STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255130	A. BUILDING _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIPPAH COUNTY NURSING HOME	1005 CITY AVENUE NORTH RIPLEY, MS 38663

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification at the facility from 01/23/24 through 1/25/24. During the survey the, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F646, F656, F740, F745, F757, F761, F880. The facility held a license for 40 beds, with a census of 29.	F 000		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and facility policy review, the facility failed to submit a Level II Preadmission Screening and Resident Review (PASARR) to the State Mental Health (SMH) Authority for a resident with a mental disorder (MD) following a significant change in mental condition for one (1) of three (3) PASARR's reviewed. Resident #23 Findings Include: Record review of the facility policy titled "Pre-admission Screening" with a revision date of 2/21/19 revealed, "Policy: ... c. If after admission, a resident is found to have a mental illness or the physician orders a psychotropic medication for	F 646	1. Resident #23 had a Change in Status Request submitted on 2/9/2024 by Social Worker. 2. All residents have the potential to be affected by this deficient practice. 3. On 1/25/2024, Social Worker was verbally educated by Administrator on regulation F646 that a Change in Status Request to the Pre Admission Screening and Resident Review (PASRR) must be submitted when a resident is found to have a mental illness	3/4/24

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

Electronically Signed | 02/16/2024

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F 646	Continued From page 1 the resident a Mississippi PASRR Level 2 Change in Status request will be submitted..." Record review of the Medical Doctor progress notes dated 11/14/23 revealed that Resident #23 was placed on an intervention of one on one for suicide watch due to suicidal ideation's. Record review of the Nurses Notes dated 11/25/23 revealed that Resident #23 was transferred to Behavior Health. An interview on 1/25/24 at 8:25 AM, with Social Services revealed she sends in a status change when a resident has a new mental illness diagnosis added or has a change in mental or physical condition. She confirmed that she did not send in a status change for Resident #23 when he transferred to behavior health. She revealed that the resident was admitted to the facility with bipolar disorder and behavior health did not deem the resident as suicidal upon discharge, so she did not see this as a significant change in mental condition. She confirmed that the resident would benefit from psychiatric services. An interview with the Director of Nursing (DON) on 1/25/24 at 9:15 AM confirmed that with Resident #23's mental diagnosis of bipolar disorder and new symptoms of suicidal ideation, the resident should have had a change in status submitted to the SMH Authority. She revealed the resident would benefit from psychiatric services. Record review of the Face Sheet revealed that Resident #23 was admitted to the facility on 8/5/21 with medical diagnoses that included Anxiety Disorder, Bipolar Disorder and Depression Unspecified.	F 646	or if the physician orders a psychotropic medication. Social Worker verbalized understanding and submitted the Change in Status Request to PASRR on 2/9/2024. On 2/9/2024, a copy of the F646 regulation and facility policy titled Preadmission Screening was given to Social Worker by Administrator for educational purposes, to ensure that this regulation is met in the future. 4. The Administrator developed a Quality Improvement Monitor on 2/9/2024 to be monitored daily times 22 days beginning 2/12/2024, then weekly times 4, then monthly times 1 year. Administrator will monitor to ensure that each resident that has a new mental illness, transfers to behavioral health, or has a new order of psychotropic medication has a Change in Status request submitted by Social Worker. Administrator added to facility Quality scorecard on 2/15/2024. The Quality Assurance Committee will review the monthly results beginning 3/4/2024 and make recommendations as needed based on those monthly results. This will be reported to Quality Assurance Committee for 1 year.	

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F 646	Continued From page 2 Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/04/23 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 6 which indicates Resident #23 is severely cognitively impaired.	F 646		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		3/4/24

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F 656	Continued From page 3 (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 interviews, record review and facility policy review, the facility failed to implement a comprehensive care plan for monitoring a resident for suicidal ideation for one (1) of twelve care plans reviewed. Resident #23 Findings Include: Review of the facility policy titled "MDS (Minimum Data Set) 3.0; Care Plans" with a revision date of 6/23/16 revealed, "Policy: The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: 1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required..."	F 656	1. Social Services began visiting with Resident #23 three times per week on 2/9/2024 to monitor for any suicidal ideations. If any suicidal ideations are noted, administration is to be notified immediately. Psychosocial and Anxiety Care Plans for Resident #23 were revised on 2/8/2024 by MDS Nurse to reflect intervention being implemented by Social Services. 2. All residents have the potential to be affected by this deficient practice. 3. On 1/25/2024, Social Worker was verbally educated by Administrator on regulation F656, that comprehensive care	

