STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255114	A. BUILDING _____ B. WING _____	02/15/2024

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CLEVELAND NURSING AND REHABILITATION CENTER	4036 HIGHWAY 8 EAST CLEVELAND, MS 38732

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey with two (2) complaint investigations (CI) MS #23882, and CI MS #24150, at the facility from 2/12/24-2/15/24. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA identified non-compliance and cited F 584 related to safe environment, F 638 related to timely quarterly assessments, F 656 related to care plan implementation, F 689 related to accident hazards, and F 725 related to sufficient nursing staff. There were no deficiencies cited for CI MS #23882 related to abuse and death or CI MS #24150 related to neglect. The census at the time of the survey was 108 and the facility is licensed for 120 beds.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		3/20/24

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

Electronically Signed | 03/01/2024

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F 584	Continued From page 1 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff, and resident interviews the facility failed to correct maintenance issues in a resident bathroom for two (2) of 28 residents sampled. Residents #39 & #46 Findings Include: Review of the written statement on facility letterhead dated 2/14/24 and signed by the Administrator revealed the facility does not have a policy regarding maintenance repairs. An interview and observation on 02/12/24 at	F 584	1. On 2/13/24, sink faucet and toilet leak in Resident bathroom #39 and #46 was repaired by the Maintenance Director. Resident #39 and Resident #46 had no ill effects from this deficient practice. 2. All residents who ambulate independently have the potential to be affected. 3. An in-service was initiated on 2/13/24 for all staff by the Staff Development Coordinator (SDC) on ensuring maintenance issues are documented in	

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F 584	Continued From page 2 11:06 AM, with Resident's #39 and #46 revealed the residents share a bathroom and the water in the bathroom will not turn on and there is a puddle of water in the floor approximately 2 feet wide by 2 feet wide between the toilet and the sink. Resident #39 & #46 revealed the sink has not worked in a long time and they both walk independently. When asked if the staff were aware their sink did not work and there appeared to be a leak, Resident #46 stated, "Yes, they have come in and looked at it, but no one's fixed it." An observation and interview on 02/13/24 at 10:30 AM, of Resident #39 & #46's shared room revealed there was still a puddle of water between the toilet and the sink that was approximately 2 feet wide by 2 feet long, that extended to the front of the toilet. Observation revealed the handle to the faucet was not attached. Resident #46 revealed that he did not know how to put the faucet handle back on. An observation and interview on 2/13/24 at 10:35 AM, with Nurse Aide (NA) #1 confirmed there was water standing in the floor of Residents #39 & #46's bathroom and that they walked independently. She confirmed that the sink handle was loose and could be removed causing the sink not to be able to be turned on and that the puddle of water could have been a fall hazard for the residents. She revealed that she is not the residents NA, but that the staff are supposed to notify nurses or the maintenance man if there is an issue that needs to be repaired. She stated that a wet floor sign needed to be put up also. An observation and interview on 2/13/24 at 10:40 AM, with NA #2 revealed she is Resident #39 & 46's nurse assistant, and she knew there was	F 584	the Maintenance Repair Log book located at the nurse's station, placing wet floor signs down for wet floors, cleaning spills and liquids off the floor as soon as possible. 4. Starting 2/19/24, the Maintenance Director and/or Assistant Maintenance Director will make resident room rounds checking bathrooms for leaks or broken faucets (five) 5 times weekly for 4 weeks, then weekly times four weeks to ensure safe environment for residents. Starting 2/23/24, results of audits and rounds are submitted to the Executive Director (ED) weekly times (eight) 8 weeks to audit for accuracy and completeness and maintained in the ED office. Starting 3/20/24, the ED will present results of the audit to the Quality Assurance (QA) committee monthly times (three) 3 months for review and further recommendations.	

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F 584	Continued From page 3	F 584		

some sort of water leak in their bathroom, and she had reported it to one of the nurses but was not sure who. She stated, "they have come and looked at it but cannot figure out where the leak is coming from." She confirmed the residents sink handle needed to be fixed, because the residents would not know how to reattach the handle on their own.

