

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

PRINTED: 03/01/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255172		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/06/2024	
NAME OF PROVIDER OR SUPPLIER STARKVILLE MANOR HEALTH CARE AND REHABILITATION CE				STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 1/29/24 through 2/06/24. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F600, F656, F657, F658, F677, F684, F686, F697, F726, F757, F761, and F851. 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 (PU) to the coccyx was seen by the Wound Nurse Practitioner (NP) and ordered an X-Ray of the coccyx to rule out Osteomyelitis. The X-Ray was not conducted until 12/27/23. The wound worsened The IJ and SQC existed at: 42 CFR§483.12 Freedom from Abuse, Neglect, and Exploitation - F600 - Scope/Severity "K" 42 CFR§483.25(b)(1) Pressure ulcers - F686 - Scope/Severity "K" IJ existed at: 42 CFR§483.21(b)(3)(i) Meet professional standards of quality - F658- Scope/Severity "K" The SA identified an IJ and SQC which began on 12/27/23 when the facility failed to monitor, act upon verbal orders, transcribe current orders to the Treatment Administration Record, and provide the ordered wound care for Resident #103.			F 000			

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

TITLE

(X6) DATE

Electronically Signed

02/28/2024

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

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F 000	Continued From page 1 IJ and SQC existed at: 42 CFR§ 483.25 Quality of care - F684 - Scope/Severity "J" IJ existed at: 42 CFR§483.35 Nursing Services - F726 - Scope/Severity "K" The facility Administrator was notified of the IJ and SQC on 01/31/24 at 4:50 PM and provided the IJ Templates. The facility provided an acceptable Removal Plan on 2/01/24, in which they alleged all corrective actions to remove IJ were completed on 02/01/24 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 2/02/24. Therefore, the scope and severity for 42 CFR§483.12 Freedom from Abuse, Neglect, and Exploitation - F600, 42 CFR§483.21(b)(3)(i) Meet professional standards of quality - F658, 42 CFR§483.25(b)(1) Pressure ulcers - F686, and 42 CFR§483.35 Nursing Services - F726 was lowered from a "K" to an "E", and 42 CFR§483.25 Quality of care - F684, was lowered from a "J" to a "D" 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. The census at the time of the survey was 116, and the facility held a license for 119 beds.	F 000			
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		3/8/24	

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F 600	Continued From page 2 §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: 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 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	F 600	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 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.		

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F 600	Continued From page 3 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 42 CFR 483.12 (a) Freedom from Abuse, Neglect, and Exploitation (F600) was lowered from a "K" to an "E", 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. Cross Reference: F658, F684, F686, F726 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 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	F 600	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 will conducted 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, 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		

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F 600	Continued From page 4 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 CROSS REFERENCE F658, F686 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 on her often to make sure that she has not had a bowel movement". The wound was measured by Wound Nurse Practitioner revealing	F 600	the monthly meeting for 6 months to ensure our solutions are sustained.		

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F 600	Continued From page 5 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, 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	F 600			

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F 600	Continued From page 6 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 wounds and if she sees her orders are not being	F 600			

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F 600	Continued From page 7 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.	F 600			

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F 600	Continued From page 8 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 CROSS REFERENCE F686, F726 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	F 600			

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F 600	Continued From page 9 daily and as needed for soilage/dislodgement..." 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.	F 600			

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F 600	Continued From page 10 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" 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 CROSS REFERENCE F684, F686, F726 During an observation and interview on 01/30/24 at 8:19 AM, Resident #103 revealed him lying in	F 600			

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F 600	Continued From page 11 bed, awake and alert. He stated he had a wound on his bottom and on his foot that caused him pain. 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 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	F 600			

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F 600	Continued From page 12 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 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	F 600			

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F 600	Continued From page 13 (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 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	F 600			

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F 600	Continued From page 14 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 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	F 600			

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F 600	Continued From page 15 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 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	F 600			

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F 600	Continued From page 16 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 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	F 600			

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F 600	Continued From page 17 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 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	F 600			

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F 600	Continued From page 18 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 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	F 600			

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F 600	Continued From page 19 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. 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	F 600			

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F 600	Continued From page 20 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 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			F 600			

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F 600	Continued From page 21 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 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	F 600			

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F 600	Continued From page 22 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." 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	F 600			

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F 600	Continued From page 23 /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 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	F 600			

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F 600	Continued From page 24 "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 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,	F 600			

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F 600	Continued From page 25 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 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.	F 600			

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F 600	Continued From page 26 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 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	F 600			

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F 600	Continued From page 27 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 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	F 600			

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F 600	Continued From page 28 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 (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	F 600			

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F 600	Continued From page 29 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 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			F 600			

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F 600	Continued From page 30 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 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	F 600			

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F 600	Continued From page 31 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 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 the 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,	F 600			

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F 600	Continued From page 32 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.	F 600			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		3/8/24	

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F 656	Continued From page 33 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to develop a care plan for a resident with wounds (Resident #103), and implement a care plan related to nail care and shaving for five (5) of twenty-four sampled residents. Resident #49, Resident #52, Resident #72, Resident #103, and Resident #105. Findings Include: Review of the facility policy titled, "Plans of Care", with a revision date of 9/25/2017, revealed it is the policy that an individualized person-centered care plan will be established by the	F 656	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 develop a care plan for residents with wounds for resident # 103 and implement a care plan related to nail care and shaving for residents #49, #52, #72, #103, and #105. ¿ Care plan was developed on 1/31/2024 for resident #103 related to wounds. 2. ¿ All residents have the potential to be affected by this deficient practice.		

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F 656	Continued From page 34 interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements. The procedure includes to Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions ...The individualized person centered care plan may include but is not limited to the following: Resident strengths and needs and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required by state and federal regulatory requirements. Resident #49 Record review of Resident #49's Care Plan Focus ...The resident has an Activities of Daily Living self-care performance deficit related to Limited Mobility, Musculoskeletal impairment, Gout... Interventions ...Personal Hygiene ...The resident requires extensive assistance by 1 staff member to perform oral hygiene and personal hygiene. During 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 his cheeks. Resident #49 revealed he would like to be shaved. Resident #49 stated "It's been a very long time since I was shaved." During an observation and interview on 01/30/24 at 11:45 AM, CNA #2 confirmed Resident #49 was shaved about a month ago and revealed his	F 656	3. On 2/2/2024 Minimum Date Set (MDS) Nurses conducted an Quality Review on facility process to develop and implement care plans for dependent residents related to nail care, shaving, and wounds. ¿ Education completed on 2/1/2024 with current Minimum Data Set (MDS) nurses by Director of Nurses on this regulation to ensure a comprehensive-person centered care plan is developed and implemented as per policy. On 2/1/2024 Director of Nurses initiated on-going education with licensed nursing staff and certified nursing assistants on ensuring a comprehensive-person centered care plan is developed and implemented as per policy. 4. ¿ Quality Assurance Improvement QAPI) meeting was held on 2/7/2024 to ensure all nail care, shaving, and wounds are care planned as per policy and implemented. MDS will conduct ongoing Quality Monitoring of care plans to ensure that a comprehensive-person centered care plan is developed and implemented for each resident 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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F 656	Continued From page 35 facial hair was long and he needed to be shaved. An interview on 01/30/24 at 3:55 PM, the Assistant Director of Nurses (ADON) confirmed the plan of care was not being followed regarding grooming the resident. She revealed the personal hygiene in the care plan includes shaving and the resident should be shaved each time he has a shower or a bed bath. An interview on 01/30/24 at 4:05 PM, the Minimum Data Set (MDS) nurse revealed the residents' care plans are to be individualized for each resident so the staff will know what they specifically need to do for each resident. She revealed the CNA's know they are supposed to do personal hygiene for the residents each day which includes shaving. She confirmed Resident #49's care plan was not being followed regarding personal hygiene. 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, gout, 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 with a Brief Interview for Mental Status (BIMS) score of 09 which indicated the resident has moderate cognitive impairment. Resident #72 Record review of Resident #72s Care Plan Focus ...The resident has an Activities of Daily Living	F 656			

