and starts any new treatment recommendations but does not put the order into the system because once she received the NP progress note, she may have changed something up with the wound care. She explained that she was instructed by the Wound NP that the clindamycin needed to be approved by nephrology, since the resident was on dialysis, so

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the resident was not started on the clindamycin when it was originally ordered on 1/24/24. The Wound Nurse confirmed that she never called the dialysis unit to get the antibiotic order approved. She revealed the wound was not cultured but did show clinical signs of infection and that all medications that the Wound NP recommends must be approved by the Primary Care Practitioner (PCP). She confirmed that she did the treatment on Resident #103's left toes without an active order in the computer and stated, "I don't get her notes until a week later, so I can't put in an order, if I don't have one." She confirmed that a verbal order from the NP should be immediately acted upon and that she was given a verbal order from the NP. She revealed not implementing physician orders immediately was a delay in treatment of the wound and treating the infection. She revealed that delay of treatment could result in possible infection, sepsis, or amputation for both Resident #52 and #103. She confirmed that other nurses had initialed Resident #103's January Treatment Administration Record (TAR) and she revealed she was the person responsible for signing since she completed the treatments.

During an interview with the Assistant Director of Nursing (ADON) on 1/31/24 at 10:05 AM, revealed that the facility had not had a consistent Wound Care Nurse for the past six (6) months. She revealed that the previous Wound Nurse worked for about three (3) months and left without notice, although she was going to be terminated due to lack of documentation on the wounds. The ADON stated that she filled in for the Wound Nurse position for about a month until the current Wound Nurse could transfer from the night shift position. The ADON stated that things were behind as far as documentation on the

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facility wounds, and the Wound Nurse had to get all the information up to date. She revealed that she had not had any concerns regarding the Wound Nurse and felt as if she did a good job. She stated that the Wound Care Nurse did treatments when she was originally hired in 2019 for about a year, so they felt she had enough experience. She revealed she had no reason to suspect anything was wrong and confirmed that the Wound Nurse had not had any wound care training after switching from the night shift supervisor role to the wound care role in January. She confirmed that Resident #52's treatment order for the coccyx had been discontinued on 1/12/24 unintentionally by a staff member. She confirmed that she was not aware that the Wound Nurse was not utilizing the TAR to complete the wound care each day. She would have caught that the order was discontinued if she had looked at the TAR and signed off after the treatment was provided. She revealed she was not sure how the nurses on the weekends were providing wound care.

During a telephone interview with the Wound Nurse Practitioner on 1/31/24 at 3:40 PM, revealed she rounds on all the facility wounds every Wednesday and during her visits she makes recommendations for wound care, but the facility does not receive the progress note until Friday evening when it's faxed over, but that when she makes rounds with the Wound Nurse, she gives verbal orders. She revealed some of her recommendations may be delayed because certain orders must go through the resident's primary care provider (PCP) or dialysis, such as antibiotics or pain medication if the resident is on dialysis. She confirmed she was aware of the delay in antibiotics that were ordered on 01/24/24 for Resident #103 because it had to be approved

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M 500	Continued From page 20 with the PCP due to high risk of drug nephrotoxicity but she assumed that the antibiotic order had been implemented by now, and confirmed that she had not been made aware that the resident still did not have an order for an antibiotic. She revealed that Resident #103 developed a dried blood blister to his left great toe that has deteriorated with a new breakdown in between the toes. She stated the resident had negative Doppler studies and ABI testing that showed moderate Peripheral Vascular Disease. She revealed that Resident #103 was a Diabetic, on dialysis and had a previous history of toe amputation, so she recommended a referral to a General Surgeon due to his high risk of the same outcome (amputation). She revealed she had not been made aware by the facility that Resident #103's left toe wound orders had not been acted upon by the Wound Nurse and the treatment ordered added in the charting system. She revealed that the current Wound Nurse just started, and she was aware that the wound care documentation was behind. She explained that Resident #52's heel wound was unchanged and had not shown any progress. She explained that she also referred the resident to a general surgeon because she was unable to perform the needed debridement in the facility setting due to pain management. She stated that she was not made aware that Resident #52's coccyx treatment order had been discontinued on 1/12/24. She stated that lack of a dressing to the coccyx wound could cause delay in healing and infection. She revealed that she had not been made aware of any concerns regarding the Wound Nurse not performing her duties or following physician orders. She confirmed that if the treatments weren't done as ordered, the wounds would deteriorate.	M 500		

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M 500	Continued From page 21 An interview with Licensed Practical Nurse (LPN) #4 on 2/01/24 at 11:05 AM, revealed that she worked the Medication Cart on 7-3 shift. She revealed that she had been doing the treatments for Resident #52 on the weekends and some during the weekdays. She explained that the facility had not had a consistent or set Wound Nurse in months. She explained that the current Monday through Friday Wound Nurse had been out some, and the nurses had been told that she was not starting full time until February. She confirmed that there were days when the treatments had not been signed off on by the Wound Nurse and the Medication nurses felt responsible for signing them off because they couldn't have things not completed on the TAR at the end of their shift. She explained that there had been times in the past month when the medication nurses were told to do all the wound care because the Wound Nurse was behind and had orders and documentation to complete. LPN #4 explained that she was working this past weekend (1/27/24 and 1/28/24), so she went to the Wound Nurse on Thursday 1/25/24 because she saw that Resident #52's coccyx order had been discontinued in the computer. She revealed that she was told by the Wound Nurse that the order had been discontinued and not to worry about it. She explained that the Wound Nurse never checked in the computer system when she asked her or got up from what she was doing at the time, she simply stated it had been discontinued. She revealed that the order to apply Santyl to the coccyx continued to come up on the TAR, so she applied Santyl to the wound on the coccyx, but did not apply a cover dressing because it was not ordered. She revealed that she was confused because she knew the resident did have a treatment order and all of a sudden, it stopped. She revealed that even when	M 500		

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M 500	Continued From page 22 she followed behind the Wound Nurse the last couple of weeks, Resident #52 never had a dressing on his coccyx. LPN #4 stated when she said something again to the Wound Nurse about the wound not having a dressing, she stated, "It's been discontinued" and acted like it wasn't a big deal. LPN #4 explained that she knew the wound should be covered to keep out urine and feces, because the resident was incontinent, which could cause infection and slow the healing of the wound. She stated that she had never been given a list or left a list of the residents with wounds and treatments for the weekend. She explained that this past Sunday, 1/28/24 they didn't find out that they didn't have a Wound Care Nurse until 1 PM and her shift was over at 3 PM and she wasn't sure who did the wound care that day. During an interview with the Assistant Director of Nursing (ADON) on 2/01/24 at 11:25 AM, revealed she had not been made aware of any concerns from the Medication Nurses related to wound care. She explained, to her knowledge, the Medication Nurses had never been asked to perform treatments so the Wound Nurse could catch up on orders or documentation. She confirmed that the nurses should not sign off on treatments that the Wound Nurse performed, and they had never been told to do so. She explained that she had never pulled the TAR to check and see who signed off on the treatments. She explained that she felt the Wound Nurse got caught up in the day-to-day processes and just didn't make sure things were done. She revealed that she was not aware of a list that was left on the weekends to know which residents needed wound care. She stated the wound care should be administered from the TAR and signed off when completed. She explained that the facility	M 500		

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M 500	Continued From page 23 did have a call in Sunday 1/28/24 with the person who was supposed to do the wound care and stated the Director of Nursing (DON) would have been responsible for letting the Unit Managers know. During an interview with the Director of Nursing (DON) on 2/1/24 at 4:35 PM, revealed that she and the Administrator (ADM) had spoken with the Wound Nurse about taking the Wound Care position when the job opened. She stated that the Wound Nurse had performed the treatments before in the facility when she was first hired, and she was knowledgeable, and she felt the Wound Nurse did a good job. She stated the Wound Nurse was full-time and worked Monday through Friday, so she wasn't sure why she told the medication cart nurses that she was just part time. She revealed that the only thing that had changed since the Wound Nurse did previous treatments was, they hired a new Wound Nurse Practitioner (NP). She confirmed that the Wound Care Nurse could have implemented the physician order when the NP visited because she was giving the verbal order, which could have been added as a verbal physician's order. She stated, "If you are given an order, you should implement that order." She revealed the Wound Nurse should have signed the treatments after they were administered, just like with giving medication. She said was not aware of the Wound Nurse telling the Medication Nurses that they were required to do treatments because she was behind with orders and documentation. She stated, "She could have because I'm not out there on the floor." The DON revealed that the Wound Nurse had not been given any wound training or expectations since she accepted the Wound Care Nurse position in January and stated, "We just trusted her that she knew what she was doing."	M 500		

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M 500	Continued From page 24 Record review of the "Freedom from Abuse Notice to Employees" revealed," ... Neglect includes, but is not limited to lack of care and supervision and unmet physical, social, emotional, spiritual, or medical needs." ... The Wound Care Nurse signed the notice on 7/11/23. Record review of the facility's "Performance Evaluation" revealed the Wound Care Nurse read and signed acknowledgment of the job description and duties assigned dated 11/04/19, 9/07/21 and 9/7/23 which revealed, " ... 8. Complete required documentation in an accurate and timely manner ...." was a requirement. The facility submitted the following acceptable Removal Plan on 2/5/24: Brief Summary of Events: On 1/31/2024 at 4:50pm State Agency (SA) notified the Executive Director (ED) of 5 Immediate Jeopardy's (IJ's) related to F 600 Free from Abuse and Neglect, F 686 Treatment /Services to Prevent /Heal Pressure Ulcers, F 684 Quality of Care, F 726 Competent Nursing Staff and F 658 services Provided Meet Professional Standards. An Immediate jeopardy template was provided to the Executive Director (ED) on 1/31/2024 at 4:50pm by the State Agency (SA). The facility failed to follow the physician's orders for wound care, failed to provide training and competency skills to the Treatment Nurse to ensure she had adequate knowledge to provide care and services to residents with skin concerns and pressure ulcers and failed to provide the treatment and services to promote healing of pressure ulcer wounds and diabetic ulcers which	M 500		

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resulted in delay of healing of pressure ulcers and diabetic ulcers for Resident #52, Resident #103, and Resident #269.