An interview and observation on 2/13/24 at 10:46 AM, with the Maintenance Supervisor revealed he was not aware that Resident #39 & #46's bathroom had a leak that was causing water to stand in the floor or that their sink faucet had come unattached. He stated, "Someone just told me about it as I was walking down the hall." He revealed that normally the staff just verbally tell him when something needs to be fixed, there is no form to fill out or computer system for maintenance request. He confirmed there was water standing in the floor in the resident's bathroom and that the sink faucet handle was not permanently attached and needed to be fixed.

An interview on 2/13/24 at 10:50 AM, with Licensed Practical Nurse (LPN) #1 revealed that she has not been notified about a water leak or the sink faucet not being attached in Residents #39 & #46's room. She confirmed that staff should put a wet floor sign up and notify the staff or maintenance of the issue so it can be fixed.

An interview on 2/13/24 at 10:55 AM, with the Administrator confirmed that if the staff find a maintenance issue that needs to be fixed they should notify a nurse or maintenance.

Record review of Resident #39's "Face Sheet" revealed the resident was admitted to the facility

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F 584	Continued From page 4 on 6/13/17 with medical diagnoses that included Other Recurrent Depressive Disorders. Record review of Resident #39's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/23/24, revealed in Section C a Brief Interview for Mental Status (BIMS) score of 13, which indicates the resident is cognitively intact and in Section GG that the resident walked independently. Record review of Resident #46's "Face Sheet" revealed the resident was admitted to the facility on 11/09/23 with medical diagnoses that included Unspecified Dementia and Unspecified Severity with Anxiety. Record review of Resident #46's MDS with an ARD of 2/9/24 revealed in Section C a BIMS score of 6, which indicates the resident is severely cognitively impaired and in Section GG that the resident walked independently.	F 584		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure a quarterly Minimum Data Set (MDS) assessment was completed timely for one (1) of 28 resident's MDS reviewed. Resident #14	F 638	1. Resident #14 was assessed by the Director of Nurses (DON) on 2/15/24 and had no noted ill effects from the facility's failure to complete the quarterly Minimum Data Set (MDS) assessment timely. Starting on 2/15/24, the MDS staff was	3/20/24

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F 638	Continued From page 5 Findings include: Record review of a document, on company letterhead, dated 2/14/24 provided by the Administrator revealed, "The facility does not have a policy on MDS completion and scheduling. The facility follows the Resident Assessment Instrument (RAI) manual." A record review of the "RAI Version 3.0 Manual", dated October 2023, "Chapter 2, Assessments for the RAI" page 2-35, "05. Quarterly Assessment", revealed "The Quarterly assessment...must be completed at least every 92 days following the previous Omnibus Budget Reconciliation Act (OBRA) assessment of any type..." Record review of the "Minimum Data Set (MDS) 3.0 Nursing Home (NH) Final Validation Report", dated 2/9/24, revealed that the Quarterly MDS, with an assessment reference date (ARD) of 1/25/24, for Resident #14 was completed late. During an interview with MDS Registered Nurse (MDS RN) on 2/14/24 at 10:25 AM, she stated that the Quarterly MDS for Resident #14 was completed late. She verified that the assessment was greater than 120 days old. In an interview on 2/14/24 at 10:27 AM, the MDS RN and MDS Licensed Practical Nurse (MDS LPN) stated that they had identified on Friday that the assessment was late but at that point there was nothing that could be done. The MDS LPN stated she is responsible for scheduling assessments and that the assessment was just missed. She stated that she thinks she may have gotten this resident mixed up with another	F 638	in-serviced by the DON on the importance of timely scheduling and completing quarterly MDS assessments. 2. All residents have the potential to be affected. 3. An in-service was initiated on 2/15/24 by the DON for the MDS Coordinator and MDS Assistant on ensuring resident MDS assessments are scheduled and completed timely. A 100% audit of MDS assessment review dates (ARD) was performed on 2/14/24 and will be ongoing weekly by the MDS Coordinator to ensure all MDS assessments are scheduled timely. 4. Starting on 2/14/24, the MDS Coordinator will conduct audits (five) 5 times per week and will continue onward with MDS assessment summary to ensure MDS assessments are completed timely. Starting on 2/19/24, the MDS Coordinator initiated a MDS assessment calendar daily check times (five) 5 days and will continue onward to ensure assessments are scheduled accurately. Starting on 2/23/24, the MDS Coordinator will submit the results to the Executive Director (ED) weekly times (eight) 8 weeks to audit for accuracy and completeness with audit results maintained in the ED office. Starting 3/20/24, the ED will forward results of the audit to the Quality Assurance (QA) committee monthly for review and further recommendations.	