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F 656	Continued From page 4 Record review of Resident #23's Psychosocial Care Plan revealed under interventions, "Monitor for suicidal ideation" and was assigned to the role of "Social Services". Record review of Resident #23's Anxiety Care Plan revealed, under interventions, "Monitor for suicidal Ideation" and was assigned to the role of "Social Services". An interview with MDS Nurse on 1/25/24 at 2:15 PM, revealed the purpose of the care plan was to address the problem and diagnosis and develop a measurable goal to reach. She confirmed that Resident #23's care plan was not followed for monitoring for suicidal ideation. An interview with Social Services on 1/25/24 at 3:15 PM, revealed that she develops the Care Plans related to social services. She revealed that she did go by to see Resident #23 every morning, but she did not document anything. She confirmed that she didn't have any documentation to support that she monitored for suicidal ideation and confirmed the target care plan was not followed. Record review of the Face Sheet reveled the Resident #23 was admitted to the facility on 8/5/21 with medical diagnoses that included Anxiety Disorder, Bipolar Disorder, and Depression. Record review of the MDS with an Assessment Reference Date (ARD) of 12/04/23 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 6 which indicates Resident # 23 is severely cognitively	F 656	plans and interventions must be implemented. Social Worker verbalized understanding. On 2/9/2024, a copy of the F656 regulation was given to Social Worker by Administrator for educational purposes to ensure that this regulation is met in the future. 4. The Administrator developed a Quality Improvement Monitor on 2/9/2024 to be monitored daily times 22 days beginning 2/12/2024, then weekly times 4, then monthly times 1 year. Administrator will monitor that care plan is followed for monitoring for suicidal ideations for Resident #23. In Care Plan Conference weekly beginning 2/14/2024, Administrator will review care plans to ensure they are being implemented times 1 year to ensure they are being implemented. Administrator added to facility Quality scorecard on 2/15/2024. The Quality Assurance Committee will review the monthly results beginning 3/4/2024 and make recommendations as needed based on those monthly results. This will be reported to Quality Assurance Committee for 1 year.	

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F 656	Continued From page 5 impaired.	F 656		
F 740 SS=F	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and facility policy review, the facility failed to provide the necessary behavior health care and services to a resident with a diagnosis of major mental illness for one (1) of 12 sampled residents. Resident #23 Findings Include: Record review of the facility policy titled "Behavioral; Health Services" with a revision date of 4/28/16 revealed, "Purpose: Services are provided to meet resident's psychological needs. Resident behavior and emotional needs are closely monitored and evaluated to ensure that they do not become obstacles to treatment goals. (Proper Name of Facility) provides care and services to prevent and manage behavioral problems..." Record review of the Departmental Notes for	F 740	1. Psychiatric Nurse Practitioner signed contract with facility on 1/25/2024. Psychiatric Nurse Practitioner will visit monthly and as needed. Residents can also be referred to Senior Intensive Outpatient Program at hospital. Residents can also be referred for individual counseling at hospital. All of this will be managed by Psychiatric Nurse Practitioner. Resident #23 was assigned to receive monthly visits by Psychiatric Nurse Practitioner starting 2/8/2024. Director of Nursing (DON) screened all residents on 2/6/2024 to determine if psychiatric services were needed. This was based on if resident is currently receiving a psychotropic medication, has been to Behavioral Health	3/4/24