Immediate Action Plan:

Treatment Nurse was suspended by the Executive Director on 2/1/2024 at 1:00 pm and terminated on 2/1/2024 at 6:43 pm. Treatment Nurse was reported to the Mississippi Board of Nursing on 2/1/2024 at 6:32 pm related to not following professional standards of practice.

On 1/31/2024 Assistant Director of Nurses initiated education with 5 Housekeeping employees, 6 Therapist, 4 Dietary employees, 8 Certified Nursing Assistants, 6 office staff, 5 Licensed Practical Nurses and 5 Registered Nurses on Abuse and Neglect with emphasis on following physician orders and timely implementation and documentation of medical treatments of wounds and diabetic ulcers. Employees will be educated prior to accepting an assignment. New hires will be in-serviced on "Abuse and Neglect" during orientation. Employees will be educated prior to accepting an assignment.

On 1/31/2024 the Regional Director of Clinical Services (RDCS) conducted a verbal review of clean dressing change competency with return verbalization from Treatment Nurse RN, RN #1, RN #2, RN #3, RN #4, and Assistant Director of Nurses.

On 1/31/2024 at 9:00 pm Assistant Director of Nurses initiated education with 5 Registered Nurses and 6 Licensed Practical Nurses on "Medication Administration and Documentation". Employees will be educated prior to accepting

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M 500	Continued From page 26 assignments. On 1/31/2024 at 5:40pm the Regional Director of Clinical Services (RDCS) conducted education with the Treatment Nurse on "Skin and Wound Guidelines", "Medication Administration and Documentation", "Abuse and Neglect", and "Following Physician Orders" and "Clean Dressing Change" checklist was reviewed verbally with return verbalization. Education included following the physician order when administering treatments, administering treatment timely, nurse that administers treatment is to sign the electronic administration record that treatment was administered, ensure all skin impairments and pressure ulcers have a physician order for treatment. Employees will be educated prior to accepting assignments. On 1/31/2024 at 1:08 pm Resident #52 received new physician orders to clean the stage 3 pressure ulcer of the coccyx with Dakin's, pat dry, apply Santyl to the wound bed at nickel thickness, cover with foam bordered dressing every day. PRN order for soilage\dislodgement. Resident #103 received new physician orders on 1/31/2024 at 2:02 pm to clean diabetic ulceration between 3rd through 5th toes on left foot with normal saline, pat dry, thread xeroform between toes, cover with dry dressing, wrap with kerlix, and secure with tape every day. PRN order for soilage/dislodgement. Order for clean left great toe blister site with normal saline, pat dry, apply Santyl to wound bed at nickel thickness, cover with dry gauze or ABD pads, wrap with kerlix, and secure with tape every day. PRN order for soilage/dislodgement. No new orders for Resident #269. On 1/31/2024 at 5:05 pm body audits were	M 500		

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initiated by Registered Nurse (RN) #1, RN #2, RN #3, RN #4, and Assistant Director of Nurses to identify skin impairment or pressure ulcers. There were 108 body audits completed and 7 refused. No new pressure ulcers or diabetic ulcers identified on the body audits conducted. Audit conducted on the 7 residents refusing body audit to determine any previous skin concerns. No areas of concern were identified.

On 1/31/2024 at 9:00 pm Assistant Director of Nurses initiated education with 6 Licensed Practical Nurses, 5 Registered Nurses, and 23 Certified Nurses Assistants on "Skin and Wound Guidelines". Employees will be educated prior to accepting assignments.

On 1/31/2024 at 9:00 pm Assistant Director of Nurses initiated education with 7 Registered Nurses and 10 Licensed Practical Nurses on "Following Physician Orders". Employees will be educated prior to accepting assignments.

On 1/31/2024 at 8:30 pm Assistant Director of Nurses reviewed physician orders and wound Nurse Practitioner progress notes consisting of diabetic ulcers, pressure ulcers, and skin concerns in the electronic health record (EHR) to ensure physician orders were implemented for 12 of 12 residents. No discrepancies were identified.

On 1/31/2024 at 5:40 pm the Regional Director of Clinical Services (RDCS) conducted education with the Treatment Nurse on "Skin and Wound Guidelines", "Medication Administration and Documentation", "Abuse and Neglect", and "Following Physician Orders" and "Clean Dressing Change" checklist was used with demonstration and return demonstration. DON and ADON are completing treatments as ordered

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M 500	Continued From page 28 Monday through Friday until treatment nurse position is filled, and treatment nurse is trained on the skills and expectations of the facility. All dayshift nurses who have completed the skills competency for wound care will provide dressing changes on the weekends. Director of Nurses and Assistant Director of Nurses are checking orders daily to ensure orders have been updated in electronic health records for nurses to complete on weekends. On 2/1/2024 at 2:00 pm Regional Vice President of Operation conducted education with Administrator on Abuse and Neglect with emphasis on thorough investigations and reporting guidelines. On 2/1/2024 at 2:30 pm the facility initiated a monitoring tool to check skin concerns, diabetic foot ulcers, pressure ulcers for appropriate orders to treat issues identified. The facility will ensure compliance with all wound care orders for accuracy daily by the Director of Nursing and Assistant Director of Nursing. QAPI: On 1/31/2024 at 7:00 PM a Quality Assurance Performance Improvement (QAPI) Committee meeting was held to review the Immediate Jeopardy template for F 600 Free from Abuse and Neglect, F 686 Treatment /Services to Prevent /Heal Pressure Ulcers, F 726 Competent Nursing Staff and F 658 services Provided Meet Professional Standards and to determine Root Cause Analysis. It was determined through Root Cause Analysis the facility failed to provide approved wound care treatment for Resident #52 and Resident #103 related to failure of the treatment nurse to obtain orders to treat from the provider. The facility failed to provide training and	M 500		

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competency skills to the Treatment Nurse to ensure she had adequate knowledge to provide care and services to residents with skin concerns and pressure ulcers and failed to provide the treatment and services to promote healing of pressure ulcer wounds and diabetic ulcers which resulted in delay of healing of pressure ulcers and diabetic ulcers due to change in position and employment status. Attendees were the Executive Director (ED), Minimum Data Service (MDS) Nurse, Medical Record Clerk (MRC), Regional Director of Clinical Services (RDCS), Assistant Director of Nurses (ADON)/Infection Preventionist, Director of Nurses (DON), Nurse Practitioner (NP), and the Medical Director (MD). Director of Nurses (DON), Nurse Practitioner (NP), and Medical Director (MD) attended by phone. It was determined through Root Cause Analysis that the facility failed to provide professional standards of practice for documenting and providing medical treatments for wounds for Resident #52, Resident #103, and Resident #269. As a result, the facility's failure to provide treatment and services for wound care, failure to follow the standards of practice, failure to follow physicians' orders, and failure to provide training and competencies skills, the resident's wound healing was delayed, antibiotic orders were delayed, which resulted in worsening wounds and a need for surgical consult to evaluate the need for amputation.

The facility initiated a monitoring tool on 2/1/2024 to check skin concerns, diabetic foot ulcers, pressure ulcers for appropriate orders to treat issues identified. The facility will ensure compliance with all wound care orders for accuracy daily by the Director of Nursing and Assistant Director of Nursing. Weekly wound meeting will be held with Inter Disciplinary Team

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M 500	Continued From page 30 (IDT) to discuss outcomes and findings. Any adverse findings will immediately be reported to the Executive Director and physician by the Director of Nurses. This process will be on-going and reported to Quality Assurance Committee quarterly. A review of policy and procedures for "Abuse and Neglect", "Skin and Wound Guidelines", Medication Administration and Documentation", and "Following Physician Order" was reviewed, and no changes made to policies. All Corrective actions were completed by 2/1/2024 and the facility alleges removal of the Immediate Jeopardy as of 2/2/2024. The State Agency (SA) validated the facility's Removal Plan on 2/06/24: On 2/06/24, the SA validated through staff interviews and record reviews that the Treatment Nurse was terminated and reported to the Mississippi Board of Nursing on 2/1/24. On 2/06/24, the SA validated through staff interviews and record review of the in-service sheet, that education was provided on Abuse and Neglect with emphasis on following physician orders and timely implementation and documentation of medical treatments of wounds and diabetic ulcers. The SA validated through interviews and record reviews that employees will be educated prior to accepting assignments and new hires will be educated during orientation. On 2/06/24, the SA validated through staff interviews and record review that a verbal review of a clean dressing change was conducted for the	M 500		

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M 500	Continued From page 31 Treatment Nurse RN, RN #1, RN #2, RN #3, RN #4, and Assistant Director of Nursing. On 2/06/24, the SA validated through in-services sign in sheets and staff interviews that education was conducted on Medication Administration and Documentation. The SA validated through staff interviews and record reviews that all employees will be educated prior to accepting assignment. On 2/06/24, the SA validated through record reviews that education was conducted for the Treatment Nurse on Skin and Wound Guidelines, Medication Administration and Documentation, Abuse and Neglect, Following Physician Orders, and Clean Dressing Change. The SA validated through staff interviews and record review that all employees will be educated prior to accepting assignments. On 2/06/24, the SA validated through record reviews that Resident #52 received a new physician order for pressure wound to the coccyx. Resident #103 received a new physician order for treatment of left great toe blister site and diabetic ulcerations between the 3rd through 5th toes on the left foot. On 2/06/24, the SA validated through staff interview and record review of body audits, that 108 resident skin audits were conducted by Registered Nurse (RN) #1, RN #2, RN #3, RN #4, and the Assistant Director of Nursing, with no new skin impairments identified. The SA validated seven (7) residents refused with an audit conducted to determine if the seven (7) residents had any previous skin concerns on prior skin sweeps and no concerns were identified. On 2/06/24, the SA validated through staff	M 500		

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interviews and record review through in-service sign in sheets, that education was provided to nurses and aides for Skin and Wound Guidelines. The SA validated all employees will be educated prior to accepting assignment.

On 2/06/24, the SA validated the nurses were educated on Following Physician Orders. The SA validated all employees will be educated prior to accepting assignment.

On 2/06/24, the SA validated through interviews and record review that Assistant Director of Nursing reviewed physician orders and wound Nurse Practitioner's progress notes for residents with skin concerns in the Electronic Health Record (EHR) to ensure physician orders were implemented for 12 of 12 residents with no discrepancies found.