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F 638	Continued From page 6 resident with the same last name. They stated the purpose for the MDS was to have an assessment of the resident to create the care plan and know how to take care of the resident. Both MDS Nurses agreed that not completing the MDS timely could result in not having an accurate assessment of the resident's needs causing the resident not to receive appropriate care . During an interview with the Administrator on 12/14/24 at 10:35 AM, she verified that the Quarterly MDS for Resident #14 was completed late and agreed it was her expectation that the MDS would be completed on time. A record review of Resident #14's "Face Sheet" revealed he was admitted to the facility on 7/5/11, with a diagnosis of Cerebral Palsy. A record review of Resident #14's Quarterly MDS revealed an ARD of 1/25/24 and a completion date of 2/2/24.	F 638		
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	F 656		3/20/24

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F 656	Continued From page 7 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review the facility failed to implement a care plan for a resident requiring two person assistance utilizing a total lift with transfers for one (1) of 28 resident care plans reviewed. Resident #55	F 656	1. On 2/12/24 Resident #55 was assessed by the Director of Nurses (DON) for ill effects related to staff not implementing a care plan for requiring (two) 2-person assistance utilizing a total lift with transfers. Resident #55 had no	

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F 656	Continued From page 8 Findings Include: Record review of the facility policy titled "Comprehensive Person-Centered Care Plan" with a revision date of 3/18 revealed "Policy ...Each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care..." Record review of Resident #55's Care Plans revealed a care plan with a problem onset date of 3/13/23, that indicated the resident required assistance with ADL's (Activities of Daily Living) related to resident has diagnosis of Cerebral Palsy with decrease mobility with interventions that included transfer assistance of two (2) staff members with the total mechanical lift. On 02/12/24 at 01:34 PM, an observation and interview revealed Nurse Assistant (NA) #3 had Resident #55 up in the total lift sling hovering over her wheelchair with no other staff member in the resident's room. An interview with NA #3 revealed she knows she is supposed to have a certified or licensed staff member with her when she uses a total lift. An interview on 2/14/24 at 1:30 PM, with Certified Nurse Assistant (CNA) #4 confirmed that Resident #55's care plan indicated the resident needed a two (2) person assist with transfers. She revealed that the staff have pocket care guides which are the residents' care plans. An interview on 2/14/24 at 2:15 PM, with the Administrator confirmed that Resident #55 had a care plan and a pocket care guide that indicated	F 656	noted ill effects. On 2/13/24, Nursing Assistant #3 received corrective counseling for not following the pocket care guide (PCG) and care plan while using a total body lift for Resident #55 transfer. On 2/13/24, an in-service was initiated for Nursing Assistant #3 on following the PCG for residents requiring two-person assistance with total lift. 2. All residents requiring use of total lift have the potential to be affected. 3. Starting on 2/13/24 an in-service was initiated to all nursing staff by the Staff Development Coordinator (SDC) on following the PCG and care plan to ensure two person assist is utilized for total lift transfers at all times. 4. Starting 2/19/24, the DON and Unit Managers will make Nurse Assistant staff observation audit rounds (three) 3 times per week for (four) 4 weeks, then weekly times four weeks to ensure care plan implementations are followed for residents using two-persons for total body lift. Starting 2/23/24, results of the observation audits rounds are submitted to the Executive Director (ED) weekly times (eight) 8 weeks to monitor for accuracy and completeness and maintained in the ED office. Starting 3/20/24, the ED will forward results of the audit to the Quality Assurance (QA) committee monthly times (three) 3 months for review and further recommendations.	