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F 656	Continued From page 36 self-care performance deficit related to Dementia and Schizoaffective disorder...Interventions ...Bathing/Showering: Check nail length and trim/clean on bath day and as necessary. ...The resident requires substantial/maximal assist by staff member 3 times per week and as needed (PRN). During 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. During 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. An interview on 01/30/24 at 3:30 PM, the MDS nurse revealed on the resident's care plans doesn't list nail care, because they only put the nail care for those that are diabetic. She revealed under Resident #72 ADL care plan it would be personal hygiene. The aides know they are to do nailcare and shaving with personal hygiene. She confirmed that Resident #72's plan of care for grooming was not being followed. An interview on 01/30/24 at 4:02 PM, the ADON revealed under personal grooming and showering/bathing the CNA's should know that includes nail care unless it is specific for the nurses. She confirmed the ADL plan of care was not being followed for Resident #72. She revealed he should have had his nails cleaned and trimmed when he had his shower.	F 656			

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F 656	Continued From page 37 A record review of the Admission Record for Resident #72 revealed he was admitted to the facility on 10/07/2022 with diagnoses of Extrapryamidal and movement disorder and Major depressive disorder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of Dec 8, 2023, revealed Resident #72 with a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident is cognitively intact. Resident #105 Record review of Resident #105's Care Plan Focus ...The resident has an Activities of Daily Living self-care performance deficit... Interventions ... Bathing/Showering: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse... Personal/hygiene... The resident requires substantial/maximal assist by staff member 3 x (times) weekly and PRN. During 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. During an observation and interview on 01/30/24 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	F 656			

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F 656	Continued From page 38 I've been shaved." An interview with Registered Nurse (RN) #2 on 01/30/24 at 5:30 PM revealed the CNA's are responsible for ensuring Resident #105 is properly groomed. She revealed this includes shaving and his nails cleaned and trimmed. She confirmed that the plan of care for personal hygiene and nail care was not being followed and it should have been. 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 Record review of Resident #52's ADL (Activities of Daily Living) Care Plan revealed under, "BATHING/SHOWERING: Check nail length and clean on bath day and as necessary. Report any changes to the nurse." ... An observation on 01/29/24 at 12:04 PM, of Resident #52, revealed long nails on both hands measuring approximately three-eighths (3/8) inch in length. An observation and interview with the Director of Nursing (DON) on 1/30/24 at 12:30 PM, confirmed that Resident #52 had long nails that	F 656			

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F 656	Continued From page 39 needed cutting. An interview with the Assistant Director of Nursing (ADON) on 2/01/24 at 8:30 AM revealed the Care Plan provides individualized treatment for staff to know the basic needs and the specific needs of each resident. She confirmed the Care Plan was not followed for Resident #52's nail care. An interview with the Minimum Data Set (MDS) Nurse on 2/01/24 at 4:30 PM, revealed the purpose of the care plan was to give the staff a guide of what care should be done for the resident daily. She confirmed the care plan was not followed for Resident #52 and nail care. 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 an ARD of 11/30/23 revealed under section C, a BIMS summary score of 11, indicating Resident #52 is moderately cognitively impaired. Resident #103 Record review of Resident #103's Care Plans revealed a Care Plan was not developed for wounds to the left great toe and in between the 3rd through 5th toes on the left foot. Record review of the Weekly Skin Integrity Review for Resident #103 dated 1/30/24 revealed under, "Notes: wounds to right great toe... preexisting wound orders noted. Wounds	F 656			

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F 656	Continued From page 40 in-between left 3rd, 4th and 4th, 5th toes..." There was a discrepancy in wound documentation related to the right great toe. Resident #103 had documentation of a previous right great toe amputation. An interview with the Assistant Director of Nursing (ADON) on 1/31/24 at 10:05 AM, confirmed Resident #103 did not have an active care plan for wounds to the left great toe and in-between the left 3rd, 4th and 5th toes. An interview with the Minimum Data Set (MDS) Nurse on 2/01/24 at 4:30 PM, revealed the purpose of the care plan was to give the staff a guide of what care should be done for the resident daily. She revealed that every morning she pulled the active, discontinued and completed orders and updates the care plans. She confirmed that because Resident #103 did not have a physician order for wound care to the left great toe and between the toes she would not have known to care plan the problem. 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, 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 MDS with an ARD of 12/05/23 revealed under section C, a BIMS summary score of 13, which indicates Resident #103 is cognitively intact.	F 656			

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F 657 F 657 SS=D	Continued From page 41 Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and facility policy review, the facility failed to revise a resident's pain Care Plan to reflect the current pain management order for one (1) of twenty-four sampled residents. Resident #103 Findings Include:	F 657 F 657	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 revise resident #103 care plan to reflect the current pain management order. Care plan was revised on		3/8/24

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F 657	Continued From page 42 Review of the facility policy titled, "Plans of Care", with a revision date of 9/25/2017, revealed "It is the policy that an individualized person-centered care plan will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirement...Procedure... Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions..." Resident #103 Record review of Resident #103's Care Plans revealed, "I have the potential for pain/discomfort ..." and under, "Interventions ... Percocet Oral Tablet 5-325 MG (milligram) (Oxycodone w/(with) Acetaminophen) "Controlled Drug" Give 1 (one) tablet by mouth every 6 (six) hours as needed for Pain" ... An interview on 1/30/24 at 12:10 PM, with Licensed Practical Nurse (LPN) #2 revealed that Resident #103 had Norco 5/325 mg (milligrams) every eight (8) hours as needed for pain and had been taking it regularly since he had a toe amputated. An interview on 1/30/24 at 4:35 PM with the Director of Nursing (DON) revealed Resident #103 was taking Percocet after a recent toe amputation, but after the prescription was exhausted, the facility Nurse Practitioner (NP) changed him over to Norco 5/325 mg (milligrams). Record review of the January Medication	F 657	1/31/2024 for resident #103 related to pain management order by Minimum Data Set (MDS) nurse. 2. All residents have the potential to be affected by this deficient practice. 3. On 2/2/2024 Minimum Date Set (MDS) Nurses initiated Quality Review on facility process to determine residents receiving pain management have a current and accurate care plan to reflect current pain medication. Education completed on 2/1/2024 with current Minimum Data Set (MDS) nurses by Director of Nurses on this regulation to ensure all residents receiving pain management have a current and accurate care plan to reflect current pain medication as per policy. 4. Quality Assurance Improvement QAPI) meeting was held on 2/7/2024 to ensure all residents receiving pain medication care plans reflect the current pain management order. MDS will conduct ongoing Quality Monitoring of care plans to ensure that care plans are timely and revised according to physicians order for each resident 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		