On 2/06/24, the SA validated through staff interviews and record review that the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were completing treatments Monday through Friday until treatment nurse position was filled. The day shift nurses that have completed the skills competency will cover the weekends. The SA validated through interviews that the DON and ADON were checking the orders daily to ensure orders have been updated in the Electronic Health Record (EHR).

On 2/06/24, the SA validated through interviews that the Administrator received education on Abuse and Neglect with emphasis on thorough investigation and reporting that was conducted by the Regional Vice President.

On 2/06/24, the SA validated through staff interviews and record review that the facility

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M 500	Continued From page 33 implemented a monitoring tool for skin concerns and to ensure orders are implemented to treat issues identified. The SA validated compliance with wound care orders will be monitored daily by the Director of Nursing and Assistant Director of Nursing. On 2/06/24, the SA validated on 1/31/24, a Quality Assurance and Performance Improvement (QAPI) meeting was held to review he cited deficient practice and determine the root cause analysis lacking appropriate interventions. In attendance were the Executive Director, Minimum Data Set (MDS), Medical Record Clerk, Regional Director of Clinical Services, Assistant Director of Nursing/Infection Preventionist, Director of Nursing, Nurse Practitioner, and the Medical Director. DON, NP, and MD attended by phone. On 2/06/24, the SA validated by staff interviews that a weekly wound meeting will be held with the Interdisciplinary Team (IDT) to discuss outcomes and findings of the new monitoring tool implemented for skin concerns and ensuring any new skin concerns has physician orders to treat issues identified. This process will be on-going and reported to Quality Assurance Committee quarterly.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming;	M 610		3/8/24

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M 610	Continued From page 34 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to provide Activities of Daily Living (ADL) Care for residents who were dependent on staff for care requiring shaving and nail care for four (4) of the twenty-four residents sampled. Resident #49, Resident #52 Resident #72, Resident #105 Findings include: Record review of facility Policies and Procedures, Subject: Activities of Daily Living with no revision date revealed, "Policy:... ADLs includes bathing, dressing, grooming, hygiene, toileting, and eating...Procedure:...4. CNA (Certified Nursing Assistant) will document care provided in the medical record." Record review of facility Policies and Procedures Grooming Activities with a revision date of 3/19/19 revealed, grooming activities are provided to assist the residents in meeting their physical needs as well as self-esteem needs. 1. Grooming Activities should be offered daily. 2. Grooming Activities should include but are not limited to Shaving...Nail Care. Resident #49	M 610	1.¿Root Cause Analysis was conducted by Quality Assurance Performance Improvement (QAPI) Committee on 2/7/2024 and based on findings the facility failed to provide Activities of Daily Living (ADL) for residents #49, #52, #72, and #105 dependent residents reviewed.¿ Activities of Daily Living was performed on 1/31/2024 for residents #49, #52, #72, and #105 for nail care, shaving, and grooming. 2.Quality Review of current dependent residents initiated on 1/31/2024 by Director of Nurses, Assistant Director of Nurses and Unit Managers to ensure all dependent residents were provided Activities of Daily Living (ADL) care.¿ All residents have the potential to be affected by this deficient practice. 3.Education initiated on 1/31/2024 with current Certified Nursing Assistants and current Licensed nurses by Director of Nurses, and Assistant Director of Nurses on this regulation to ensure all dependent residents are provided Activities of Daily Living (ADL) care with emphasis on nail care, shaving, and grooming.¿ All Certified Nursing assistants and licensed nurses will have education on ADL care, new hires will receive education upon hire. 4. Quality Assurance Improvement QAPI)	

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M 610	Continued From page 35 An observation and interview on 01/29/24 at 10:29 AM, revealed Resident #49 lying in bed with approximately 1-inch facial hair growth on his chin, above his lip, and on the sides of his cheeks. Resident #49 revealed he would like to be shaved. Resident #49 stated "It's been a very long time since I have been shaved." An observation on 01/29/24 at 2:55 PM, revealed Resident #49 lying in bed with no change in appearance. An observation and interview on 01/30/24 at 9:05 AM revealed Resident #49 remains unshaven. Resident #49 revealed "I still haven't been shaved it's been such a long time." An interview on 01/30/24 at 11:25 AM, with Certified Nurses Aide (CNA) #1 revealed when a resident comes to the shower room for a shower that she normally shaves them unless they request to be shaved by the beauty shop lady when she comes on Tuesdays. She revealed if a resident gets a bed bath they are supposed to be shaved as well. She revealed Resident #49 didn't come to the shower room yesterday but should have had a bed bath and been shaved then. An interview and observation on 01/30/24 at 11:45 AM, with CNA #2 revealed she is assigned to the resident today. She revealed she normally shaves her residents every 2 weeks or once a month unless they go to the beauty shop to get shaved on Tuesdays. She confirmed Resident #49 was shaved about a month ago and revealed his facial hair was long and he needed to be shaved. She revealed he probably needs to be shaved every two weeks since his hair grows quickly, and he doesn't go to the beauty shop.	M 610	meeting was held on 2/7/2024 to ensure all current dependent residents were provided Activities of Daily Living (ADL) care. Quality Review of Activities of Daily Living (ADL) for dependent residents to include nail care, shaving, and grooming to be conducted by Director of Nurses 4 x weekly x 4 weeks, then 3 x weekly x 3 weeks, then weekly x 4, then monthly for 6 months to ensure all information is accurate prior to submitting.¿ On 2/26/2024, conducted a QAPI meeting to review our findings from our Quality Monitoring to ensure all solution is sustained.¿ We will review all finding from our Quality Monitoring on the last Tuesday of each month during the QAPI meeting by the QAPI Committee in the monthly meeting for 6 months to ensure our solutions are sustained.	

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M 610	Continued From page 36 During an observation and interview on 01/30/24 at 12:01 PM, Licensed Practical Nurse (LPN) #2 confirmed that Resident #49's facial hair was long, and it looked like it's been a while since he was shaven. He revealed it is the responsibility of the aides to make sure the residents are bathed and that includes shaving unless they go to the beauty shop. During observation and interview on 01/30/24 at 12:15 PM, the Administrator (ADM) confirmed that the resident needed to be shaved. The ADM revealed he should be shaved according to his preference, but it looked like it had been a while since he was shaved. Resident #49 stated to the ADM that he wanted to be shaved and liked to be kept shaved. A record review of the Admission Record for Resident #49 revealed he was admitted to the facility on 09/07/2017 with diagnoses of Cerebrovascular disease, and Major depressive disorder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of Nov 26, 2023, revealed Resident #49 had a Brief Interview for Mental Status (BIMS) score of 09 which indicated the resident has moderate cognitive impairment. Resident #72 An observation on 01/29/24 at 10:32 AM, revealed Resident #72's fingernails on bilateral hands were approx. ½-inch long and jagged with a brown substance under his fingernails. An observation on 01/29/24 at 1:30 PM and again at 3:35 PM, revealed Resident #72 nails	M 610		

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continued to be long with a brown substance under nails.

An observation on 01/30/24 at 8:45 AM, revealed Resident #72 lying in bed. No change in appearance from the previous day.

An observation and interview on 01/30/24 at 10:55 AM, revealed Resident #72 fingernails were long and jagged with a brown substance under his nails. Resident #72 stated he wanted his nails cut.

An interview and observation on 01/30/24 at 11:35 AM, CNA #1 revealed she is assigned to the resident today. She revealed if a resident is not diabetic then we are supposed to do their nailcare. She confirmed Resident #72's nails were long and needed to be cleaned and trimmed and revealed she wasn't sure if he was diabetic or not.

An observation and interview on 01/30/24 at 11:45 AM, LPN #2 revealed, Resident #72's fingernails were "horrible and needed to be taken care of." LPN #2 revealed, the resident could scratch himself and cause a skin tear.

A record review of the Admission Record for Resident #72 revealed he was admitted to the facility on 10/07/2022 with diagnoses of Extrapyramidal and movement disorder, Major depressive disorder,

Record review of the MDS with an ARD of Dec 8, 2023, revealed Resident #72 with a BIMS score of 13 which indicated the resident is cognitively intact.

Resident #105

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M 610	Continued From page 38 An observation and interview on 01/29/24 at 10:25 AM, revealed Resident #105 had facial hair that was approximately ¾ inch long on the resident's chin and sides of his face. Bilateral fingernails were approximately ½ inch long and had a brown substance under each nail. Resident #105 revealed it's been a while since he was shaved and wasn't sure of the last time his nails were trimmed. An observation and interview on 01/29/24 at 11:50 AM, CNA #1 confirmed he looked like he had about a week's worth of facial stubble and confirmed his nails needed to be cleaned and cut. She revealed his shower days are Monday, Wednesday, and Friday and he should have been shaved and his nails done then. CNA #1 revealed she usually works in the shower room but is not sure why the resident was not shaved, and his nails cleaned and trimmed. An observation on 01/29/24 at 3:00 PM, revealed Resident #105 lying in bed. The resident remained unshaved, and his nails were long and jagged with a brown substance under his fingernails. An observation and interview on 01/30/24 at 5:05 PM, revealed Resident #105 lying in bed. The resident remains unshaven, and his nails are long and jagged on both hands with a brown substance under his nails. Resident #105 revealed he tried to get shaved this morning at the beauty shop before he went to dialysis, but he wasn't able to. He revealed the same thing happened last Tuesday he wanted to be shaved but couldn't be done by the beauty shop lady because of dialysis. He revealed he doesn't care who shaves him, but he wants to be shaved.	M 610		

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M 610	Continued From page 39 An observation and interview on 01/30/24 at 5:17 PM, LPN #3 confirmed that the resident needed to be shaved, and his nails were long and jagged and needed to be cleaned. Resident #105 revealed "It's been over at least two weeks since I've been shaved." A record review of the Admission Record for Resident #105 revealed he was admitted to the facility on 08/24/2023 with diagnoses of Chronic Diastolic (Congestive) Heart Failure, End-stage renal disease. Record review of the MDS with an ARD of Dec 1, 2023, revealed Resident #105 with a BIMS score of 07 which indicated the resident has severe cognitive impairment. Resident #52 An observation and interview with Resident #52 on 01/29/24 at 12:04 PM, revealed him sitting in a wheelchair in his room. The resident was observed with long nails on both hands, measuring approximately three-eights (3/8) inch in length. The resident reported he had his nails trimmed once since he came to the facility. An observation and interview with the Director of Nursing (DON) on 1/30/24 at 12:30 PM, confirmed Resident #52 had long nails that needed cutting. She explained the nurses were responsible for cutting the resident's nails because he was a diabetic. She revealed the nails should be trimmed at least monthly to prevent the resident from scratching himself and	M 610		

