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M 000	Initial Comments Level IV The State Agency (SA) conducted an annual recertification survey, as well as Complaint Investigation (CI) MS #23999 at the facility from 2/11/24 through 2/20/24. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm and cited M0030, M175, M190, M500, M610, M645, M655, M1230, and M1570. The SA investigated the complaints related to resident abuse and misappropriation of property and issued no citations. The SA identified an Immediate Jeopardy (IJ)and Substandard Quality of Care (SQC) that began on 11/02/23 when the facility failed to recognize, evaluate, and address Resident #13's nutritional needs, which resulted in an unintended significant weight loss of 6.92% (percent) in one (1) month, which further led to a significant weight loss of 17.52% (percent) in four (4) months. The facility's failure to consult a Registered Dietician (RD), notify the attending physician of a significant change in condition, and act upon the residents' weight loss, placed the resident, and all other residents residing in the facility at risk for serious harm, serious injury, serious impairment, and possibly death. The IJ and SQC existed at: Rule 45.17.2 - Resident Rights - M500 - Scope/Severity -Level IV Pattern Rule 45.21.9 - Nutrition - M645 - Scope/Severity - Level IV IJ existed at:	M 000		

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M 000	Continued From page 1 Rule 45.2.1 Administrator M 0030 Level IV Pattern The facility Administrator was notified of the IJ and SQC on 2/13/24 at 4:30 PM. The facility provided an acceptable Removal Plan on 2/14/24, in which they alleged all corrective actions to remove the IJ were completed on 2/13/24 and the IJ removed on 2/14/24. The SA validated the Removal Plan on 2/20/24 and determined the IJ was removed on 2/14/24. Therefore, the scope and severity (s/s) for Rule 45.2.1 Administrator M 0030, Rule 45.17.2 - Resident Rights - M500 and Rule 45.21.9 - Nutrition - M645 was lowered from a "Level IV" to a s/s of "Level II" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The census at the time of survey was 60, and the facility held a license for 66 beds.	M 000		
M 030	45.2.1 Administrator Administrator. The term "administrator" shall mean a person who is delegated the responsibility for the interpretation, implementation, and proper application of policies and programs established by the governing authority and are delegated responsibility for the establishment of safe and effective administrative management, control, and operation of the services provided. The administrator may be titled manager, superintendent, director, or otherwise. The administrator shall be duly licensed by the Mississippi State Board of	M 030		3/19/24

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M 030	Continued From page 2 Nursing Home Administrators. This Statute is not met as evidenced by: Level IV Pattern Based on observation, resident and staff interview, record review, and job description review, the facility failed to be administered in a manner that ensured residents with significant weight loss would get the necessary nutritional support and services to ensure their well-being for two (2) of three (3) residents sampled for abuse/neglect as evidenced by: Resident #13 and Resident #20 1) failed to recognize, evaluate, and address a resident's nutritional needs, which resulted in an unintended significant weight loss of 6.92% (percent) in one (1) month, which further led to a significant weight loss of 17.52% (percent) in four (4) months. Resident #13. The facility's failure to consult a Registered Dietician (RD), notify the attending physician of a significant change in condition, and act upon the residents' weight loss, placed the resident, and all other residents residing in the facility at risk for serious harm, serious injury, serious impairment, and possibly death. 2) failed to identify and address a resident at risk for malnutrition due to prolonged nausea and vomiting, and failure to identify a decrease in food intake due to pain and nausea resulted in an unintended significant weight loss of 40.5 pounds in six (6) months. Resident #20. The facility's failure to implement a Registered Dietician (RD) recommendation, notify the attending physician of a significant change in condition, and address the residents' prolonged symptoms of nausea and vomiting, and decreased food intake placed the resident and all other residents residing in the	M 030	1. On 02/11/2024, antiemetic medication was ordered for resident #20. On 02/14/2024, resident #20 was ordered appetite stimulant. On 02/14/2024, Resident #20 was admitted to hospice services. On 02/14/2024, Resident #20 received an order for a laxative and was administered a laxative and abdominal x-ray. On 02/15/2024, resident #20 still had no results from laxative, provider was notified, and order received for enema with results noted. On 2/15/2024, resident #13 was ordered fortified cereal and fortified mashed potatoes. 2. All residents in the facility have the potential to be affected by the alleged negligent practices. 3. Starting 02/13/2024, licensed nurses in-serviced on notifying provider of changes in condition with posttest to confirm understanding. One-on-One in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records Nurse, and Minimum Data Set Nurse regarding weights, care plans, notifying physician, Quality Assurance and Performance Improvement meetings, Registered Dietitian Recommendations, Documentation, and Administration were conducted by the Regional Nurse Consultant. On 02/13/2024, the Regional Director of Operations conducted and One-on-One inservice with the Administrator regarding weights, care plans, notifying physician Starting 03/08/2024, Rehab Director to in-service	