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F 657	Continued From page 43 Administration Record (MAR) for Resident #103 revealed an order dated 10/12/23, "Hydrocodone-Acetaminophen oral Tablet 5-325 MG (milligram) Give 1 (one) tablet by mouth every 8 (eight) hours as needed for Pain" ... An interview on 2/01/24 at 8:30 AM with the Assistant Director of Nursing (ADON) revealed the Care Plan provides individualized treatment for staff to know the basic needs and the specific needs of each resident. She confirmed the Care Plan was not revised for Resident #103's active pain medication order. Record review of the Admission Record revealed Resident #103 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 from Left Middle Cerebral Artery, Pressure Ulcer Left Heel, Stage 3, Pain Unspecified, End Stage Renal Disease, and Dependence on Renal Dialysis. Record review of Resident #103's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/5/23 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 13, which indicates the resident is cognitively intact.	F 657	solutions are sustained.		
F 658 SS=K	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658		3/8/24	

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F 658	Continued From page 44 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on state Nurse Practice Standards, observation, staff interview, record review, and facility policy review, the facility failed to follow the professional standards of practice for documenting and providing medical treatments for wounds for three (3) of five (5) wound observations. Resident #52, Resident #103 and Resident #269. The facility's failure to follow standards of practice by failing to implement and follow physician orders for wound care and treatments caused serious harm to Resident #52, Resident #103 and Resident #269 and placed all other residents who are at risk for skin breakdown at risk for 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.	F 658	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 provide professional standards of practice for documenting and providing medical treatment of wounds 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 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 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,		

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F 658	Continued From page 45 The Survey Agency (SA) validated the Removal Plan on 2/06/24 and determined the Immediate Jeopardy (IJ) was removed on 2/02/24. Therefore, the scope and severity for CFR 483.12 Freedom from Abuse, Neglect, and Exploitation, CFR 483.21(b)(3)(i) Meet professional standards of quality, CFR 483.25 Quality of care, CFR 483.25(b)(1) Pressure ulcers, and CFR 483.35 Nursing Services, will be lowered to a "E", 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: CROSS REFERENCE F684 Review of the facility policy titled 'LTC Facility's Pharmacy Services and Procedures Manual' with a revision date of 1/01/22 revealed under,"8.3 Facility staff should immediately record the new orders in the resident's medical record and medication administration record. ... Also revealed under, "13.5 Facility should ensure that the person receiving a verbal order immediately records it in the resident's chart or electronic order system ..." Mississippi Board of Nursing; Source: Miss. Code Ann. § 73-15-17 (1972, as amended) read: Rule 2.2 Responsibility. The LPN shall be responsible and accountable for: A. Knowledge of and compliance with the laws and regulations governing the practice of nursing in the State of Mississippi. B. Practicing within the scope of practice as	F 658	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 assignment. 4. ¿Quality Assurance Improvement QAPI) meeting was held on 1/31/2024 to ensure all staff understands the policy and procedures of professional standards of practice for documenting and providing medical treatment of wounds. On 2/1/2024 Director of Nurses and Assistant Director of Nurses will conduct ongoing Quality Monitoring for all licensed nursing staff to ensure professional standards of care with emphasis on documentation and providing medical treatments of wounds are met per policy prior to accepting shift 4 x weekly for 4 weeks, 3 x weekly for 3 weeks, then 1 x weekly for 3 weeks, and monthly x 6 months. 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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F 658	Continued From page 46 established by the Board and according to generally accepted standards of practice. C. Accepting responsibility for individual nursing actions, competence, decisions and behavior in the course of nursing practice. Source: Miss. Code Ann. § 73-15-17 (1972, as amended). 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 an order dated 12/29/23 on Resident #52's January 2024 Treatment Administration Record (TAR) that read, "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. An order dated 1/18/24 on Resident #52's Order Summary Report revealed , "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" ... 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	F 658			

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F 658	Continued From page 47 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 which was not the current order. An observation 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 that she did not follow the latest wound care orders by failing to apply the prescribed hydrogel to the left heel wound. 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. Record review of the Admission Record revealed Resident #52 was admitted to the facility 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.	F 658			

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F 658	Continued From page 48 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. 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 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 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	F 658			

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F 658	Continued From page 49 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. 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 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 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	F 658			

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F 658	Continued From page 50 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 (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 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	F 658			

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F 658	Continued From page 51 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. Also revealed under section M, diabetic foot ulcer(s) were not checked for the MDS look back period. Resident #52 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, first starting out as the Wound Nurse, then transferred over to the night shift supervisor and filling in on the medication cart. 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 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	F 658			

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F 658	Continued From page 52 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 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 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. The interview with the Wound Care Nurse on 1/31/24 at 9:45 AM also revealed that Resident #103's left great toe wound continued to worsen, with new ulcers that developed in between the toes. 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 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. 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." During the interview with the Wound Care Nurse	F 658			

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F 658	Continued From page 53 on 1/31/24 at 9:45 AM, 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 the Assistant Director of Nursing (ADON) on 1/31/24 at 10:05 AM revealed that 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 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 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 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			F 658			

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F 658	Continued From page 54 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 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 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	F 658			

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F 658	Continued From page 55 wounds would deteriorate. 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 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 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	F 658			

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F 658	Continued From page 56 that she knew the wound should be covered to keep out urine and feces, because the resident was incontinent. 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. 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 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	F 658			

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F 658	Continued From page 57 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 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.	F 658			

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F 658	Continued From page 58 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 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.	F 658			

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F 658	Continued From page 59 Complete required documentation in an accurate and timely manner" was a requirement. Resident #269 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 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." NP was asked if the treatment for the Osteomyelitis was delayed because the x-ray was not obtained when it was ordered on	F 658			

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F 658	Continued From page 60 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 or Assistant Director of Nursing ADON if there is a problem with wounds and if she sees her orders are not being implemented. 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 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 10:15 AM with RN #3, Unit Manager confirmed that she was not aware that there was an order for an x-ray on Resident	F 658			

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F 658	Continued From page 61 #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 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: Brief Summary of Events: On 1/31/2024 at 4:50 pm 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 4:50 pm by the State Agency (SA).	F 658			

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F 658	Continued From page 62 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 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 Assisted Director of	F 658			

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F 658	Continued From page 63 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, 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	F 658			

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F 658	Continued From page 64 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 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	F 658			