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M 610	Continued From page 40 causing injury to the skin. The DON stated the diabetic nail care task was on the Treatment Administration Record (TAR) for the nurses to document when it was provided. Record review of the January 2024 Treatment Administration Record (TAR) for Resident #52 revealed there was not a diabetic nail care task to prompt the nurses to provide nail care. An observation and interview with the Director of Nursing (DON) on 1/30/24 at 3:02 PM, revealed that nail care was not on the Treatment Administration Record (TAR) to prompt the nurses to provide care and confirmed that it should have been, to ensure the care was provided. Record review of the Admission Record revealed Resident #52 was admitted to the facility on 3/08/22 with medical diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction, Type 2 Diabetes Mellitus with Diabetic Neuropathy and Peripheral Vascular Disease. Record review of the MDS with an ARD of 11/30/23, revealed under section C, a BIMS summary score of 11, indicating Resident #52 is moderately cognitively impaired.	M 610		
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable.	M 615		3/8/24

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M 615	Continued From page 41 This Statute is not met as evidenced by: Level IV Based on observation, interview, record review and facility policy review, the facility failed to ensure residents received the necessary care and treatment for pressure ulcers to prevent complications and worsening of wounds for three (3) of five (5) residents reviewed for pressure ulcers. Resident #52, Resident #103 and #269 The facility's failure to provide necessary care and treatments for pressure ulcers caused worsening of pressure ulcers for Resident #52, Resident #103, and Resident #269 and placed all other residents at risk for skin breakdown in a situation with the likelihood of serious harm, injury, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 9/20/23 when Resident #269, who had an existing wound to coccyx was seen by the Wound Nurse Practitioner (NP) and an X-ray was ordered of the coccyx to rule out Osteomyelitis. The order for the X-Ray was not performed until 12/27/23, (almost 3 months later) which caused the residents coccyx wound to worsen. The facility Administrator was notified of the IJ and SQC and was presented with an IJ template on 1/31/24 at 4:50 PM. The facility provided an acceptable Removal Plan, in which they alleged all corrective action to remove the IJ was completed on 2/01/24 and the IJ was removed as of 02/02/24. The SA validated the Removal Plan on 2/06/24 and determined the IJ and SQC was removed on	M 615	1. Root Cause Analysis was conducted by Quality Assurance Performance Improvement (QAPI) Committee on 1/31/2024 and based on findings the facility failed to ensure residents received the necessary care and treatment for pressure ulcers to prevent complications and worsening of wounds for three of five residents reviewed for pressure ulcers for residents #52, #103, and #269. On 2/1/2024 at 1:00 pm wound nurse was suspended by Executive Director and terminated on 2/1/2024 at 6:43pm. Wound Nurse was reported to the Mississippi Board of Nursing on 2/1/2024 at 6:32pm related to not following professional standards of practice. 2. All residents have the potential to be affected by this deficient practice. 3. On 1/31/2024 at 5:05 pm body audits were initiated by Assistant Director of Nurses to identify skin impairment or pressure ulcers. There were 108 body audits completed and 7 refused. No new pressure ulcers or diabetic ulcers identified on the body audits conducted. Audit conducted on the 7 residents refusing body audit to determine any previous skin concerns. No areas of concern were identified. On 1/31/2024 at 9:00 pm Assisted Director of Nurses initiated education with 6 Licensed Practical Nurses, 5 Registered Nurses, and 23 Certified Nurses Assistants on “Skin and Wound Guidelines”. Employees will be educated prior to accepting	

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M 615	Continued From page 42 2/02/24. Therefore, the scope and severity for Rule 45.21.3 Pressure Sores M 610 was lowered from a Level IV to a Level II while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Record review of the facility policy titled "Skin and Wound" with a revision date of 1/24/22 revealed under, "Policy: To provide a system for identifying risk, and implementing resident centered interventions to promote skin health, prevention and healing of pressure injuries...Pressure Injury Prevention: ... 3. Nurse to complete skin evaluation weekly and prior to transfer/discharge and document in the medical record... Skin Impairment Identification: 1. Document presence of skin impairment(s) / new skin impairments(s) when observed and weekly until resolved 2. Nurse to report changes in skin integrity to the physician/physician extender, resident /resident representative and document in the medical record 3. Develop resident centered interventions and document on the plan of care and the Nurse Aide Kardex ...5. Monitor residents' response to treatment, modify as indicated" ... Resident # 52 Record review of Resident #52's January 2024 Treatment Administration Record (TAR) revealed an order dated 12/29/23, "Wound Care: Cleanse stage 4 pressure ulcer to coccyx with normal saline, pat dry with gauze, apply Santyl to wound bed and cover with foam bordered dressing daily" with a D/C (discontinue) date of 1/12/24, which	M 615	assignment. 4. Quality Assurance Improvement QAPI) meeting was held on 1/31/2024 to ensure all staff understands the policy and procedures of the necessary care and treatment for pressure ulcers to prevent complications and worsening of wounds. Director of Nurses and Assistant Director of Nurses will conduct ongoing Quality Monitoring for all residents with wounds to ensure proper treatments are in place to prevent the worsening of the wounds as per policy 4 x weekly x 4 weeks, then 3 x weekly x 3 weeks, then weekly x 4, then monthly for 6 months to ensure all solutions are sustained. On 2/26/2024, conducted a QAPI meeting to review our findings from our Quality Monitoring. We will review all finding from our Quality Monitoring on the last Tuesday of each month during the QAPI meeting by the QAPI Committee in the monthly meeting for 6 months to ensure our solutions are sustained.	

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revealed there was not an active wound care physician's order for the pressure wound to the coccyx after 1/11/24.

An observation of Resident #52's wound care with the Wound Nurse on 1/30/24 at 3:38 PM revealed, there was not a wound dressing to the resident's coccyx upon initiating the wound care. The coccyx wound bed was 90% yellow, adherent slough, 10% granulation tissue with redness and maceration to the wound edges. The Wound Nurse cleansed the wound with Dakin's solution, patted dry, applied a layer of Santyl and covered with a foam dressing.

Record review of Resident #52's Order Summary Report revealed an order dated 1/18/24, "Wound Care: "Clean unstageable pressure ulcer of left heel with Dakins, pat dry, apply nickel thickness Santyl, apply hydrogel, cover with foam bordered dressing, wrap with kerlix, and secure with tape daily and as needed for soilage/dislodgement" ...

Continued observation on 1/30/24 at 3:38 PM of the left heel pressure wound revealed, 100% adhering brown eschar to the wound bed. Slight redness observed to the peri-wound. The Wound Nurse stated the treatment orders for the left heel were to cleanse the wound with Dakin's solution, pat dry, apply a layer of Santyl, cover with foam and wrap with gauze wrap.

An interview with the Wound Nurse on 1/30/24 at 3:45 PM confirmed that the resident did not have a dressing to the coccyx area and that urine and stool could get inside the wound and cause infection and delay the healing of the wound. She revealed the purpose of having the dressing over the wound was to keep bacteria out and provide a moist environment for healing. She revealed that

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she did not apply the prescribed hydrogel to the left heel wound as ordered. She revealed the hydrogel was ordered along with Santyl to debride the adherent eschar and that the resident recently completed antibiotics due to the left heel wound being infected. She stated they have a Wound Nurse Practitioner (NP) that visits the resident every Wednesday and measures the wounds and prescribes the treatment orders. She stated the NP wanted the resident to see a general surgeon due to the left heel not showing any progress of healing or improvement, and a recent X-ray of the heel could not rule out osteomyelitis.

Record review of Resident #52's January 2024 Treatment Administration Record (TAR) revealed an order dated 12/29/23, "Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to coccyx topically everyday shift for Stage 4 Pressure Ulcer" initialed as performed by the Wound Nurse two (2) of the thirty-one days in January 1/30 and 1/31. All the other days were initiated as performed by other facility nurses.

Record review of Resident #52's January 2024 Treatment Administration Record (TAR) revealed, an order dated 12/29/23, "Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to left heel topically everyday shift for DTI (deep tissue injury)" initialed as performed by the Wound Nurse two (2) of the thirty-one days in January 1/30 and 1/31. All the other days were initialed as performed by other facility nurses.

Record review of Resident #52's January 2024 Treatment Administration Record (TAR) revealed an order dated 12/28/23, "Santyl External Ointment 250 UNIT/GM (grams) (collagenase) Apply to Coccyx topically as needed for Soling or Dislodgement" not documented as administered

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for the month of January.

Record review of Resident #52's January 2024 Treatment Administration Record (TAR) revealed an order dated 12/28/23, "Santyl External Ointment 250 UNIT/GM (grams) (collagenase) Apply to Left Heel topically as needed for Soling or Dislodgement" not documented as administered for the month of January.

Record review of the Wound Diagnostic Report for Resident #52 dated 1/12/24, revealed a culture and sensitivity was performed of the left heel and under Summary Report Organisms identified, were Staphylococcus aureus and Enterococcus faecalis with Moderate growth.

Record review of Resident #52's Order Summary Report revealed an order dated 1/15/24, "Obtain Xray of left heel r/t (related to) increased pain and clinical symptoms of osteoporosis."

Record review of the Radiology Report dated 1/20/24 for Resident #52 revealed under, "Conclusion: Subtle cortical bone loss at the dorsal lateral aspect of the calcaneus which may represent early osteomyelitis .... "

Record review of the Weekly Wound Report: Pressure Injury for the Week of 11/08/23 for Resident #52 revealed, "Facility Acquired Date and Stage ... 11/10/23 Stage 2 Measurements 2.5 cm (centimeters) x 3.5 cm (centimeters)" ...