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F 740	Continued From page 6 Resident #23 revealed the following entries: 11/5/23, "Resident called for help repeatedly to get up and lay down." 11/7/23, "He does not participate in many activity programs due to him having anxiety when around groups of people." 11/7/23, "Resident did have behavior issues today. Resident refused lunch and states I will just starve to death. Hollering and cussing and saying he wants to die." 11/8/23, Resident makes statements like "He's coming to the end of the road", "He'll just starve to death..." 11/9/23, "Resident has been hollering this am, he has been upset wanting someone to help him with his breakfast..." 11/11/23, "Resident has been yelling Help, and I am blind." Record review of Doctor's Progress Notes for Resident #23 revealed an entry dated 11/14/23, "Pt (patient) with some suicidal talk. He has on/off talk about depression. Will ref (refer) to behavior if this doesn't improve ..." Record review of the Departmental Notes for Resident #23 dated 11/15/23 revealed the resident was transferred to behavior health due to suicidal ideation and returned to the facility on 11/27/23. An interview on 1/24/24 at 2:00 PM, with the Administrator (ADM) revealed we do not currently have a contract with any Psychiatric services.	F 740	in the past year, or is currently displaying behaviors in facility. Facility referred 22 residents to Psychiatric Nurse Practitioner. 2. All residents have the potential to be affected by this deficient practice. 3. Psychiatric Nurse Practitioner was obtained by facility on 1/25/2024. On 2/9/2024, Behavioral Health Services policy was updated to remove the behavioral health service that voided their contract and to add the new psychiatric services facility obtained. This policy was sent to Medical Director on 2/12/2024 and was approved. It was sent to Quality Assurance Committee on 2/15/2024 and was approved. Per facility policy, it will be presented to medical Staff on 2/28/2024 and Board of Directors on 3/4/2024. On 2/9/2024, a copy of the F740 regulation was given to Social Worker by Administrator for educational purposes. DON and Administrator educated staff on updated Behavioral Health Services policy at staff meetings on 2/12/2024, 2/14/2024, and 2/15/2024.	

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F 740	Continued From page 7 She revealed we are in the process of getting new behavioral health services; the company we were using voided our contract without notice due to their staffing shortages. She confirmed the facility had been without behavioral health services since Sept. 11, 2023. She revealed, to her knowledge, Resident #23 was not getting any psychiatric services before and following his recent behavioral health stay. She confirmed that with the resident's diagnosis of bipolar disorder, he would have benefited from these specialized services. An interview with Social Services on 1/25/24 at 8:30 AM, revealed that she was notified by the staff that Resident #23 was making suicidal threats. She revealed that she went down to talk with the resident that day, and he stated he did not plan to hurt himself. She revealed that she did a suicide risk assessment on the resident and rated him not suicidal. She revealed that she called the resident's wife regarding the issue, and she stated that the resident had never threatened to harm himself in the past, and this was new behavior. She revealed a referral was then sent to behavioral health. The Survey Agency inquired whether the resident was receiving psychiatric services before the recent behavioral health stay in November 2023, and she revealed he had not received any kind of psychiatric services since he was admitted to the facility. She revealed that when the resident was sent back from behavior health, all she knew was that he was not deemed suicidal during his stay. She revealed that behavioral health did not make any recommendations on discharge. She confirmed that the resident would have benefited from specialized psychiatric services before and following the behavior stay, due to his mental	F 740	4. The Administrator developed a Quality Improvement Monitor on 2/9/2024 to be monitored daily times 22 days beginning 2/12/2024, then weekly times 4, then monthly times 1 year. Administrator will monitor that Behavioral Health Services are available to residents in facility. Administrator added to facility Quality scorecard on 2/15/2024. The Quality Assurance Committee will review the monthly results beginning 3/4/2024 and make recommendations as needed based on those monthly results. This will be reported to Quality Assurance Committee for 1 year.	

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F 740	Continued From page 8 illness diagnosis. She revealed that the Administrator had been working to get psychiatric services in the building, but currently had not been able to find anyone. She confirmed that the facility was not providing services and support based on individualized resident needs. Record review of Resident #23's Medication Administration Record (MAR) revealed an order dated 11/29/23, "Seroquel 50 mg tablet take one tablet by mouth twice day for Bipolar with behaviors." Also revealed an order dated 11/27/23, "Zoloft 25 mg tablet one tablet by mouth daily for Major Depressive Disorder." Record review of the Face Sheet revealed the Resident #23 was admitted to the facility on 8/5/21 with medical diagnoses that included Anxiety Disorder, Bipolar Disorder and Major Depression. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/04/23 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of six (6) which indicates Resident #23 is severely cognitively impaired. Also, revealed under Behavioral Symptoms in section E, the resident had verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) that occurred 4 to 6 days, but less than daily during the MDS look back period.	F 740		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or	F 745		3/4/24