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F 658	Continued From page 65 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 competency skills to the Treatment Nurse to ensure she had adequate knowledge to provide care and services to	F 658			

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F 658	Continued From page 66 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 (IDT) to discuss outcomes and findings. Any adverse findings will immediately be reported to the Executive Director and physician by the	F 658			

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F 658	Continued From page 67 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 Treatment Nurse RN, RN #1, RN #2, RN #3, RN #4, and Assistant Director of Nursing.	F 658			

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F 658	Continued From page 68 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 interviews and record review through in-service sign in sheets, that education was provided to	F 658			

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F 658	Continued From page 69 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 implemented a monitoring tool for skin concerns	F 658			

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F 658	Continued From page 70 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.	F 658			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident	F 677	1.¿Root Cause Analysis was conducted		3/8/24

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F 677	Continued From page 71 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 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	F 677	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) 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		

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F 677	Continued From page 72 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. 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.	F 677	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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F 677	Continued From page 73 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 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	F 677			

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F 677	Continued From page 74 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 Extrapramidal 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 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	F 677			

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F 677	Continued From page 75 #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. 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	F 677			

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F 677	Continued From page 76 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-eighths (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 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	F 677			

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F 677	Continued From page 77 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.	F 677			
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review,	F 684	1. Root Cause Analysis was conducted	3/8/24	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/06/2024
NAME OF PROVIDER OR SUPPLIER STARKVILLE MANOR HEALTH CARE AND REHABILITATION CE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 HOSPITAL ROAD STARKVILLE, MS 39759		
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F 684	Continued From page 78 and facility policy review, the facility failed to provide treatment and services to promote the healing of wounds for one (1) of five (5) wound care observations. Resident #103 The facility's failure to implement and follow physician orders for wound care and treatments put Resident #103 and all other residents who are at risk for skin breakdown at risk for serious harm, injury, impairment, or death. The State Agency (SA) determined the situation to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 12/27/23 when Resident #103 developed a bruised area to the left great toe that deteriorated and became a bruised/blood blister covered in eschar (dead tissue) by 1/24/24. The facility failed to act upon verbal orders resulting in delay in treatment, failed to transcribe these orders into the medical record, and provide treatment for Resident #103's wounds according to the Wound Nurse Practitioner's orders. 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 2/02/24. Therefore, the scope and severity for 42 CFR 483.25 Quality of Care was lowered from a "J" to a "D", while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains	F 684	by Quality Assurance Performance Improvement (QAPI) Committee on 1/31/2024 and based on findings the facility failed to provide treatment and services to promote the healing of wounds for one of five wound care observations for resident #103. 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 assignment. 4. Quality Assurance Improvement QAPI) meeting was held on 1/31/2024 to ensure		

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F 684	Continued From page 79 compliance with regulatory requirements. CROSS REFERENCE F600, F658, F726 Findings Include: Record review of the facility policy titled "Skin and Wound" with a revision date of 1/24/22 revealed, "Policy: To provide a system for identifying risk, and implementing resident centered interventions to promote skin health, prevention and healing of pressure injuries...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 #103 An observation of wound care for Resident #103, with the Wound Nurse on 1/30/24 at 3:55 PM, revealed removal of 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 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.	F 684	all staff understands the policy and procedures of providing treatment and services to promote the healing of wounds. Director of Nurses and Assistant Director of Nurses will conduct ongoing Quality Monitoring for all residents with wounds to ensure compliance with all wound care orders for accuracy 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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F 684	Continued From page 80 Record review of the January 2024 Treatment Administration Record (TAR) for Resident #103 revealed there was not a Physician's order for wound care for 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 Physician Order Details in the Wound Nurse Practitioner notes for Resident #103 dated 1/24/24 revealed the following orders were not transcribed to the TAR and were not followed during the wound care observation on 1/30/24 with the Wound Nurse, "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 boggiess 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."	F 684			

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F 684	Continued From page 81 An observation of wound care for Resident #103, with the Wound Nurse on 1/30/24 at 3:55 PM, revealed removal of 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 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 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. On 1/30/24 at 3:50 PM, an interview with the Wound Nurse revealed Resident #103 has 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. Record review of the Wound Nurse Practitioner Progress Note Details dated 12/27/23 for	F 684			

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F 684	Continued From page 82 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 ... "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 from the Wound NP notes for Resident #103 dated 1/10/24 revealed, "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..." This order was not transcribed to the TAR. 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	F 684			

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F 684	Continued From page 83 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. On 1/31/24 at 9:45 AM, an interview and record review with the Wound Care Nurse 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 that she worked Monday-Friday and had been doing all the wound care in the facility on those days. 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 already signed off on the orders 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	F 684			

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F 684	Continued From page 84 to it. She explained that Resident #103's left great toe wound developed as a dry piece of skin that has continued to worsen, with new areas 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 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. Record review of the January 2024 Medication Administration Record (MAR) revealed the Clindamycin order was not implemented. 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	F 684			

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F 684	Continued From page 85 treating the infection. She revealed that delay of treatment could result in possible infection, sepsis, or amputation for Resident #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 off on the TAR if she completed the treatments. On 1/31/24 at 10:05 AM, an interview with the Assistant Director of Nursing (ADON) confirmed that she was not aware that the Wound Nurse was not utilizing the TAR to complete the wound care each day. She stated the Wound Nurse would have caught that there wasn't a physician's order for care for Resident #103 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 or if they even were since there was nothing on the TAR for the resident. On 1/31/24 at 3:40 PM, a telephone interview with the Wound Nurse Practitioner 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. She stated 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	F 684			

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F 684	Continued From page 86 nephrotoxicity but she assumed that the antibiotic order had been implemented by now. She 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 Ankle Brachial Index (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 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. On 2/01/24 at 11:25 AM, an interview with the ADON 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	F 684			

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F 684	Continued From page 87 that she had never pulled the TAR to check and see who signed off on the treatments or if all the physicians orders for wounds were on the TAR. 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. On 2/1/24 at 4:35 PM, an interview with the Director of Nursing (DON) 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. 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." Record review of the "Skills Competency 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 facility's "Performance Evaluation" revealed the Wound Care Nurse read	F 684			

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F 684	Continued From page 88 and signed acknowledgment of the job description and duties assigned dated 9/7/23 which revealed, " ... 8. Complete required documentation in an accurate and timely manner" was a requirement. 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, 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. The facility submitted the following acceptable Removal Plan on 2/5/24: Brief Summary of Events: On 1/31/2024 at 4:50 pm 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 4:50 pm by the State Agency (SA). The facility failed to follow the physician's orders for wound care, failed to provide training and			F 684			

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NAME OF PROVIDER OR SUPPLIER STARKVILLE MANOR HEALTH CARE AND REHABILITATION CE			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 HOSPITAL ROAD STARKVILLE, MS 39759		
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F 684	Continued From page 89 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 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	F 684			

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F 684	Continued From page 90 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, cover with dry dressing, wrap with kerlix, and secure with tape every day. PRN order for soilage\dislodgement. Order for clean left great	F 684			