Record review of the Weekly Wound Report: Pressure Injury for the Week of 1/24/24 for Resident #52 revealed, "Facility Acquired Date and Stage ... 11/10/23 Stage 2 ... Visualized Stage UNS (unstageable) ...Measurements 3.5 cm (centimeters) x 6.2 cm (centimeters) ...Lt

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M 615	Continued From page 46 (left) heel" ... Record review of Resident #52's Pressure Ulcer Wound Rounds dated 12/28/23 revealed, "Site Left heel ... Type Pressure ... Length 2.5 Width 5 Depth 0 ... Stage Suspected Deep Tissue Injury "Also revealed, "Site Coccyx ... Type Pressure ... Length 6 Width 4 Depth 0 ... Stage IV" ... Record review of Resident #52's Physician Order Details dated 1/24/24 revealed, "Wound #1 Left Heel ... Clean wound with ¼ (one-fourth) Strength Dakins ... Enzymatic Debriding Agent Apply nickel thickness Santyl to the wound bed only. Apply Hydrogel ... Other - Foam pad, kerlix ...Change dressing Every day and as needed .... Wound #2 Coccyx ... Clean wound with ¼(one-fourth) strength Dakins. ... Enzymatic Debriding Agent Apply nickel thickness Santyl to the wound bed only. Apply duoderm or hydrocolloid - or FBD (foam bordered dressing) ... Change dressing every day and as needed" ... Record review of the Wound Nurse Practitioner (NP) visit notes for Resident #52 dated 1/24/24, "The wound to the left heel remains unstageable due to eschar .... Will continue orders for Santyl and add hydrogel in an attempt to loosen the slough .... The patient has been referred to "Proper Name" for further evaluation due to HX (history) of amputation, unable to manage pain for deep debridement .... A recent Xray indicated subtle cortical bone loss at the dorsal lateral aspect of the calcaneus which may represent early Osteomyelitis." ... Record review of the Wound Nurse Practitioner (NP) visit notes for Resident #52 dated 1/24/24, "Wound #1 Left Heel is an Unstageable Pressure Injury Obscured full-thickness skin and tissue	M 615		

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M 615	Continued From page 47 loss Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 3.5 cm (centimeters) length x 6.2 cm (centimeters) width with no measurable depth, with an area of 21.7 Sq (square) cm (centimeters) .... Wound #2 Coccyx is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 5.2 cm (centimeters) length x 3.6 cm (centimeters) width x 0.2 cm (centimeters) depth, with an area of 18.72 sq (square) cm (centimeters) and volume of 3.744 cubic cm (centimeters)." ... Record review of the Wound Nurse Practitioner (NP) visit notes for Resident #52 dated 1/3/24 revealed, "Wound #1 Left Heel is an Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 2 cm (centimeters) length x 4.5 cm (centimeters) width x 0.1 cm (centimeter) depth, with an area of 9 sq (square) cm (centimeter) and volume of 0.9 cubic cm (centimeters) .... There is a scant amount of yellow drainage noted which has odor .... Wound bed has no, granulation, 51-75% slough, 1-25%eschar, no epithelialization present. The wound is deteriorating .... Wound #2 Coccyx is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements 8.2 cm (centimeters) length x 2.3 cm (centimeters) depth, with an area of 18.86 sq (square) cm (centimeters) and a volume of 3.772 cubic cm (centimeters) .... There is a small amount of sero-sanguineous drainage noted which has no odor .... The wound margin is well defined Wound bed has no, granulation, 76-100% slough; no eschar and no epithelialization present." ...	M 615		

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(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) COMPLETE DATE
M 615	Continued From page 48 Record review of the Weekly Skin Integrity Review for Resident #52 dated 1/12/24 revealed, "Coccyx pressure ulcer ... Left heel unstageable" and under, "Notes: Tx (treatment) in process." Record review of the Weekly Skin Integrity Review for Resident #52 dated 1/19/24 revealed, "Coccyx Pressure Ulcer ... Left heel Unstageable" and revealed under, "Notes: Continue Current Tx (treatment)." Record review of the Weekly Skin Integrity Review for Resident #52 dated 1/26/24 revealed, "Coccyx pressure ... Left heel pressure" and revealed under, "Notes: Tx (treatment) in progress)" Record review of the Braden Scale for Predicting Pressure Sore Risk for Resident #52 dated 12/27/23 revealed a Braden Score of 14, indicating the resident is at Moderate Risk for pressure wound development. Record review of the Admission Record revealed the facility admitted Resident #52 on 3/8/22 with medical diagnoses that included Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Type 2 Diabetes Mellitus with Diabetic Peripheral Angiopathy without Gangrene, Acute on Chronic Systolic (congestive) Heart Failure, Peripheral Vascular Disease, pain and Pressure Ulcer of Left Heel, Stage 2. Record review of Resident #52's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/30/23 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 11, which indicates the resident is	M 615		

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M 615	Continued From page 49 moderately cognitively impaired. Also revealed under section M, the current number of Unhealed Pressure Ulcers/Injuries at Each Stage, one (1) Stage 2 pressure ulcer was marked. Resident #103 An observation and interview on 01/30/24 at 8:19 AM, with Resident #103 revealed him lying in bed, awake and alert. He stated he had a wound on his bottom and on his foot that caused him pain. An interview with the Wound Nurse on 1/30/24 at 3:50 PM revealed Resident #103 was admitted to the facility with a pressure wound on the left heel that has not showed improvement. She revealed an appointment had been made with a general surgeon due to the wounds not healing and the resident's history of previous amputation of the right great toe due to a necrotic wound. An observation of wound care for Resident #103, with the Wound Nurse on 1/30/24 at 3:55 PM, revealed she removed the soiled dressing from the wounds on the left foot. Record review of the Treatment Administration Record (TAR) for Resident #103 revealed there was not a wound care order for the ulcer on the left great toe or the breakdown between the inner toes. Record review of the Order Summary Report for Resident #103 revealed there was not a Physician Order for wound care to the left great toe or in between the toes on the left foot.	M 615		

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M 615	Continued From page 50 Record review of Resident #103's Order Summary Report revealed an order dated 7/8/23, "Weekly skin sweeps on Tuesday 3-11 every evening shift every Tue (Tuesday)" ... Record review of the Weekly Skin Integrity Review for Resident #103 dated 1/23/24 revealed under, "Notes: wounds to right great toe, left heel, preexisting wound orders noted. wounds in-between left 3rd,4th and 4th, 5th toes. treatment nurse aware" Record review of the Weekly Skin Integrity Review for Resident #103 dated 1/30/24 revealed under, "Notes: wounds to right great toe, left heel, preexisting wound orders noted. Wounds in-between left 3rd,4th and 4th,5th toes." ... Record review of the Order Summary Report for Resident #103 revealed an order dated 1/25/24, "Appointment with "Proper Name" (General Surgeon) 2/13/24 @ (at) 0800. One time only for NON-HEALING WOUNDS for 2 days" ... Record review of Resident #103's Doppler Report dated 12/19/23 revealed under, "Conclusion: Moderate peripheral vascular disease in the left lower extremity." Record review of Resident #103's Treatment Administration Record (TAR) for January 2024 revealed an order dated 12/28/23, "Wound Care: Clean Left heel stage 3 pressure ulcer with normal saline, pat dry with gauze, apply Medi honey to wound bed, cover with foam dressing, wrap with kerlix and secure with tape daily" with a	M 615		

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M 615	Continued From page 51 D/C (discontinue) date of 1/18/24. The order was not initiated as completed by the Wound Nurse any of the 18 days in January the order was active. The wound care was not documented as administered on 1/22 and 1/28, which was a total of 2 missed wound treatments. Record review of Resident #103's Treatment Administration Record (TAR) for January 2024 revealed an order dated, 12/28/23, "Wound Care: Cleanse right foot great toe amputation site with soap and water and apply A&D ointment daily" initialed as completed by the Wound Care Nurse two (2) of the 31 days in January. The other dates were initialed as completed by other facility nurses. Also, the wound care was not documented as administered on 1/22 and 1/28, which was a total of 2 missed wound treatments. Record review of Resident #103's Treatment Administration Record (TAR) for January 2024 revealed an order dated 12/15/23, "Wound Care: Cleanse shearing abrasion to left buttock with NS (normal saline), apply triad daily" initialed as completed by the Wound Care Nurse two (2) of the 31 days in January. The other dates were initialed as completed by other facility nurses. Also, the wound care was not documented as administered on 1/22 and 1/28, which was a total of 2 missed wound treatments. Record review of Resident #103's Treatment Administration Record (TAR) for January 2024 revealed an order dated 1/19/24, "Wound Care: Clean left heel stage 3 pressure ulcer with normal saline, pat dry with gauze, apply Santyl to wound bed at nickel thickness, cover with foam dressing, wrap with kerlix and secure with tape daily" initialed as completed by the Wound Nurse two	M 615		

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M 615	Continued From page 52 (2) of the 13 days that the order was active. The other dates were initialed as completed by other facility nurses. The dates of 1/22 and 1/28 have no initials to support wound care was performed, which was a total of 2 missed treatments. Record review of the Progress Note Details dated 12/27/23 for Resident #103 revealed under, "There is also a 0.8 × 1.5 × 0.0 bruised area on the left great toe that was noted at his most recent visit ... "Also revealed under, "General Notes: Will continue to monitor left great toe." ... Record review of the Progress Note Details dated 1/03/24 for Resident #103 revealed under, "Wound Assessment(s) ... Wound #3 Left Toe blister and has received a status of Not Healed. Initial wound encounter measurements are 1 cm (centimeter) length x 1.2 cm (centimeter) width with no measurable depth, with an area of 1.2 sq (square) cm (centimeters)." ... Also revealed under," General Notes: Will continue to monitor left great toe. Staff to notify of any changes." ... Record review of the Physician Order Details for Resident #103 dated 1/10/24 revealed under, "Wound #3 Left Toe ... Care of Wound: Apply Xeroform cover with Foam Bordered Dressing ... Change dressing Every day and as needed" ... Also revealed under, "Progress Note Details ... Wound #3 is a Partial Thickness Blister and has received a status of Not healed. Subsequent wound encounter measurements are 0.8 cm (centimeter) length x 1.5 cm (centimeter) width x 0.1 cm (centimeter) depth, with an area of 1.2 cubic cm (centimeter) .... There is a scant amount of sero-sanguineous drainage noted which has no odor." ...	M 615		