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F 745	Continued From page 9 maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review and facility policy review, the facility failed to provide or arrange for the necessary mental/psychosocial counseling services for a resident with a history of mental illness and suicidal ideation for one (1) of twelve sampled residents. Resident #23 Findings Include: Record review of the facility policy titled "Social Service Program" with a revision date of 5/10/16 revealed under, "Policy: It is the policy of this facility to provide medically related social services to attain or maintain the highest practicable physical, mental, or psychosocial well-being of each resident." Also revealed under, "Program Description: The Social Work Services Department is responsible for: ... 4. Monitoring the resident's progress in improvement of physical, mental, and psychosocial functioning...6. Providing counseling services to residents and families..." Record review of the Departmental Notes for Resident #23 dated 11/15/23 revealed the resident was transferred to behavior health due to suicidal ideation and returned to the facility on 11/27/23. An observation of Resident #23 on 1/23/24 at 10:04 AM, revealed him lying in bed. The resident asked, "Where am I?" An interview on 1/24/24 at 2:00 PM, with the	F 745	1. Resident #23 had a Psychosocial Assessment completed by Social Worker on 2/16/2024. Psychiatric Nurse Practitioner signed contract with facility on 1/25/2024. Psychiatric Nurse Practitioner will visit monthly and as needed. Residents can also be referred to Senior Intensive Outpatient Program at hospital. Residents can also be referred for individual counseling at hospital. All of this will be managed by Psychiatric Nurse Practitioner. Resident #23 was assigned to receive monthly visits by Psychiatric Nurse Practitioner starting 2/8/2024. Director of Nursing (DON) screened all residents on 2/6/2024 to determine if psychiatric services were needed. This was based on if resident is currently receiving a psychotropic medication, has been to Behavioral Health in the past year, or is currently displaying behaviors in facility. Facility referred 22 residents to Psychiatric Nurse Practitioner. 2. All residents have the potential to be affected by this deficient practice. 3. On 1/25/2024, Social Worker was	

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F 745	Continued From page 10 Administrator (ADM) revealed, to her knowledge, Resident #23 was not getting any psychiatric services before and following his recent behavioral health stay for suicidal ideation. She confirmed that with the resident's diagnosis of bipolar disorder, he would have benefited from these specialized services. She revealed the facility did not currently have a contract with any psychiatric services, and no referrals for Resident #23 to be seen by an outside source. An interview with Social Services on 1/25/24 at 8:30 AM revealed that when the resident was discharged back from behavior health, all that she knew about his stay was that he was not deemed suicidal. An interview with Social Services on 1/25/24 at 3:15 PM revealed that when Resident #23 returned from behavior health, she did go down to see him every morning, but she didn't document anything in the notes. She revealed that she didn't have a set schedule of when she visited Resident #23 and that she usually checks on every resident in the morning, but she didn't always document the things she had done. She confirmed that if the assessment was not charted, then it wasn't done. She confirmed that with no documentation, the facility could not show proof of providing services and support based on individualized resident needs. She revealed that no referrals had been made to any outside sources for the resident's mental health needs. Record review of Departmental Notes dated 11/29/23 revealed Social Services met with Resident #23 and his wife following behavior health stay. No documentation to support a psychosocial assessment was conducted.	F 745	verbally educated by Administrator on regulation F745, that all residents must receive the services they need including monitoring their psychosocial needs and providing them. Social Worker also verbally educated on 1/25/2024 on documenting all visits with residents. Social Worker verbalized understanding to education. Psychiatric Nurse Practitioner was obtained by facility on 1/25/2024. On 2/9/2024, Behavioral Health Services policy was updated to remove the behavioral health service that voided their contract and to add the new psychiatric services facility obtained. This policy was sent to Medical Director on 2/12/2024 and approved. This policy was taken to Quality Assurance Committee on 2/15/2024 and was approved. Per facility policy, it will be presented to medical Staff on 2/28/2024 and Board of Directors on 3/4/2024. Psychiatric Nurse Practitioner visited Resident #23 on 2/8/2024. On 2/9/2024 a copy of the F745 regulation was given to the Social Worker by Administrator for educational purposes to ensure that this regulation is	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 745	Continued From page 11 Record review of the Face Sheet revealed that Resident #23 was admitted to the facility on 8/5/21 with medical diagnoses that included Anxiety Disorder, Bipolar Disorder and Major Depression. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/04/23 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 6 which indicates Resident # 23 is severely cognitively impaired. Also, revealed under Behavioral Symptoms in section E, the resident had verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) that occurred 4 to 6 days, but less than daily during the MDS look back period.	F 745	met in the future. DON and Administrator educated staff on the update to the Behavioral Health Services policy at staff meetings on 2/12/2024, 2/14/2024, and 2/15/2024. 4. The Administrator developed a Quality Improvement Monitor on 2/9/2024 to be monitored daily times 22 days beginning 2/12/2024, then weekly times 4, then monthly times 1 year. Administrator will monitor that residents are receiving services to meet their psychosocial needs. Administrator added to facility Quality scorecard on 2/15/2024. The Quality Assurance Committee will review the monthly results beginning 3/4/2024 and make recommendations as needed based on those monthly results. This will be reported to Quality Assurance Committee for 1 year.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including	F 757		3/4/24