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F 684	Continued From page 91 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 of 12 residents. No discrepancies were identified.	F 684			

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F 684	Continued From page 92 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 Jeopardy template for F 600 Free from Abuse	F 684			

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F 684	Continued From page 93 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	F 684			

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F 684	Continued From page 94 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 interviews and record review of the in-service			F 684			

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F 684	Continued From page 95 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.			F 684			

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F 684	Continued From page 96 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	F 684			

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F 684	Continued From page 97 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 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	F 684			

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F 684	Continued From page 98 new skin concerns has physician orders to treat issues identified. This process will be on-going and reported to Quality Assurance Committee quarterly.	F 684			
F 686 SS=K	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: 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.	F 686	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	3/8/24	

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F 686	Continued From page 99 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 2/02/24. Therefore, the scope and severity for 42 CFR 483.25(b)(1)(i)(ii) Pressure Ulcers was lowered from a "K" to a "E", 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: CROSS REFERENCE F600, F658, F726 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	F 686	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 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		

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F 686	Continued From page 100 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 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.	F 686	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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F 686	Continued From page 101 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 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.	F 686			

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F 686	Continued From page 102 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 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	F 686			

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F 686	Continued From page 103 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 (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	F 686			

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F 686	Continued From page 104 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 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	F 686			

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F 686	Continued From page 105 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." ... 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	F 686			

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F 686	Continued From page 106 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 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	F 686			

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F 686	Continued From page 107 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. 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)" ...	F 686			

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F 686	Continued From page 108 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 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.	F 686			

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F 686	Continued From page 109 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 (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.	F 686			

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F 686	Continued From page 110 Record review of the Progress Note Details dated 12/27/23 for Resident #103 revealed under, "There is also a 0.8 x 1.5 x 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." ... 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	F 686			

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F 686	Continued From page 111 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 boggiess 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 cognitively intact. Also revealed under section M, diabetic foot ulcer(s) were not checked for the MDS look back period.	F 686			

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F 686	Continued From page 112 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 a list of the residents with wounds so that the nurses will know whom to perform wound care	F 686			

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F 686	Continued From page 113 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 resident was on dialysis, so the resident was not	F 686			

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F 686	Continued From page 114 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	F 686			

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F 686	Continued From page 115 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	F 686			

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F 686	Continued From page 116 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 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	F 686			

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F 686	Continued From page 117 that 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. 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.	F 686			

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F 686	Continued From page 118 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 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	F 686			

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F 686	Continued From page 119 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 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	F 686			

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F 686	Continued From page 120 Assessment: Clean Dressing Change" revealed the wound nurse completed the training on hire (9/8/21). Record review of the "Skills Competency 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	F 686			

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F 686	Continued From page 121 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 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.			F 686			

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F 686	Continued From page 122 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. 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.	F 686			

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F 686	Continued From page 123 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. 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	F 686			

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F 686	Continued From page 124 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 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	F 686			

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F 686	Continued From page 125 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 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.	F 686			

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F 686	Continued From page 126 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 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.	F 686			

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F 686	Continued From page 127 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 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.	F 686			

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F 686	Continued From page 128 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 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).	F 686			

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F 686	Continued From page 129 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 (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	F 686			

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F 686	Continued From page 130 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 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	F 686			

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F 686	Continued From page 131 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 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.	F 686			

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F 686	Continued From page 132 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 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	F 686			

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F 686	Continued From page 133 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.	F 686			
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to assess and provide effective pain management for a resident with wounds for one (1) of five (5) residents reviewed for wound care. Resident #103	F 697	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 assess and provide effective pain management for a resident with wounds, resident #103. On 1/31/2024 the Director		3/8/24

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F 697	Continued From page 134 Findings Include: Record review of the facility policy titled "Pain Management Guideline" with a revision date of 8/28/17 revealed, "Policy: The center strives to improve patient/resident comfort and minimize pain in order to help a resident attain or maintain his or her highest practicable level of well-being...Pain Evaluation: Identify if a resident is experiencing pain using either the resident's self report of pain (utilizing a 0-10 scale) or for those patient/resident's who cannot self-report, use the non-verbal clinical indicators..." Resident #103 An interview with Resident #103 on 01/30/24 8:19 AM, revealed he had a wound on his bottom and foot that caused him pain. He explained that he had pain medication but could only have it every eight (8) hours. The resident voiced it did not hold him the entire time and that sometimes he asked for pain medication, and they told him it was too early to take it. He revealed that he spoke with the Wound Nurse last week, and she was going to speak to the Nurse Practitioner (NP) about increasing his medication, but so far, his pain medication had remained the same. An interview with Licensed Practical Nurse (LPN) #2 on 1/30/24 at 12:10 PM, revealed that Resident #103 had Norco 5/325 mg (milligrams) every eight (8) hours as needed for pain. He revealed that the resident had been taking it regularly since he had a toe amputated. He stated on medication follow-up, the resident always voiced that the medication was effective. LPN #2 stated that the resident will ask for the medicine in 8 hours, exactly when it's due, and	F 697	of Nurses notified Nurse Practitioner of medication not being effective to control residents' pain during wound treatment. A new order was received for Norco 7.5-325MG every 6 hours as needed for pain. 2. All residents have the potential to be affected by this deficient practice. 3. On 2/1/2024 Assistant Director of Nurses initiated Quality Review of facility process to determine if pain medications were effective for residents receiving wound care. Director of Nurses and Assistant Director of Nurses initiated with licensed nursing staff, certified nursing assistants, and therapy staff on the components of this regulation with emphasis on ensuring pain management is effective during care and if not, treatment must be stopped and Medical Director or Nurse Practitioner must be notified. 4. Quality Assurance Improvement QAPI meeting was held on 2/7/2024 to ensure all residents pain medication is effective during treatment. Director of Nurses and Assistant Director of Nurses will conduct ongoing Quality Monitoring effectiveness of pain management for each resident receiving wound care 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		