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M 615	Continued From page 53 Record review of the Physician Order Details for Resident #103 dated 1/24/24 revealed, "Wound #3 Left Toe ... Care of Wound: Enzymatic debriding agent nickel thickness Santyl to the wound bed only. Cover dressing with dry gauze and wrap with Kling/kerlix. Do not put tape directly on the skin. Other: D/C (discontinue) xeroform to left great toe ... Thread toes with xeroform on left foot .... Secure dressing with tape ... Change dressing every day and as needed." ... Also revealed under, "Progress Note Details ... The bruised/blood blister area to the left great toe is now covered in eschar with bogginess palpated. There are also scattered wounds to the 4th and 5th toes of recent onset .... Recent amputation to right great toe. Scattered wounds noted to 4th and 5th toes as well on left foot of recent onset with worsening of left great toe. Refer to "Proper Name" (General Surgeon) for further evaluation .... 1/25/24: Order for Clindamycin 300 mg (milligrams) 1 (one) po (by mouth) bid (twice daily) x 10 days." ... Record review of the Admission Record for Resident #103 revealed he was admitted to the facility on 7/07/23 with medical diagnoses that included Encounter for Orthopedic Aftercare Following Surgical Amputation, acquired absence of Right Great Toe, Nontraumatic Subarachnoid Hemorrhage Left Middle Cerebral Artery, End Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Pressure Ulcer of Left Heel, Stage 3, and Pain. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/05/23 revealed under section C, a Brief Interview for Mental Status (BIMS) summary score of 13, which indicates Resident #103 is	M 615		

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M 615	Continued From page 54 cognitively intact. Also revealed under section M, diabetic foot ulcer(s) were not checked for the MDS look back period. An interview with the Wound Care Nurse on 1/31/24 at 9:45 AM revealed she had worked at the facility for 3 years. She stated she had been back in the Wound Nurse position since January 1, 2024. She revealed prior to her taking the position, they had another wound nurse who worked for about 3 months and resigned, leaving the facility in a bind due to her lack of inconsistent wound charting. She revealed all the wound documentation was behind, and she had to catch things up when she transferred to the position. She revealed that the facility was sending the residents with wounds out to the "Proper Name" hospital but changed over to "Proper Name" Wound clinic on Sept. 1, 2023. She stated all the wounds were seen in the facility by the Wound Nurse Practitioner (NP) once weekly on Wednesdays and the Wound NP did not give any orders the day she visited but tells her what she wants to be changed up or makes recommendations for the treatments, and she will send the facility the progress notes the following Friday or Monday. An interview with the Wound Care Nurse on 1/31/24 at 9:45 AM also revealed that Resident #52's left heel pressure wound developed in the facility and was initially a Stage 2 blister and was now unstageable. She stated she was unsure what interventions were put in place to prevent skin breakdown since she had only been in the wound position for a month. She revealed that she worked Monday-Friday and had been doing all the wound care in the facility on those days. She explained that on the weekends, she leaves	M 615		

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a list of the residents with wounds so that the nurses will know whom to perform wound care on. She confirmed that her initials were not listed on Resident #52's Treatment Administration Record (TAR) for the month of January 2024 except for 1/30 and 1/31. She stated that she did do the treatments but did not sit down to initial them until the evenings and occasionally the other nurses had signed off on them already. She revealed that the Medication Cart Nurses did help her with holding certain residents, so they could have gone in and signed the TAR before she got to it. She revealed that she was not aware that Resident #52's treatment order for the coccyx pressure wound had been discontinued on 01/12/24. She explained that she had no idea who would have discontinued the treatment order out of the system and acknowledged that she did not follow the TAR for treatment orders, or she would have caught the error.

An interview with the Wound Care Nurse on 1/31/24 at 9:45 AM also revealed that Resident #103's left great toe wound developed as a dry piece of skin that has continued to worsen, with new ulcers that developed in between the toes. She revealed the Wound NP visited him last week to assess the wound and made the recommendation to apply xeroform gauze and start clindamycin for infection, but she did not enter the orders into the system. She confirmed that she would be the person responsible for implementing the orders and that she goes ahead and starts any new treatment recommendations but does not put the order into the system because once she received the NP progress note, she may have changed something up with the wound care. She explained that she was instructed by the Wound NP that the clindamycin needed to be approved by nephrology, since the

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resident was on dialysis, so the resident was not started on the clindamycin when it was originally ordered on 1/24/24. The Wound Nurse confirmed that she never called the dialysis unit to get the antibiotic order approved. She revealed the wound was not cultured but did show clinical signs of infection and that all medications that the Wound NP recommends must be approved by the Primary Care Practitioner (PCP). She confirmed that she did the treatment on Resident #103's left toes without an active order in the computer and stated, "I don't get her notes until a week later, so I can't put in an order, if I don't have one." She confirmed that a verbal order from the NP should be immediately acted upon and that she was given a verbal order from the NP. She revealed not implementing physician orders immediately was a delay in treatment of the wound and treating the infection. She revealed that delay of treatment could result in possible infection, sepsis, or amputation for both Resident #52 and #103. She confirmed that other nurses had initialed Resident #103's January Treatment Administration Record (TAR) and she revealed she was the person responsible for signing since she completed the treatments.

An interview with Licensed Practical Nurse (LPN) #4 on 2/01/24 at 11:05 AM revealed that she had been doing the treatments for Resident #52 on the weekends and some during the weekdays. She explained that the facility had not had a consistent or set Wound Nurse in months. She revealed that the facility just hired a new Wound Nurse for the weekends, but she had not started yet. She explained that the current Monday through Friday Wound Nurse had been out some, and the nurses had been told that she was not starting full time until February. She confirmed that there were days when the treatments had not

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been signed off on by the Wound Nurse and the Medication nurses felt responsible for signing them off because they couldn't have things not completed on the TAR at the end of their shift. She explained that there had been times in the past month when the medication nurses were told to do all the wound care because the Wound Nurse was behind and had orders and documentation to complete. LPN #4 explained that she was working this past weekend (1/27 and 1/28), so she went to the Wound Nurse on Thursday 1/25/24 because she saw that Resident #52's coccyx order had been discontinued in the computer. She revealed that she was told by the Wound Nurse that the order had been discontinued and not to worry about it. She explained that the Wound Nurse never checked in the computer system when she asked her or got up from what she was doing at the time, she simply stated it had been discontinued. She revealed that the order to apply Santyl to the coccyx continued to come up on the TAR, so she applied Santyl to the wound on the coccyx, but did not apply a cover dressing because it was not ordered. She revealed that she was confused because she knew the resident did have a treatment order and all of a sudden, it stopped. She revealed that even when she followed behind the Wound Nurse the last couple of weeks, Resident #52 never had a dressing on his coccyx. LPN #4 stated when she said something again to the Wound Nurse about the wound not having a dressing, she stated, "It's been discontinued" and acted like it wasn't a big deal. LPN #4 explained that she knew the wound should be covered to keep out urine and feces, because the resident was incontinent, which could cause infection and slow the healing of the wound. She stated that she had never been given a list or left a list of the residents with wounds and treatments for the

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weekend. She explained that this past Sunday, 1/28/24 they didn't find out that they didn't have a Wound Care Nurse until 1PM and her shift was over at 3PM and she wasn't sure who did the wound care that day.

An interview with the Assistant Director of Nursing (ADON) on 1/31/24 at 10:05 AM revealed that the facility had not had a consistent Wound Care Nurse for the past 6 months. The ADON stated that she filled in for the Wound Nurse position for about a month until the current Wound Nurse could transfer from the night shift position. The ADON stated that things were behind as far as documentation on the facility wounds, and the Wound Nurse had to get all the information up to date. She revealed that she had not had any concerns regarding the Wound Nurse and felt as if she did a good job. She confirmed that the Wound Nurse had not had any wound care training after switching from the night shift supervisor role to the wound care role in January. She revealed that the Wound Nurse brought a list of the wounds to the last Quality Assurance and Performance Improvement (QAPI) meeting held this month, where the wounds were discussed. She revealed that the facility just QAPI'd the wounds back in December 2023 after the other Wound Nurse left and all the orders were compared to the NP orders versus the Treatment Administration Record (TAR) and verified accuracy by 12/27/23. She confirmed that Resident #52's treatment order for the coccyx had been discontinued on 1/12/24 unintentionally by a staff member. She confirmed that she was not aware that the Wound Nurse was not utilizing the TAR to complete the wound care each day that she would have caught that the order was discontinued if she had looked at the TAR and

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M 615	Continued From page 59 signed off after the treatment was provided. She revealed she was not sure how the nurses on the weekends were providing wound care. A telephone interview with the Wound Nurse Practitioner on 1/31/24 at 3:40 PM revealed she rounds on all the facility wounds every Wednesday and during her visits she makes recommendations for wound care, but the facility does not receive the progress note until Friday evening when it's faxed over, but that when she makes rounds with the Wound Nurse she gives verbal orders. She revealed some of her recommendations may be delayed because certain orders must go through the resident's primary care provider (PCP) or dialysis, such as antibiotics or pain medication if the resident is on dialysis. She confirmed she was aware of the delay in antibiotics that were ordered on 01/24/24 for Resident #103 because it had to be approved with the PCP due to high risk of drug nephrotoxicity but she assumed that the antibiotic order had been implemented by now, and confirmed that she had not been made aware that the resident still did not have an order for an antibiotic. She stated that she was not made aware that Resident #52's coccyx treatment order had been discontinued on 1/12/24. She stated that lack of a dressing to the coccyx wound could cause delay in healing and infection. She revealed that she had not been made aware of any concerns regarding the Wound Nurse not performing her duties or following physician orders. She confirmed that if the treatments were not done as ordered, the wounds would deteriorate. An interview with the Assistant Director of Nursing (ADON) on 2/01/24 at 11:25 AM revealed she had	M 615		

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not been made aware of any concerns from the Medication Nurses related to wound care. She explained, to her knowledge, the Medication Nurses had never been asked to perform treatments, so the Wound Nurse could catch up on orders or documentation. She confirmed that the nurses should not sign off on treatments that the Wound Nurse performed, and they had never been told to do so. She explained that she had never pulled the TAR to check and see who signed off on the treatments. She explained that she felt the Wound Nurse got caught up in the day-to-day processes and just didn't make sure things were done. She revealed that she was not aware of a list that was left on the weekends to know which residents needed wound care. She stated the wound care should be administered from the TAR and signed off when completed. She explained that the facility did have a call in Sunday 1/28/24 with the person who was suppose to do the wound care and stated the Director of Nursing (DON) would have been responsible for letting the Unit Managers know.