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F 656	Continued From page 9 the resident should have two people assisting with the total body lift and since the staff did not use two (2) people then the care plan was not implemented. She revealed the purpose of a care plan and pocket care guide was to provide the information the staff need to care for the residents. An interview on 2/15/24 at 8:20 AM, with the Director of Nursing (DON) confirmed that Resident #55's care plan indicated the need for two persons assist with the total body lift and since NA #3 did not use two (2) people then the care plan was not implemented. Record review of Resident #55's "Face Sheet" revealed the resident was admitted to the facility on 7/21/21 with medical diagnoses that included Unspecified Cerebral Palsy. Record review of Resident #55's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/7/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 14, which indicates the resident is cognitively intact and in Section G that the resident needed a two-person physical assist with transfers.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		3/20/24

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F 689	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, record review and facility policy review, the facility failed to ensure an environment free of accident hazards as evidenced by one staff member using a two-person total body lift to transfer Resident #55 and standing water in a bathroom (Resident's #39 & 46) for three (3) of 28 residents reviewed on sample. Findings Include Review of the typed statement on facility letterhead dated 2/14/24 and signed by the Administrator revealed the facility does not have a policy regarding accident and hazard prevention. Review of the facility policy titled, "Invacare Total Lift" with a revision date of 8/16 revealed under the "Policy...The Invacare Total Lift is used for total lifts and/or to obtain a resident's weight from bed to chair, chair to bed, or from the floor..." Resident #55 An observation and interview on 02/12/24 at 01:34 PM, revealed Nurse Assistant (NA) #3 had Resident #55 up in the total lift sling hovering over her wheelchair with no other staff member in the resident's room. An interview with NA #3 revealed she is not certified, and she knows she is supposed to have a certified or licensed staff member with her when she uses a total lift because of the risk of the resident falling or slipping out of the sling. She stated the resident was so wet and needed changing and she just could not find anyone to help her. This interview	F 689	1. On 2/1/24, Resident #55 was assessed by the Director of Nurses (DON) for any ill effects related to staff not implementing a care plan for requiring (two) 2-person assistance utilizing a total lift with transfers. Resident #55 had no noted ill effects. On 2/12/24, Nursing Assistant #3 received corrective counseling for not following the pocket care guide (PCG) and care plan while using a total body lift for Resident #55 transfer. On 2/12/24 an in-service was initiated for Nursing Assistant #3 on following the PCG for residents requiring two-person assistance with total lift. On 2/13/24 Resident #39 and Resident #46 sink faucet and sink toilet leak in bathroom was repaired by the Maintenance Director. Resident #39 and Resident #46 had no ill effects from this deficient practice. 2. All residents have the potential to be affected. 3. An in-service was initiated on 2/13/24 for all staff by the Staff Development Coordinator (SDC) on ensuring maintenance issues are documented in the Maintenance Repair Log book located at the nurse's station, placing wet floor signs down for wet floors, cleaning spills and liquids off the floor as soon as possible. An in-serivce was initiated to all nursing staff on 2/13/24 by the Staff Development Coordinator (SDC) on following the PCG and care plan for	