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F 697	Continued From page 135 sometimes early. During an observation of wound care with the Wound Nurse on 1/30/24 at 3:55 PM, Resident # 103 immediately voiced complaints of left foot pain. Resident #103 stated, "It's hurting; Can you put that pillow under my foot?" Certified Nurse Aide (CNA) #4 placed a pillow under the left foot while waiting on the Wound Nurse to gather the needed supplies. The Wound Nurse entered the room and did not assess the resident's pain. She removed the soiled dressing from the left foot and the resident cried out. During the cleaning of the wounds to the left great toe and the left heel, the resident hollered out "Oh god!" The resident told the wound nurse "That's it" and he tried to pull back his left leg. The resident allowed the nurse to complete the treatment. The Wound Nurse did not stop treatment to address the resident's voiced complaints of pain. An interview with Resident #103 with Wound Nurse present on 1/30/24 at 4:10 PM revealed that he took a pain pill today at 1:00 PM and confirmed it was not controlling his pain during wound care. She stated Resident #103 did have increased pain with wound care, and she had discussed this with the Director of Nursing (DON) last week. She revealed that the Wound Nurse Practitioner (NP) did not prescribe pain medication. She explained that they have another Nurse Practitioner (NP) and a Medical Director that could prescribe pain medication, but cannot because the resident is on dialysis and all his medication must be approved through his nephrologist. The Wound Nurse revealed the resident received Norco and confirmed it was not effective at pain management during wound care. She revealed	F 697	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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F 697	Continued From page 136 the resident had been experiencing increased pain for about a week. An interview with the Director of Nursing (DON) on 1/30/24 at 4:35 PM, confirmed that she was notified by the Wound Nurse last week that Resident #103 was experiencing increased pain during wound care. She explained that she told the Wound Nurse that day "let's monitor him" and she would follow up to assess his pain. She revealed that she checked on him on Friday, 1/26/24 while he was in the dining room and the resident told her his pain was "ok". She confirmed that the Wound Nurse should have assessed the resident's pain before starting the treatment and stopped when the resident experienced pain and called the physician. She explained that the resident's pain medication was not ordered through dialysis. The DON stated he was taking Percocet after his recent toe amputation, but after the prescription was exhausted, the facility Nurse Practitioner (NP) changed him over to Norco 5/325 mg (milligrams). The DON revealed that the resident should be comfortable during wound care and confirmed she should have notified the NP of the residents' increased pain last week. Record review of the Admission Record revealed Resident #103 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, Pressure Ulcer Left Heel, Stage 3, Pain Unspecified, End Stage Renal Disease, and Dependence on Renal Dialysis. Record review of Resident #103's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/5/23 revealed, under section C, a	F 697			

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F 697	Continued From page 137	F 697			
F 726 SS=K	Brief Interview for Mental Status (BIMS) summary score of 13, which indicates the resident is cognitively intact. Also revealed under section J, the resident experienced frequent pain with a numeric rating (pain intensity) of 07 on a scale from 1-10 during the 5-day MDS look back period for pain presence. Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents'	F 726		3/8/24	

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F 726	Continued From page 138 needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review 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 for two (2) of five (5) residents reviewed with wounds. Resident #52 and Resident #103 The facility's failure to ensure licensed staff had appropriate training and competency skills to provide wound treatments put Resident #52 and Resident #103 and all other residents who are at risk for skin breakdown at risk for serious harm, serious injury, serious impairment, or death. The State Agency (SA) determined the situation to be an Immediate Jeopardy (IJ) that began on 12/27/23 when Resident #103 developed a bruised area to the left great toe that deteriorated and became a bruised/blood blister covered in eschar (dead tissue) by 1/24/24. The facility failed to act upon verbal orders resulting in delay in treatment, failed to transcribe these orders into the medical record, and provide treatment for Resident #103's wounds according to the Wound Nurse Practitioner's orders. The facility Administrator was notified of the Immediate Jeopardy (IJ) 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.	F 726	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 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 for two of five residents reviewed with wounds for residents #52 and #103. 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 5:40 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. Director of Nurses and Assistant Director of Nurses are completing treatments as ordered Monday through Friday until treatment nurse		

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F 726	Continued From page 139 The Survey Agency (SA) validated the Removal Plan on 2/06/24 and determined the Immediate Jeopardy (IJ) was removed on 2/02/24. Therefore, the scope and severity for 42 CFR 483.35(a)(3)(4) Nursing Services, was lowered from a "K" to an "E", 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: The facility provided documentation on letter head, undated, revealed "Skills Competency Assessment is utilized for evaluation of staff competency and training." Resident # 52 On 01/29/24 at 12:04 PM, an observation and interview 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. 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	F 726	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. 4. Quality Assurance Improvement (QAPI) meeting was held on 1/31/2024 to ensure all licensed nurses performing treatments will have completed the skills competency for wound care prior to accepting shift. Director of Nurses and Assistant Director of Nurses will conduct ongoing Quality Monitoring for all licensed nursing staff to ensure skills competencies are met per policy prior to accepting shift. 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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F 726	Continued From page 140 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 Xray of left heel r/t (related to) increased pain and clinical symptoms of osteoporosis."	F 726			

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F 726	Continued From page 141 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. 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. 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 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	F 726			

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F 726	Continued From page 142 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. 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. 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 of the Progress Note Details dated 12/27/23 for Resident #103 revealed, "There is also a 0.8 x 1.5 x 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 the Treatment Administration Record (TAR) for Resident #103 revealed there was not a wound care order for the wound on the left great toe or the breakdown between the inner	F 726			

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F 726	Continued From page 143 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 Resident #103's Treatment Administration Record (TAR) for January 2024 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	F 726			

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F 726	Continued From page 144 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 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. 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, first starting out as the Wound Nurse, then transferred over to the night shift supervisor and filling in on the medication cart. 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	F 726			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255172	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/06/2024
NAME OF PROVIDER OR SUPPLIER STARKVILLE MANOR HEALTH CARE AND REHABILITATION CE			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETION DATE	
F 726	Continued From page 145 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 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 who 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	F 726			

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F 726	Continued From page 146 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 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	F 726			

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F 726	Continued From page 147 #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 the Assistant Director of Nursing (ADON) on 1/31/24 at 10:05 AM, revealed that the facility had not had a consistent Wound Nurse for the past six (6) months. She revealed that the previous Wound Nurse worked for about 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 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 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 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 reviewed the wounds back in December 2023 after the other Wound Nurse left and all the orders were compared to the NP orders versus the TAR and verified accuracy by	F 726			

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F 726	Continued From page 148 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. The ADON stated the Wound Nurse 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. 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 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 revealed that Resident #103 was a Diabetic, on dialysis and had a	F 726			

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F 726	Continued From page 149 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 was not 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 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. 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. 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. LPN #4 explained that she	F 726			

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F 726	Continued From page 150 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 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. An interview with the Assistant Director of Nursing (ADON) on 2/01/24 at 11:25 AM revealed she had	F 726			

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F 726	Continued From page 151 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			F 726			

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F 726	Continued From page 152 revealed that the NP caused the delay because 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 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." 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 "Skills Competency Assessment: Clean Dressing Change" revealed the wound nurse completed the training on hire (9/8/21). Record review of the "Skills Competency 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	F 726			

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F 726	Continued From page 153 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 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	F 726			

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F 726	Continued From page 154 pressure ulcer wounds and other wounds which resulted in delay of healing of pressure ulcers and wounds 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 Assisted Director of Nurses initiated education with 5 Registered Nurses and 6 Licensed Practical Nurses on	F 726			

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F 726	Continued From page 155 "Medication Administration and Documentation". Employees will be educated prior to accepting 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	F 726			

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F 726	Continued From page 156 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 of 12 residents. No discrepancies were identified. On 1/31/2024 at 5:40 pm the Regional Director of Clinical Services (RDSCS) conducted education with the Treatment Nurse on "Skin and Wound Guidelines", "Medication Administration and Documentation", "Abuse and Neglect", and	F 726			

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F 726	Continued From page 157 "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 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	F 726			