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F 757	Continued From page 12 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 interviews and record review, the facility failed to monitor a resident receiving anticoagulant medication for signs of bruising and bleeding for one (1) of five (5) residents reviewed for unnecessary medications. Resident #23 Findings Include: The facility provided the State Agency (SA) documentation on letterhead, "(Proper Name of Facility) does not have a specific policy for monitoring for signs and symptoms of bleeding/bruising for residents on anticoagulant therapy." Record review of Resident #23's Medication Administration Record (MAR) revealed an order dated 7/14/23, "Coumadin 7.5 mg (milligrams) by mouth every day except Wednesday for Circulation". Also revealed an order dated 10/20/23,"Coumadin 2.5 mg tablet take one tablet	F 757	1. On 1/24/2024, Director of Nursing (DON) implemented a monitoring tool to fire out to electronic Medication Administration Record (MAR) for nurse to check every shift (8hrs) for excessive bruising/bleeding for residents taking anticoagulant. On 2/22/2024, Administrator and DON assessed all residents taking anticoagulants. The monitoring tool to fire out to electronic MAR for nurse to check every shift (8 hrs) for excessive bruising/bleeding was added to these residents on 2/22/2024. There were 8 additional residents this was added to.	

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F 757	Continued From page 13 by mouth on Wednesday for circulation." Both physician orders had a discontinuation date of 1/20/24. Record review of Resident #23's MAR revealed an order dated 1/21/24, "Warfarin Sodium 5 mg tablet by mouth daily at 5 PM for circulation." Record review of the Physician order list and the Medication Administration Record (MAR) revealed there was not a monitoring tool for staff to monitor for signs of bruising and bleeding with the anticoagulant medication Coumadin. An interview with Licensed Practical Nurse (LPN) #1 on 1/24/24 at 1:20 PM, revealed that Resident #23 recently had a Coumadin dose change. She confirmed that they do not have a monitoring tool on the MAR to document any signs of bleeding or bruising. She revealed that when the aides put the residents to bed, they usually come and tell the nurse if they observed any bruising on the skin. An interview with Registered Nurse (RN) #1 on 1/24/24 at 1:25 PM, revealed they do not have a monitoring tool to alert the nurses to observe a resident on an anticoagulant medication for signs of bruising/bleeding. She stated, "It's just something known." An interview with LPN #2 on 1/24/24 at 1:28 PM, revealed the facility does weekly body audits on all the residents and the aides were good at reporting any bruising or bleeding. An interview with the Director of Nursing (DON) on 1/24/24 at 2:50 PM, revealed the only monitoring they provided for the residents taking	F 757	2. All residents have the potential to be affected by this deficient practice. 3. On 2/92024, Administrator created a policy on monitoring for signs and symptoms of bleeding/bruising for residents on anticoagulant therapy. This policy was approved by Medical Director on 2/12/2024. This policy was taken to Quality Assurance Committee on 2/15/2024 and was approved. Per facility protocol, it will be presented to Medical Staff on 2/28/2024 and Board of Directors on 3/4/2024. On 2/12/2024, 2/14/2024, and 2/15/2024, staff was in-serviced by Administrator and DON on new policy on monitoring for signs and symptoms of bleeding/bruising for residents on anticoagulant therapy. 4. The Administrator developed a Quality Improvement Monitor on 2/9/2024 to be monitored daily times 22 days beginning 2/12/2024, then weekly times 4, then monthly times 1 year. DON will review the MAR to ensure that all residents that are taking anticoagulants are being monitored every shift for excessive bruising and bleeding and report this to	