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F 689	Continued From page 11 continued at the nurse's station where we found Licensed Practical Nurse (LPN) #2 and Registered Nurse (RN) #1. NA #3 informed them that she had lifted the resident with a total lift and no assistance from another staff member. RN #1 stated," why did you not come get one of us" and NA #3 stated she could not find anyone. RN #1 and LPN #2 revealed that the resident needs a two person assist with a total lift to prevent falls. NA #3 stated that she had been in-serviced on how to use the total lift and knows that she should have just waited to get help from another staff member. An interview on 2/14/24 at 1:30 PM, with Certified Nurse Assistant (CNA) #4 confirmed that sometimes the aides use the total lifts alone because there is not enough staff to help. She stated we usually know the residents that we can use one person with the total lift and those that would need two (2). She stated that the policy is to use two (2)staff members with a total body lift and has been in-serviced. She stated that to be honest we just do the only thing we can. An interview on 2/14/24 at 2:15 PM, with the Administrator revealed that the staff have "Pocket Care Guides" that tell them what each resident's care needs are and that Resident #55's indicated she needed a two person assist with total lifts. An interview on 2/15/24 at 8:20 AM, with the Director of Nursing (DON) confirmed that staff are expected to use two (2) people with the total body lift and the NA should have gone out and got someone to help her. She confirmed that the aides have a pocket care guide, and she expects them to use it. She confirmed that the staff receive in-services and training regarding using	F 689	residents requiring lift to use two-person assistance at all times. 4. Starting 2/19/24, the Maintenance Director and/or Assistant Maintenance Director will make resident room rounds checking bathrooms for leaks or broken faucets (five) 5 times weekly for 4 weeks, then weekly times four weeks to ensure safe environment for residents. The Director of Nurses (DON) or Unit Managers will make rounds (three) 3 times per week for (eight) 8 weeks to ensure care plan implemented and followed for residents using two-persons for total body lift starting 2/19/24. Starting 2/23/24, results of audits and rounds are submitted to the Executive Director (ED) weekly times (eight) 8 weeks to audit for accuracy and completeness and will be maintained in the ED office. Starting 3/20/24, the ED will forward the results of the audit to the Quality Assurance (QA) committee monthly times (three) 3 months for review and further recommendations.	

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	255114	A. BUILDING _____ B. WING _____	02/15/2024

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F 689	Continued From page 12	F 689		

the total body lift on hire and annually. She confirmed that NA #3 was in-serviced on the use of the total body lift.

Record review of NA #3 State approved Nurse Aide Training Program (NATP) certificated revealed it was completed on 11/17/23.

Record review of the facility in-services revealed the facility had an in-service dated 11/15/23 regarding full body lifts and that noncertified staff were not to use the lift and that was attended by nursing staff including NA #3. Another in-service was completed on 12/9/23 regarding full body lifts, "students cannot use lift without a certified CNA and to follow the pocket care guide" that was attended by NA #3.

Record review revealed NA #3 had received a "Competency Evaluation and Assessment Total Lift" on 12/9/23 that indicated the staff member demonstrated proper use of the total lift.

Review of the Manufacturers General Guidelines for the Total Body Lift indicated under "Operating the Lift...The use of one assistant is based on the evaluation of the health care professional for each individual case."

Record review of Resident #55's "Admission/Readmission Evaluation" dated 3/13/23, revealed under "Mobility-that the resident needed a two (2) person assist with a full body lift.

Record review of Resident #55's "Daily Care Guide" revealed the resident needed a two (2) person assist with a total mechanical lift for transfers.

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Record review of Resident #55's "Face Sheet" revealed the resident was admitted to the facility on 7/21/21 with medical diagnoses that included Unspecified Cerebral Palsy.

Record review of Resident #55's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/7/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 14, which indicates the resident is cognitively intact and in Section G that the resident needed a two-person physical assist with transfers.

Resident #39 and #46

During an interview and observation on 02/12/24 at 11:06 AM, with Resident's #39 and 46 revealed the resident's bathroom had a puddle of water in the floor approximately two (2) feet wide by two (2) feet wide between the toilet and the sink. An interview with Resident #39 & 46 revealed they both walk independently. When asked if the staff were aware there was a possible leak, Resident #46 stated, yes, they have come in and looked at it, but no one's fixed it.

During an observation and interview on 02/13/24 at 10:30 AM, of Resident #39 & 46's bathroom revealed there was still a puddle of water between the toilet and the sink that was approximately two (2) feet wide by two (2) feet long, that extended to the front of the toilet.