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F 726	Continued From page 158 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 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,	F 726			

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F 726	Continued From page 159 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 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	F 726			

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F 726	Continued From page 160 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. 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	F 726			

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F 726	Continued From page 161 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. 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).	F 726			

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F 726	Continued From page 162 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 the 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.	F 726			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs	F 757		3/8/24	

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F 757	Continued From page 163 CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide monitoring for the signs and symptoms of hypo/hyperglycemia for a resident receiving insulin for two (2) of five (5) residents reviewed for unnecessary medications. Resident #60 and Resident #81 Findings Include: The facility provided documentation on letter head, undated, that read, "We do not have a policy on hypo/hyperglycemia for diabetics."	F 757	1. Root Cause Analysis was conducted by the Quality Assurance Performance Improvement (QAPI) Committee on 2/7/2024. Based on findings, the facility failed to provide monitoring for the signs and symptoms of hypo/hyperglycemia for a resident receiving insulin for resident #60 and resident #81. On 2/1/24, Director of Nurses updated MAR to include monitoring for signs and symptoms of hypo/hyperglycemia. 2. All diabetic residents have the potential		

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F 757	Continued From page 164 Resident #60 Record review of Resident #60's January 2024 Medication Administration Record (MAR), revealed an order dated 10/24/23, "FIASP 100 UNIT/ML FLEXTOUCH (3 ML) inject 12 units subcutaneously before meals related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS". Also revealed an order dated 11/28/23, "Basaglar Kwikpen Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 60 unit subcutaneously at bedtime related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS ..." Record review of Resident #60's January 2024 Medication Administration Record (MAR), revealed there was not any monitoring conducted for the signs and symptoms of hypo/hyperglycemia. Record review of the Admission Record revealed Resident #60 was admitted to the facility on 3/18/19 with medical diagnoses that included Type 2 Diabetes Mellitus with Hyperglycemia, Long Term (current) use of Insulin. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/27/23 revealed under section N, the resident received 7 days of insulin injections during the MDS look back period. Resident #81 Record review of Resident #81's January 2024 Medication Administration Record (MAR), revealed an order dated 11/21/23, "Lantus Solostar 100 UNIT/ML (3 ML) inject 15 units	F 757	to be affected by this deficient practice . 3. On 2/1/2024, Director of Nurses, Assistant Director of Nurses, and Medical Records Nurse initiated Quality Review of facility process to determine diabetic residents needing monitoring for signs and symptoms of hypo/hyperglycemia. On 2/1/2024, the Director of Nurses and Assistant Director of Nurses begin education with licensed nursing staff on the components of this regulation with emphasis on ensuring all diabetic residents must have documentation to monitor for signs and symptoms of hypo/hyperglycemia. Newly hired licensed nurses will be educated by the Director of Nurses on the policies and procedures that govern monitoring for signs and symptoms of hypo/hyperglycemia for diabetic residents. 4. Quality Assurance Improvement QAPI) meeting was held on 2/7/2024 to ensure all diabetic residents have monitoring in place for hypo/hyperglycemia. On 2/1/2024, the Director of Nurses, Assistant Director of Nurses, and Unit Managers will conduct ongoing quality monitoring for diabetic residents to ensure they are monitored for signs and symptoms of hypo/hyperglycemia, 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 diabetics are monitored for signs and symptoms of hypo/hyperglycemia. On 2/26/2024, we conducted a QAPI meeting to review our findings from our Quality Monitoring to		

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F 757	Continued From page 165 subcutaneously one time a day related to TYPE 2 DIABETES MELLITUS WITHOUT COMPLICATIONS" Record review of Resident #81's January 2024 Medication Administration Record (MAR) revealed there was not any monitoring conducted for the signs and symptoms of hypo/hyperglycemia. An interview with the Director of Nursing (DON) on 1/30/24 at 4:30 PM, confirmed that the facility did not have any hypo/hyperglycemia monitoring tool in place for the residents that were diabetics and receiving insulin. She revealed the Medication Administration Record (MAR) only addressed a PRN (as needed) hypoglycemia protocol for what the nurse should do for a blood glucose reading less than 60. She confirmed that insulin was a high-risk medication that should be monitored appropriately. An interview with Licensed Practical Nurse (LPN) #2 on 1/31/24 at 8:20 AM, revealed he had never seen any type of monitoring tool for the diabetics that were receiving insulin. He confirmed that insulin was considered a high-risk medication and should be monitored on the MAR. Record review of the Admission Record revealed Resident #81 was admitted to the facility on 7/14/21 with medical diagnoses that included Polyneuropathy, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Long Term (current) use of Insulin. Record Review of the MDS with an ARD of 12/22/23 revealed under section N, the resident received 7 days of insulin injections during the	F 757	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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F 757	Continued From page 166	F 757			
F 761 SS=D	MDS look back period. Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review the facility failed to store drugs properly for two (2) of 116 residents reviewed on initial observation in the facility. Resident #106 and Resident #85. Findings include:	F 761	1. Root Cause Analysis was conducted by the Quality Assurance Performance Improvement (QAPI) Committee on 2/7/2024. Based on observations, interview, record review, and facility policy review, the facility failed to store drugs properly for two (2) of 116 residents on	3/8/24	

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F 761	Continued From page 167 Record review of facility policy titled, "Administering Medications" dated April 2019, revealed, "Medications are administered in a safe and timely manner, and as prescribed." Record review of facility policy titled, "LTC (Long Term Care) Facility's Pharmacy Services and Procedures Manual", dated January 2022, revealed, "2. Facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding." Policy also revealed, "3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors." An observation and interview during initial tour on 1/29/24 at 10:45 AM, in Resident #106's room, revealed a medication cup with one capsule that was red/maroon on one end and clear with stone gray colored pellets inside capsule on the resident's overbed table. Resident was lying in bed in his room. Resident #106 revealed the nurse left this medication at his bedside for him to take and he forgot to take it. He stated he thought the medication was his stomach medication that he takes before he eats but wasn't sure. An interview and observation DATE/TIME in Resident #106's room with Licensed Practical Nurse (LPN) #1 confirmed the medication in the medication cup on bedside overbed table was left unsecured. She stated when she was doing medication pass this morning, the Psychiatric	F 761	initial observation in the facility for resident #106 and resident #85. On 1/29/24, Director of Nurses conducted a 1:1 with Licensed Practical Nurse (LPN) #1 that included the proper procedure of pulling and administering medications. Policy on "Storage and Expiration Dating of Medications, Biologicals" was reviewed. 2. All residents have the potential to be affected by this deficient practice. 3. On 1/29/2024, the Director of Nurses and Assistant Director of Nurses initiated education with licensed nursing staff on the components of "Storage and Expiration Dating of Medications, Biologicals". Newly hired licensed nurses will be educated by the Director of Nurses on the policies and procedures that govern the proper procedure of pulling and administering medications. 4. Quality Assurance Improvement (QAPI) meeting was held on 2/7/2024 to ensure all staff understands the policies and procedures of "Storage and Expiration Dating of Medications, Biologicals" with emphasis on the proper procedure of pulling and administering medications. On 2/7/2024, the Director of Nurses, Assistant Director of Nurses, and Unit Managers will conduct ongoing quality monitoring for all residents to ensure policies regarding Label and storage of drugs and biologicals along with ensuring no medication is left at bedside, 4 x weekly x 4 weeks, then 3 x weekly x 3 weeks, then weekly x 4 weeks, then		