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F 757	Continued From page 14 anticoagulant medication was a weekly skin audit. She confirmed lack of monitoring for anticoagulants placed the residents at risk for bleeding and death. Record review of the Face Sheet reveled the Resident #23 was admitted to the facility on 8/5/21 with medical diagnoses that included Unspecified Atrial Fibrillation, Long Term (current) use of Anticoagulants, and Personal history of other Venous Thrombosis and Embolism. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/04/23 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 6 which indicates Resident # 23 is severely cognitively impaired.	F 757	Administrator. Administrator added to facility Quality scorecard on 2/15/2024. The Quality Assurance Committee will review the monthly results beginning 3/4/2024 and make recommendations as needed based on those monthly results. This will be reported to Quality Assurance Committee for 1 year.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		3/4/24

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F 761	Continued From page 15 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, staff interviews, record review and facility policy review, the facility failed to assure that medications were secure and inaccessible to unauthorized staff and residents during two (2) of 10 medication observations. Findings Include: Record review of the facility policy titled, "Medication Administration" with a revision date of 6/07/16 revealed, "...Essential Points: ... 3. Never leave medication on top of medication cart unattended..." During an observation of medication pass with Registered Nurse (RN) #1 on 1/23/24 at 11:15 AM, Resident #3 was ordered Novolog Insulin per sliding scale for a blood glucose reading of 285 mg/dl (milligrams/deciliter). RN #1 revealed the insulin was not stored on the medication cart, and she must go get the prescribed insulin from the medication room. Upon returning to the medication cart, RN #1 placed a clear open storage container on top of the med cart that contained nine (9) boxes of insulin and one (1) insulin pen. RN #1 entered Resident #3's room and administered the prescribed insulin and left the container filled with insulin on top of the medication cart unattended. RN #1 then entered	F 761	1. On 1/23/2024, RN#1 was verbally counseled by Director of Nursing (DON) and Administrator on never leaving medications, including insulin, on top of medication cart unattended. 2. All residents have the potential to be affected by this deficient practice. 3. Current Medication Administration Policy was given to nurses by DON and Administrator during Staff Meeting on 2/12/2024, 2/14/2024, and 2/15/2024 for educational purposes to ensure that this is done correctly in the future. Medication Pass Observation Check Off Sheet was created by Clinical Development Nurse on 1/24/2024. These were given to nurses by DON and Administrator during Staff Meeting on 2/12/2024, 2/14/2024, and 2/15/2024 for educational purposes to ensure that this is done correctly in the future.	

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F 761	Continued From page 16 Resident #12's room twice to perform a blood glucose check and then returned to give the prescribed sliding scale insulin while the plastic container filled with insulin remained unattended on top of the medication cart. An interview with RN #1 on 1/23/24 at 11:45 AM, revealed that they do not store insulin on the medication carts. She revealed the insulin was kept in the med room refrigerator in the plastic container. She revealed when they have glucometer checks, they bring the entire container of insulin out and return it to the medication room refrigerator when they are finished. She revealed that she left the insulin on top of the cart because the container was too big to fit inside the cart. RN #1 confirmed that the insulin should not have been left unattended on top of the cart due to the risk of a resident wandering by and picking it up. An interview with the Director of Nursing (DON) on 1/24/24 at 8:52 AM, revealed that anything could happen when medications were left on top of the medication cart unattended and confirmed that a resident could come by and take them. Record review of the Staff Meeting conducted December 2023 and January 2024 revealed, "... No meds on top of med carts." ... Registered Nurse (RN) #1 was in attendance for both meetings.	F 761	Medication Pass Observation Check Off was done on RN#1 concerning not leaving medication unattended on 2/16/2024 by DON. Beginning 2/16/2024, Medication Pass Observation Check Offs were initiated by the DON and Clinical Development Nurse. 4. The Administrator developed a Quality Improvement Monitor on 2/9/2024 to be monitored daily times 22 days beginning 2/12/2024, then weekly times 4, then monthly times 1 year. Administrator will monitor that DON and Clinical Development Nurse are completing check offs on nurses doing medication administration weekly times 4, then monthly times 1 year to ensure that nurses are completing correctly and not leaving medications unattended. Administrator added to facility Quality scorecard on 2/15/2024. The Quality Assurance Committee will review the monthly results beginning 3/4/2024 and make recommendations as needed based on those monthly results. This will be reported to Quality Assurance Committee for 1 year.	
F 880 SS=D	Infection Prevention & Control	F 880		3/4/24