In an interview on 2/13/24 at 10:50 AM, with Licensed Practical Nurse (LPN) #1 revealed that she has not been notified about a water leak in Residents #39 & 46's room. She confirmed that staff should put a wet floor sign up and notify the

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F 689	Continued From page 14 staff or maintenance of the issue so it can be fixed. She confirmed that both of those residents walk independently, and it could have been a fall hazard. During an interview on 2/13/24 at 10:55 AM, with the Administrator confirmed that if the staff find a maintenance issue that needs to be fixed then they need to notify a nurse or maintenance. She confirmed that the water in the floor could have been a fall hazard for the residents in that room. Record review of Resident #39's "Face Sheet" revealed the resident was admitted to the facility on 6/13/17 with medical diagnoses that included Other Recurrent Depressive Disorders. Record review of Resident #39's MDS with an ARD of 1/23/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 13, which indicates the resident is cognitively intact and in Section GG that the resident walked independently. Record review of Resident #46's "Face Sheet" revealed the resident was admitted to the facility on 11/09/23 with medical diagnoses that included Unspecified Dementia, Unspecified Severity with Anxiety. Record review of Resident #46's MDS with an ARD of 2/9/24 revealed in Section C a BIMS score of 6, which indicates the resident is severely cognitively impaired and in Section GG that the resident walked independently.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		3/20/24

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F 725	Continued From page 15 §483.35(a) Sufficient Staff. 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)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, Payroll Based Journal data, record review and facility policy review the facility failed to provide adequate staffing to provide nursing and related services to meet the residents' needs safely and in a timely manner for one (1) of 28 sampled residents during survey and five (5) of 5 weekends in July 2023. Findings Include.	F 725	1. On 2/13/24, the Director of Nurses (DON) assessed Resident #55 for any ill effects and none noted from inadequate staffing to provide nursing and related services to meet the resident's needs safely and in a timely manner. 2. All residents have the potential to be affected.	

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F 725	Continued From page 16 The Administrator (ADM) provided on facility letterhead that the facility does not have a policy on staffing, the facility follows the State Department of Health Licensure regulations. A record review of "PBJ Staffing Data Report CASPER Report 1705D FY (Fiscal Year) Quarter 4 2023 (July1-September 30)", revealed "Excessively Low Weekend Staffing - Triggered. Triggered = Submitted Weekend Staffing data is excessively low". During an observation and interview on 02/12/24 at 01:34 PM revealed Nurse Assistant (NA) #3 had Resident #55 up in the total lift sling hovering over her wheelchair with no other staff member in the resident's room. An interview with NA #3 revealed she is not certified, she stated she has completed her course but is waiting to take her exam and it has been close to four (4) months. She revealed she knows she is supposed to have a certified or licensed staff member with her when she uses a total lift, because of the risk of the resident falling or slipping out of the sling. She stated the resident was so wet and needed changing and she just could not find anyone to help her. An interview on 2/12/24 at 1:38 PM with NA #3 revealed Licensed Practical Nurse (LPN) #2 and Registered Nurse (RN) #1 were sitting at the nurse's station. NA #3 informed them that she had lifted the resident with a total lift and no assistance from another staff member. RN #1 stated, " why did you not come get one of us"? NA #3 stated she could not find anyone. RN #1 and LPN #2 revealed that the resident needs a two person assist with a total lift to prevent falls.	F 725	3. An in-service was provided on 2/16/24 to the Staff Development Coordinator (SDC) and Director of Nurses (DON) by the Executive Director (ED) on sufficient staffing on a 24-hour basis to provide nursing care to all residents in accordance with each resident's care plan following the state licensure and federal certification regulations. Staffing levels have been reviewed with the SDC and steps to be taken to address call-ins. A staff meeting/in-service was initiated by the SDC and DON to all nursing staff on 2/23/24 to review importance of coming to work and the call-in policy and procedure which includes calling in two hours prior to shift. The SDC and DON will take all call-ins. Unscheduled Certified Nursing Assistants (CNA) will be called and/or scheduled CNA's will be asked to stay over to cover shifts for call-ins. If unable to get shift covered with a CNA, a licensed nurse will be called to fill the CNA shift. The DON has a weekly meeting with the SDC to discuss open positions, applicant flow, and new hires in process starting 2/19/24. Starting 2/23/24, the SDC, DON, and ED will meet every Friday to ensure adequate staffing to meet resident needs on the weekend. 4. The SDC or DON will audit Weekend staffing schedule daily times (three) 3 days per week (Friday, Saturday, and Sunday) for eight weeks for levels to ensure adequate staffing on the weekends starting 2/16/24. Results of the audit will be forwarded to the ED weekly times eight weeks starting 2/23/24 to audit	