An interview with the Director of Nursing (DON) on 2/1/24 at 4:35 PM revealed that she and the Administrator (ADM) had spoken with the Wound Nurse about taking the Wound Care position when the job opened. She stated that the Wound Nurse had performed the treatments before in the facility when she was first hired, and she was knowledgeable, and she felt the Wound Nurse did a good job. She stated the Wound Nurse was full-time and worked Monday through Friday, so she wasn't sure why she told the medication cart nurses that she was just part time. She revealed that the only thing that had changed since the Wound Nurse did previous treatments was, they hired a new Wound Nurse Practitioner (NP). She revealed that the NP caused the delay because

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she sent the orders/progress notes over to the facility later in the week after she visited the residents. She confirmed that the Wound Care Nurse could have implemented the physician order when the NP visited because she was giving the verbal order, which could have been added as a verbal physician's order. She stated, "If you are given an order, you should implement that order." She revealed the Wound Nurse should have signed the treatments after they were administered, just like with giving medication. She explained that she was not aware of the Wound Nurse telling the Medication Nurses that they were required to do treatments because she was behind with orders/documentation. She stated, "She could have because I'm not out there on the floor." The DON revealed that the Wound Nurse had not been giving any wound training or expectations since she accepted the Wound Care Nurse position in January and stated, "We just trusted her that she knew what she was doing." She revealed all the nurses were checked off on clean dressing changes, but that was the extent of the wound care training that the facility did.

Record review of Quality Assurance and Performance Improvement (QAPI) meeting minutes dated 1/12/24 revealed, "Wound Care ... 100% audit. Wound Care nurse resigned. New Wound care nurse starts 1/1/2024" completed 12/27/23 with a status of Ongoing.

Record review of "Skills Competency Assessment: Clean Dressing Change" revealed the wound nurse completed the training on hire (9/8/21).

Record review of the "Skills Competency

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M 615	Continued From page 62 Assessment: Clean Dressing Change" dated 7/11/23 revealed under, " ... 26. Document in the medical Record (TAR) (Treatment Administration Record) after completion of dressing change document findings in the nurse's notes and / or contact the physician when indicated ..." The Wound Nurse completed this training on 7/1/23. Record review of the "Education In-service Attendance Record" dated 5/1/23-5/5/23 revealed an in-service was conducted on wounds and skin sweeps and the Wound Care Nurse was in attendance. Record review of the "Freedom from Abuse Notice to Employees" revealed," ... Neglect includes, but is not limited to lack of care and supervision and unmet physical, social, emotional, spiritual, or medical needs." ... The Wound Care Nurse signed the notice on 7/11/23. Record review of the facility's "Performance Evaluation" revealed the Wound Care Nurse read and signed acknowledgment of the job description and duties assigned dated 11/04/19, 9/07/21 and 9/7/23 which revealed, " ... 8. Complete required documentation in an accurate and timely manner ...." was a requirement. Resident #269 An observation and interview with the NP and the Wound Care Nurse on 01/31/24 at 12:00 PM of wound care for Resident #269 confirmed that the resident has a Stage 4 Pressure Ulcer to her Sacrum/Coccyx area. The wound care nurse removed a duoderm from the resident's coccyx area. There was a large amount of fresh brown stool inside the residents wound. RN#1 cleaned the wound with 1/4 strength Dakins solution, packed the wound with ¼ strength Dakins	M 615		

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moistened gauze and covered with Duoderm. The Wound NP confirmed that the pressure ulcer is in an area that is very hard to keep a dressing on and to keep clean when the resident has a bowel movement. The dressing was not completely sealed across the bottom due to being in between the folds of the buttocks. The Wound Nurse Practitioner was asked if the order for the wound care may benefit by having the wound care as needed (PRN) after each bowel movement and daily would work better due to the wound covering not sealing well and the potential for stool to get into the wound and she replied, "They check on her often to make sure that she has not had a bowel movement". The wound was measured by Wound Nurse Practitioner revealing measurements 5cm x 5.4cm x 2.2cm. There is undermining of the wound at 10 to 2 maximum depths of 2.4 cm.

Wound Nurse Practitioner was unable to determine when Osteomyelitis to the Sacrum/Coccyx pressure ulcer began and replied, "I don't believe it will ever close completely, the goal is to keep infection out of the wound."

Record review of the Order Summary Report revealed that the current treatment order was to cleanse stage 4 sacrum with ¼ strength Dakin's, pack with ¼ strength Dakin's moistened gauze and cover with foam bordered dressing.

Record review revealed documentation from Wound Nurse Practitioner on 09/20/23 that the resident was less talkative and appeared to not feel well and wound has bone exposure and an x-ray was ordered with the visit to rule out Osteomyelitis.

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M 615	Continued From page 64 Wound Nurse Practitioner visit note on 09/27/23 revealed, "Nurse Practitioner to follow up with x-ray and final culture report". Wound Nurse Practitioner visit note on 10/04/23 revealed "an x-ray was ordered with a previous visit and is pending." Wound Nurse Practitioner visited again on 10/11/23, 10/18/23, 10/25/23, 11/01/23, 11/08/23, 11/15/23,11/30/23, 12/06/23, 12/13/23, and 12/27/23 and continued to document that the Xray was pending. Wound Nurse Practitioner visit note on 01/03/24 revealed "a recent x-ray indicated Osteomyelitis and a midline was placed and the patient is currently receiving Meropenem with recommendations for IV course of antibiotics for a minimum of six weeks", and for patient to be started on probiotic for duration of antibiotic use. An interview, on 01/31/24 at 4:00 PM with Wound Nurse Practitioner confirmed that she was aware that the x-ray that she ordered on 09/20/23 to rule out Osteomyelitis was not acted upon and done until 12/27/23. Wound Nurse Practitioner stated she had not reported to the Director of Nursing or the Assistant Director of Nursing (ADON) that the x-ray had not been performed at any point between the order date of 09/20/23 and the x-ray date of 12/27/23. The Wound NP stated, "I would have started the IV whenever the x-ray was gotten if it had showed Osteomyelitis." The NP confirmed that the failure of the facility to treat an infection timely could have brought about sepsis or even death for this resident. An interview on 02/01/24 at 8:45 AM with the Administrator confirmed that it is the expectation that the Wound Nurse Practitioner notify the Director of Nursing or Assistant Director of Nursing ADON if there is a problem with wounds and if she sees her orders are not being implemented.	M 615		

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M 615	Continued From page 65 An interview on 02/01/24 at 9:50 AM with Assistant Director of Nursing confirmed that the Wound Nurse Practitioner did not make her aware that the x-ray she ordered on 09/20/23 had not been completed. The ADON stated she found the x-ray order on 12/27/23 had not been done on an audit that she had completed. The ADON confirmed that she immediately called the doctor and got the x-ray ordered and made both the Wound Nurse Practitioner and the Facility Nurse Practitioner aware that the x-ray order had not been completed. She confirmed that the Wound Nurse Practitioner should have reported that the x-ray was not followed through to her or the Director of Nursing immediately, but that she failed to do that. An interview on 02/01/24 at 10:06 AM with Licensed Practical Nurse (LPN) #5 confirmed that she is the primary nurse for Resident #269 and was unaware that the Wound Nurse Practitioner had ordered an x-ray on 09/20/23. LPN #5 stated, "She doesn't tell us anything about the wounds when she sees them." LPN #5 confirmed that the pressure ulcer is in a location that is hard to keep dressings on and that's why they change it every day. An interview on 02/01/24 at 10:15 AM with RN #3, Unit Manager confirmed that she was not aware that there was an order for an x-ray on Resident #269 on 09/20/23. RN #3 confirmed that new orders are reviewed each morning in their stand-up meeting and that she never saw an order come through for Resident #269 for an x-ray. Review of the face sheet for Resident #269 revealed that the resident was admitted to the	M 615		

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facility on 12/23/22 with a diagnosis of Heart Failure, Local Infection of the skin and subcutaneous tissue, Pressure Ulcer of Sacral Region Stage 4, Rhabdomyolysis, and chronic kidney disease.

A review of the Minimal Data Set (MDS) with an Assessment Reference Date (ARD) of 11/13/23 revealed a Brief Interview for Mental Status (BIMS) score of 07 which indicated Resident #269 was cognitively impaired.

The facility submitted the following acceptable Removal Plan on 2/5/24:

Treatment Nurse was suspended by the Executive Director on 2/1/2024 at 1:00 pm and terminated on 2/1/2024 at 6:43 pm. Treatment Nurse was reported to the Mississippi Board of Nursing on 2/1/2024 at 6:32 pm related to not following professional standards of practice.

On 1/31/2024 Assistant Director of Nurses initiated education with 5 Housekeeping employees, 6 Therapist, 4 Dietary employees, 8 Certified Nursing Assistants, 6 office staff, 5 Licensed Practical Nurses and 5 Registered Nurses on Abuse and Neglect with emphasis on following physician orders and timely implementation and documentation of medical treatments of wounds and diabetic ulcers. Employees will be educated prior to accepting an assignment. New hires will be in-serviced on "Abuse and Neglect" during orientation. Employees will be educated prior to accepting an assignment.

On 1/31/2024 the Regional Director of Clinical

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M 615	Continued From page 67 Services (RDCS) conducted a verbal review of clean dressing change competency with return verbalization from Treatment Nurse RN, RN #1, RN #2, RN #3, RN #4, and Assistant Director of Nurses. On 1/31/2024 at 9:00 pm Assisted Director of Nurses initiated education with 5 Registered Nurses and 6 Licensed Practical Nurses on "Medication Administration and Documentation". Employees will be educated prior to accepting assignments. On 1/31/2024 at 5:40 pm the Regional Director of Clinical Services (RDCS) conducted education with the Treatment Nurse on "Skin and Wound Guidelines", "Medication Administration and Documentation", "Abuse and Neglect", and "Following Physician Orders" and "Clean Dressing Change" checklist was reviewed verbally with return verbalization. Education included following the physician order when administering treatments, administering treatment timely, nurse that administers treatment is to sign the electronic administration record that treatment was administered, ensure all skin impairments and pressure ulcers have a physician order for treatment. Employees will be educated prior to accepting assignments. On 1/31/2024 at 1:08 pm Resident #52 received new physician orders to clean the stage 3 pressure ulcer of the coccyx with Dakin's, pat dry, apply Santyl to the wound bed at nickel thickness, cover with foam bordered dressing every day. PRN order for soilage\dislodgement. Resident #103 received new physician orders on 1/31/2024 at 2:02 pm to clean diabetic ulceration between 3rd through 5th toes on left foot with normal saline, pat dry, thread xeroform between toes,	M 615		

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cover with dry dressing, wrap with kerlix, and secure with tape every day. PRN order for soilage/dislodgement. Order for clean left great toe blister site with normal saline, pat dry, apply Santyl to wound bed at nickel thickness, cover with dry gauze or ABD pads, wrap with kerlix, and secure with tape every day. PRN order for soilage/dislodgement. No new orders for Resident #269.