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F 761	Continued From page 168 Nurse Practitioner was at the resident's bedside so she left the medication on his bedside table for the resident to take when the Nurse Practitioner left the room. She stated this medication was Creon (Pancrelipase Oral Capsule), which was his stomach medication, and he was scheduled to take this before meals. She stated she had been in-serviced on medication administration and knew she was not to leave medications unattended at bedside. LPN #1 revealed the risk of leaving medications unattended at the bedside was the resident not receiving medications as ordered and also was a risk for other residents or visitors gaining access to the medications and taking these. During an interview on 1/30/24 at 4:40 PM, the Director of Nursing revealed medications are not to be left unattended at the bedside of any resident's room. She stated the nurse must watch the resident take the medication to ensure the resident receives the medication that was ordered. She also stated for the safety of other residents and visitors and to prevent others from taking the medication, the medications can not be left unattended at the bedside. She confirmed the facility failed to ensure proper storage of medication when that was left unattended at a resident's bedside and this could lead to a resident not receiving ordered medication or medications could be taken by another individual. Record review of Resident #106's Order Summary Report revealed an order dated 9/28/23 for Pancrelipase Oral Capsule Delayed Release Particles 24000-76000 unit one capsule by mouth before meals and at bedtime related to Alcohol-Induced Chronic Pancreatitis.	F 761	monthly for 6 months. On 2/26/2024, we 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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F 761	Continued From page 169 Record review of Resident #106's Electronic Medication Administration Record revealed Pancrelipase Oral Capsule Delayed Release Particles 24000-76000 unit one capsule by mouth before meals was marked for administration of the 11:00 AM dose on 1/29/24 by LPN #1. Record review of Resident #106's "Admission Record" revealed resident was admitted to the facility on 9/18/23. Diagnoses included Alcohol-induced Chronic Pancreatitis and Other Chronic Pancreatitis, Record review of Resident #106's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/16/23 revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated the resident was cognitively intact. Resident #85 An observation on 01/29/24 at 11:05 AM, with Resident #85 revealed resident is lying in the bed, alert and disoriented, but agitated. Observed a small plastic medicine cup sitting on the bedside table next to the resident's bed. Inside the cup was a mashed-up substance, beige in color with small pieces of medicine mixed up in the substance. There was a white plastic spoon inside the small medicine cup. An interview on 01/29/24 at 11:20 AM with LPN #1 confirmed that she is the nurse for Resident #85 and that the substance inside of the plastic medicine cup is the resident's morning medication that was crushed. LPN #1 stated "I got sidetracked when someone came into the room and I sat it down on the bedside table and completely forgot to go back and give it to her, I	F 761			

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F 761	Continued From page 170 never do that." LPN #1 confirmed that leaving it there could result in anyone picking it up and taking it and could result in the resident not feeling well because she didn't get her medication. LPN#1 stated, "I can't really remember (what meds it was), it was her morning medicines. I believe it was Paxil, a multivitamin, Seroquel and a medicine for Schizophrenia." A record review of Resident #85 Medication Administration Record revealed that the resident receives Aspirin EC delayed release 81milligram (mg), ICAPS multi vitamins-minerals, MiraLAX oral Powder 17 grams (gm), Paliperidone ER extended release 1mg, Paxil 40mg, and Seroquel 25mg daily at 09AM. A review of the Admission Record for Resident #85 revealed that she was admitted to the facility on 01/05/22 and has diagnoses that included Unspecified dementia, Schizoaffective disorder depressive type and Major depressive disorder. A review of the MDS with an ARD of 01/18/23 revealed a BIMS score of 08 which indicated Resident #85 was cognitively impaired.	F 761			
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by	F 851		3/8/24	

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F 851	Continued From page 171 CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.	F 851			

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F 851	Continued From page 172 §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to submit accurate staffing data into the Payroll-Based Journal (PBJ) system for one (1) of four (4) quarters reviewed. 4th Quarter 2023. Findings Include: Record review of the facility policy titled, "Exempt (Salaried) Staff" undated, revealed, "If a salaried position covers a direct care position, you may move up to 8 hours out of the home department to direct care Registered Nurse (RN) via PBJ Instance on (Proper name of facility). Record review of the facility policy titled, "Recap-Your role as Executive Director undated, revealed, under Timely and accurate timekeeping. Daily review. Weekly review prior to payroll close, and review weekend RN coverage. Record review of "PBJ Staffing Data Report CASPER Report 1705D FY (Fiscal Year) Quarter 4 2023 (July 1-September 30)", revealed the facility triggered on this report for excessively low weekend staffing.	F 851	1. Root Cause Analysis was conducted by the Quality Assurance Performance Improvement (QAPI) Committee on 2/7/2024. Based on findings, the facility failed to submit accurate staffing data into the Payroll-Based Journal (PBJ) system for one of four quarters. 2. All residents have the potential to be affected by this deficient practice. 3. On 2/1/2024, Executive Director and Human Resource Director conducted Quality Review of facility process to determine if accurate staffing data was entered into PBJ. On 2/1/2024 Executive Director educated Human Resource Director on the components of this regulation with emphasis on ensuring all staffing data is accurate prior to submitting to PBJ. 4. Quality Assurance Improvement QAPI) meeting was held on 2/7/2024 to ensure all information is accurate prior to submitting to PBJ. On 2/1/2024, the Executive Director and Human Resource		

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F 851	Continued From page 173 During an interview on 01/31/24 at 2:50 PM, the Administrator (ADM) revealed there have been times that the salaried nurses would have to work the weekend for adequate coverage. She revealed the shifts for the fourth quarter of 2023 were covered, however, the data was entered incorrectly and did not capture the direct care on the PBJ. She revealed the Corporate Office submits the PBJ and the error was found in December 2023 and was corrected by them. During an interview on 02/01/24 at 8:45 AM, the Assistant Director of Nurses (ADON) revealed on the weekends when someone calls in, we just work on getting that position filled and use salaried staff to get it taken care of if need be. She revealed if a nurse works on the weekend, we give them a day off during the week and we will let human resources (HR) know and she will change our days and hours to reflect the correct day. During an interview on 02/01/24 at 11:20 AM, the Human Resources Director revealed that when a salary staff member works the weekend shift, they can take a day off during the week. She revealed I go in and delete the hours for the day they are taking off and put it on the day they work on the weekend. She confirmed during the fourth quarter of 2023 she failed to submit the staffing hours correctly which caused the discrepancy with the PBJ information.	F 851	Director will conduct ongoing quality monitoring for accuracy of staffing to ensure accurate staffing is submitted prior to submitting to PBJ, 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.		