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F 725	Continued From page 17 NA #3 admitted that she had been in-serviced on how to use the total lift and knows that she should have waited to get help from another staff member. An interview on 02/14/24 at 9:00 AM, with the Staffing Coordinator confirmed that the number of staff needed daily in the facility for hands on care is determined by the number of residents inside of the facility and the acuity of those residents requiring care. She confirmed that if there are call-ins or shifts and she is unable to fill in, she notifies the Director of Nursing (DON) and then the DON attempts to get additional staff to come in for hands-on care. She stated the DON and ADM are made aware of additional needs on the schedule. An interview on 2/14/24 at 1:30 PM, with Certified Nursing Assistance (CNA) #4 revealed she had been at the facility for years and she is now the restorative aide. She stated that she has never seen it as bad as it is right now with staffing, and "we need more CNA's." She stated that they are doing the best they can and sometimes it's all they can do to turn them, clean them, and feed them, so they may not get three baths a week, they may only get two (2). She confirmed that sometimes the aides use the total lifts alone because there are not enough staff to help., She stated we usually know the residents that we can use one person with the total lift and those that would need 2. She revealed the policy states there must be 2 staff members with a total body lift and has been in-serviced on the policy, but to be honest we just do the only thing we can. An interview on 02/14/24 at 2:54 PM with the ADM confirmed that she was not aware that the	F 725	for accuracy and completeness and will be maintained in the ED office. Starting 3/20/24, the ED will submit results of the audits to the Quality Assurance (QA) committee monthly times (three) 3 months for review and further recommendations.	

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facility had triggered on the CASPER report for low weekend staffing. She stated that she has not seen a CASPER report and only receives a report from her corporate office. The ADM stated, " I don't know how to pull that information, I have never pulled it".

An interview on 02/14/24 at 3:00 PM, with the Account Manager for the facility confirmed that she is unaware of how to pull a report to show where the facility triggered for low weekend staffing. The Account Manager stated, " We use a system called Smart Link that pulls from the time clock when people clock in and we compare it to the schedule then reconcile with payroll and then we generate that information into the Payroll Based Journal (PBJ) system, but we don't get a message or a notice that the facility triggers for low staffing".

A record review of staffing numbers that the facility reported in the Payroll Based Journal (PBJ) revealed that the facility had excessively low staffing for five (5) out of 5 weekends during July 2023.

An interview on 02/15/24 at 8:00 AM, with the ADM confirmed that the facility was excessively low on staffing for 5 of 5 weekends in the month of July 2023. The ADM stated, " I knew we were low on some of those dates, and we tried to get staff to come in".

An interview on 02/15/24 at 8:30 AM, with the DON confirmed that she was unaware of the facility was short on the weekends. She reported that when they don't have enough staff that they are supposed to call additional people in to work and that she doesn't look at the numbers to make

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F 725	Continued From page 19 sure that there was enough staff in the facility. The DON confirmed that staff are expected to use 2 people with the total body lift and the CNA should have gone to get someone to help her, anyone like a nurse. She stated they offer incentives to the CNA's when we are not fully staffed, but they quit offering incentive to the CNAs about a month ago.	F 725		