On 1/31/2024 at 5:05 pm body audits were initiated by Registered Nurse (RN) #1, RN #2, RN #3, RN #4, and Assistant Director of Nurses to identify skin impairment or pressure ulcers. There were 108 body audits completed and 7 refused. No new pressure ulcers or diabetic ulcers identified on the body audits conducted. Audit conducted on the 7 residents refusing body audit to determine any previous skin concerns. No areas of concern were identified.

On 1/31/2024 at 9:00 pm Assisted Director of Nurses initiated education with 6 Licensed Practical Nurses, 5 Registered Nurses, and 23 Certified Nurses Assistants on "Skin and Wound Guidelines". Employees will be educated prior to accepting assignments.

On 1/31/2024 at 9:00 pm Assisted Director of Nurses initiated education with 7 Registered Nurses and 10 Licensed Practical Nurses on "Following Physician Orders". Employees will be educated prior to accepting assignments.

On 1/31/2024 at 8:30 pm Assistant Director of Nurses reviewed physician orders and wound Nurse Practitioner progress notes consisting of diabetic ulcers, pressure ulcers, and skin concerns in the electronic health record (EHR) to ensure physician orders were implemented for 12

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M 615	Continued From page 69 of 12 residents. No discrepancies were identified. On 1/31/2024 at 5:40 pm the Regional Director of Clinical Services (RDCS) conducted education with the Treatment Nurse on "Skin and Wound Guidelines", "Medication Administration and Documentation", "Abuse and Neglect", and "Following Physician Orders" and "Clean Dressing Change" checklist was used with demonstration and return demonstration. DON and ADON are completing treatments as ordered Monday through Friday until treatment nurse position is filled, and treatment nurse is trained on the skills and expectations of the facility. All dayshift nurses who have completed the skills competency for wound care will provide dressing changes on the weekends. Director of Nurses and Assistant Director of Nurses are checking orders daily to ensure orders have been updated in electronic health records for nurses to complete on weekends. On 2/1/2024 at 2:00 pm Regional Vice President of Operation conducted education with Administrator on Abuse and Neglect with emphasis on thorough investigations and reporting guidelines. On 2/1/2024 at 2:30 pm the facility initiated a monitoring tool to check skin concerns, diabetic foot ulcers, pressure ulcers for appropriate orders to treat issues identified. The facility will ensure compliance with all wound care orders for accuracy daily by the Director of Nursing and Assistant Director of Nursing. QAPI: On 1/31/2024 at 7:00 PM a Quality Assurance Performance Improvement (QAPI) Committee meeting was held to review the Immediate	M 615		

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M 615	Continued From page 70 Jeopardy template for F 600 Free from Abuse and Neglect, F 686 Treatment /Services to Prevent /Heal Pressure Ulcers, F 726 Competent Nursing Staff and F 658 services Provided Meet Professional Standards and to determine Root Cause Analysis. It was determined through Root Cause Analysis the facility failed to provide approved wound care treatment for Resident #52 and Resident #103 related to failure of the treatment nurse to obtain orders to treat from the provider. The facility failed to provide training and competency skills to the Treatment Nurse to ensure she had adequate knowledge to provide care and services to residents with skin concerns and pressure ulcers and failed to provide the treatment and services to promote healing of pressure ulcer wounds and diabetic ulcers which resulted in delay of healing of pressure ulcers and diabetic ulcers due to change in position and employment status. Attendees were the Executive Director (ED), Minimum Data Service (MDS) Nurse, Medical Record Clerk (MRC), Regional Director of Clinical Services (RDCS), Assistant Director of Nurses (ADON)/Infection Preventionist, Director of Nurses (DON), Nurse Practitioner (NP), and the Medical Director (MD). Director of Nurses (DON), Nurse Practitioner (NP), and Medical Director (MD) attended by phone. It was determined through Root Cause Analysis that the facility failed to provide professional standards of practice for documenting and providing medical treatments for wounds for Resident #52, Resident #103, and Resident #269. As a result, the facility's failure to provide treatment and services for wound care, failure to follow the standards of practice, failure to follow physicians' orders, and failure to provide training and competencies skills, the resident's wound healing was delayed, antibiotic orders were delayed, which resulted in worsening	M 615		

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M 615	Continued From page 71 wounds and a need for surgical consult to evaluate the need for amputation. The facility initiated a monitoring tool on 2/1/2024 to check skin concerns, diabetic foot ulcers, pressure ulcers for appropriate orders to treat issues identified. The facility will ensure compliance with all wound care orders for accuracy daily by the Director of Nursing and Assistant Director of Nursing. Weekly wound meeting will be held with Inter Disciplinary Team (IDT) to discuss outcomes and findings. Any adverse findings will immediately be reported to the Executive Director and physician by the Director of Nurses. This process will be on-going and reported to Quality Assurance Committee quarterly. A review of policy and procedures for "Abuse and Neglect", "Skin and Wound Guidelines", Medication Administration and Documentation", and "Following Physician Order" was reviewed, and no changes made to policies. All Corrective actions were completed by 2/1/2024 and the facility alleges removal of the Immediate Jeopardy as of 2/2/2024. The State Agency (SA) validated the facility's Removal Plan on 2/06/24: On 2/06/24, the SA validated through staff interviews and record reviews that the Treatment Nurse was terminated and reported to the Mississippi Board of Nursing on 2/1/24. On 2/06/24, the SA validated through staff	M 615		

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M 615	Continued From page 72 interviews and record review of the in-service sheet, that education was provided on Abuse and Neglect with emphasis on following physician orders and timely implementation and documentation of medical treatments of wounds and diabetic ulcers. The SA validated through interviews and record reviews that employees will be educated prior to accepting assignments and new hires will be educated during orientation. On 2/06/24, the SA validated through staff interviews and record review that a verbal review of a clean dressing change was conducted for the Treatment Nurse RN, RN #1, RN #2, RN #3, RN #4, and Assistant Director of Nursing. On 2/06/24, the SA validated through in-services sign in sheets and staff interviews that education was conducted on Medication Administration and Documentation. The SA validated through staff interviews and record reviews that all employees will be educated prior to accepting assignment. On 2/06/24, the SA validated through record reviews that education was conducted for the Treatment Nurse on Skin and Wound Guidelines, Medication Administration and Documentation, Abuse and Neglect, Following Physician Orders, and Clean Dressing Change. The SA validated through staff interviews and record review that all employees will be educated prior to accepting assignments. On 2/06/24, the SA validated through record reviews that Resident #52 received a new physician order for pressure wound to the coccyx. Resident #103 received a new physician order for treatment of left great toe blister site and diabetic ulcerations between the 3rd through 5th toes on the left foot.	M 615		

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M 615	Continued From page 73 On 2/06/24, the SA validated through staff interview and record review of body audits, that 108 resident skin audits were conducted by Registered Nurse (RN) #1, RN #2, RN #3, RN #4, and the Assistant Director of Nursing, with no new skin impairments identified. The SA validated seven (7) residents refused with an audit conducted to determine if the seven (7) residents had any previous skin concerns on prior skin sweeps and no concerns were identified. On 2/06/24, the SA validated through staff interviews and record review through in-service sign in sheets, that education was provided to nurses and aides for Skin and Wound Guidelines. The SA validated all employees will be educated prior to accepting assignment. On 2/06/24, the SA validated the nurses were educated on Following Physician Orders. The SA validated all employees will be educated prior to accepting assignment. On 2/06/24, the SA validated through interviews and record review that Assistant Director of Nursing reviewed physician orders and wound Nurse Practitioner's progress notes for residents with skin concerns in the Electronic Health Record (EHR) to ensure physician orders were implemented for 12 of 12 residents with no discrepancies found. On 2/06/24, the SA validated through staff interviews and record review that the Director of Nursing (DON) and Assistant Director of Nursing (ADON) were completing treatments Monday through Friday until treatment nurse position was filled. The day shift nurses that have completed the skills competency will cover the weekends.	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	53SM	A. BUILDING: _____ B. WING _____	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 615	Continued From page 74 The SA validated through interviews that the DON and ADON were checking the orders daily to ensure orders have been updated in the Electronic Health Record (EHR). On 2/06/24, the SA validated through interviews that the Administrator received education on Abuse and Neglect with emphasis on thorough investigation and reporting that was conducted by the Regional Vice President. On 2/06/24, the SA validated through staff interviews and record review that the facility implemented a monitoring tool for skin concerns and to ensure orders are implemented to treat issues identified. The SA validated compliance with wound care orders will be monitored daily by the Director of Nursing and Assistant Director of Nursing. On 2/06/24, the SA validated on 1/31/24, a Quality Assurance and Performance Improvement (QAPI) meeting was held to review he cited deficient practice and determine the root cause analysis lacking appropriate interventions. In attendance were the Executive Director, Minimum Data Set (MDS), Medical Record Clerk, Regional Director of Clinical Services, Assistant Director of Nursing/Infection Preventionist, Director of Nursing, Nurse Practitioner, and the Medical Director. DON, NP, and MD attended by phone. On 2/06/24, the SA validated by staff interviews that a weekly wound meeting will be held with the Interdisciplinary Team (IDT) to discuss outcomes and findings of the new monitoring tool implemented for skin concerns and ensuring any new skin concerns has physician orders to treat issues identified. This process will be on-going	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 615	Continued From page 75 and reported to Quality Assurance Committee quarterly.	M 615		