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F 880	Continued From page 17 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 18 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review and facility policy review, the facility failed to appropriately clean and disinfect a blood glucose meter between resident use for three (3) of nine (9) residents who require blood glucose finger sticks. Findings Include: Record review of the facility policy titled, "Glucose	F 880	1. Glucometer was appropriately cleaned by Director of Nursing (DON) on 1/23/2024 with a Sani-Cloth (purple top) disinfecting wipe for appropriate 2 minute wet time. On 1/23/2024, RN#1 was verbally counseled by DON and Administrator of the	

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F 880	Continued From page 19 Checks" with a revision date of 6/07/16 revealed, "...Procedure:... 8. Clean glucometer after use for a wet time of 2 (two) minutes using purple top sani-wipe..." An observation of Registered Nurse (RN) #1 on 1/23/24 at 11:02 AM, revealed after she completed a blood glucose check for Resident # 3 using a multi-use glucometer, she used a Sani-cloth (purple top) disinfecting wipe to briskly wipe down the glucometer machine for approximately five (5) seconds and placed the machine on a napkin barrier to air dry. RN #1 then performed blood glucose checks for Resident #183 and Resident # 12 and followed the same process for disinfecting the blood glucose monitor after resident use. An interview with Registered Nurse (RN) #1 on 1/23/24 at 11: 45 AM, revealed that she usually wipes the glucometer down front and back and allows it to air dry according to the recommendation on the disinfecting wipes. She revealed she was unsure of the recommended wet time, but after reading the label on the wipes, she verified the wet time was 2 minutes. She revealed that she did not know that the wet time meant the blood glucose machine should remain wet (in contact with the disinfecting wipe) for a total of 2 minutes. She confirmed that she did not disinfect the machine properly and this was an infection control concern. An interview with the Director of Nursing (DON) on 1/24/24 at 9:02 AM, revealed the facility used Sani-cloth germicidal disposable wipes and the glucometers were to be cleaned between resident use. She revealed the nurses were to wipe the glucometers good and allow it to sit inside the	F 880	requirement to properly disinfect glucometer with Sani-Cloth (purple top) disinfecting wipe with a 2 minute wet time after each use. 2. 9 residents have the potential to be affected by this deficient practice. 3. On 2/12/2024, 2/14/2024, and 2/15/2024, nurses were in-serviced during Staff Meeting by Administrator and DON on how to properly disinfect glucometer with a Sani-Cloth (purple top) disinfecting wipe with a 2 minute wet time. Current Medication Administration Policy was given to nurses by DON and Administrator during Staff Meeting on 2/12/2024, 2/14/2024, and 2/15/2024 for educational purposes to ensure that this is done correctly in the future. Medication Pass Observation Check Off Sheet was created by Clinical Development Nurse on 1/24/2024. These were given to nurses by DON and Administrator during Staff Meeting on 2/12/2024, 2/14/2024, and 2/15/2024 for educational purposes to ensure that this is done correctly in the future. Medication Pass observation check off was completed on RN#1 on cleaning glucometer	

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F 880	Continued From page 20 wipe for 2 minutes. She confirmed improper disinfecting of the blood glucose monitor could spread infection. She revealed that all nurses had been recently in-serviced on the proper cleaning and disinfection of the multi-use glucometer. Record review of the Staff Meeting conducted December 2023 revealed, "... cleaning equipment, including glucometers, with 2 min wet time for purple wipes." Registered Nurse (RN) #1 was in attendance. Record review of the Staff Meeting conducted for January 2024 revealed under, " ... cleaning equipment, including glucometers, with 2 min wet time for purple wipes." Registered Nurse (RN) #1 was in attendance.	F 880	correctly by DON on 2/16/2024. Beginning 2/16/2024, Medication Pass Observation Check Offs were initiated by the DON and Clinical Development Nurse. 4. The Administrator developed a Quality Improvement Monitor on 2/9/2024 to be monitored daily times 22 days beginning 2/12/2024, then weekly times 4, then monthly times 1 year. Administrator will monitor that DON and Clinical Development Nurse are completing check offs on nurses doing medication administration weekly times 4, then monthly times 1 year to ensure that nurses are completing correctly and are cleaning glucometers correctly. Administrator added to facility Quality scorecard on 2/15/2024. The Quality Assurance Committee will review the monthly results beginning 3/4/2024 and make recommendations as needed based on those monthly results. This will be reported to Quality Assurance Committee for 1 year.	