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M 030	Continued From page 3 facility at risk for serious harm, serious injury, serious impairment, and possibly death. The facility's neglect also resulted in a functional decline for Resident #20, which possibly resulted in the resident's admission to hospice services on 2/14/24. The State Agency (SA) identified an Immediate Jeopardy (IJ) that began on 11/02/23 when the facility failed to recognize, evaluate, and address Resident #13's nutritional needs. The IJ existed at: Rule 45.2.1 Administrator M 0030 Level IV The facility Administrator was notified of the IJ on 2/13/24 at 4:30 PM and provided the IJ Template. The facility provided an acceptable Removal Plan on 2/14/24, in which they alleged all corrective actions to remove the IJ were completed on 2/13/24 and the IJ removed on 2/14/24. The SA validated the Removal Plan on 2/20/24 and determined the IJ was removed on 2/14/24. Therefore, the scope and severity for Rule 45.2.1 Administrator M 0030 Level IV was lowered from a Level IV to a Level II while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Review of the Job Description for the Nursing Home Administrator (NHA) with a revision date of 8/10/27 revealed, "Summary: As Nursing Home Administrator, you will be responsible for the	M 030	therapy staff to notify nurse of changes in resident conditions and concerns promptly. On 03/07/24, a new registered dietician began covering facility. Starting 02/13/2024, all staff will be in-serviced on abuse and neglect and will be provided with a posttest to confirm understanding. On, 03/08/2024, all residents receiving an opioid pain medication were assessed for side effects with provider notification and orders as needed. Starting 03/08/2024, licensed staff were educated regarding the side effects of opioid medications, observation orders, and signs and symptoms to report to the provider. 4. Regional Director of Operations will conduct weekly visits starting 02/13/2024 for four weeks then monthly for 3 months to conduct facility audits including Quality Assurance and Performance Improvement meeting minutes, At-Risk meetings including weights and wounds, all open Performance Improvement Plans, and compliance with plan of correction. Regional Director of Operations will attend Quality Assurance and Performance Improvement meetings starting 03/19/2024 and then for 3 months. The Regional Director of Operations will report all audit findings to the Quality Assurance and Performance Improvement Meetings monthly for 4 months, starting on 03/19/2024, then as needed.	

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overall operations, leadership, management and success of the facility in accordance with resident/employee needs, government regulations, and company policy. Responsible for ... quality assurance, regulatory management, ... and resident care...Essential Duties And Responsibilities: ... Direct and coordinate medical, nursing and administrative staffs and services. ... Conduct regular rounds to monitor delivery of nursing care and operation of support departments. ... Ensure consultants and other support resources are appropriately utilized. "

Review of the Job Description for the Director of Nursing (DON) with a revision date of 8/10/17 revealed, "Summary: To manage overall operation of the Nursing Services Department in accordance with Company Policies, standards of nursing practices and governmental regulations so as to maintain excellent care of all the Residents' and employee's needs...Essential Duties And Responsibilities: Work with the Administrator, Consultants, and facility staff in planning all aspects of nursing services to include interface with other disciplines and departments. ... Conduct regular rounds to review care. Assess resident's physical and psychosocial status. Monitor care activities and documentation to ensure the delivery of nursing care according to the physician's order, care plans, and established standards and facility policies. ... Follow and ensures compliance with State, Federal, and company QAPI (Quality Assurance and Performance Improvement) standards. Follow and ensures medication administration is conducted in accordance with nursing standards and facility policies..."

Review of the Job Description for the Assistant Director of Nursing (ADON) with a revision date

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of 8/10/17 revealed, "Summary: ... Also assist the Director of Nursing in managing overall operations of the Nursing Services Department in accordance with Company policies, standards of nursing practices and government regulations so as to maintain excellent care of all the Residents' and employee's needs....Essential Duties And Responsibilities: ... Responsible for overseeing nursing services in the absence of the Director of Nursing. ... Assists in conducting regular rounds to monitor resident activity and ensure resident quality of care. Assess resident's physical and psychosocial status. ... Personally participates in the assessment and delivery of care. ... Follow and ensures compliance with State, Federal, and Company QAPI standards." ...

Record review of the facility policy titled "Dietician" with a review date of 7/24/23 revealed, "Policy Interpretation and Implementation: 1. A qualified dietician or other clinically qualified nutrition professional will help oversee food and nutrition services provided to the residents. ... 9. Our facility's dietician is responsible for, but not necessarily limited to: a. assessing nutritional needs of residents; ... f. participating in quality assurance and performance improvement (QAPI) when food and nutrition services are involved... "

Resident #20

Observation and interview with Resident #20 on 2/11/24 at 3:19 PM, revealed her lying in a fetal position at the foot of the bed with garbage can located on the floor beside the resident. The resident stated she was sick to her stomach and had a washcloth in her hand and was wiping her face. The resident's color was pale, lips were dry, and she was thin in appearance.

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Interview with the DON on 2/11/24 at 3:55 PM, revealed Resident #20's condition had declined over the past couple of months. She explained that the resident had a significant decline after she fell in December 2023, and received a fracture of the T-12 vertebrae and had to be placed on strong pain medications. She stated, to her knowledge, the resident had not experienced any nausea and vomiting until yesterday when the Survey Agency brought it to her attention. She stated none of the staff had reported it to her and that she should be aware of what was happening with the resident. She revealed she was aware that the resident was not eating or drinking and had been refusing meals.

An interview with the Assistant Director of Nursing (ADON) on 2/11/24 at 6:18 PM, revealed she had not been informed by the staff that Resident #20 had been experiencing nausea and vomiting and stated she was unsure how long the resident had been sick.

Observation of Resident #20 on 2/12/24 at 8:29 AM, revealed her lying on her right side in bed. The garbage can was located on the floor, close by the resident. The breakfast tray was located on the bedside table untouched. Certified Nurse Aid CNA #2 entered the resident's room and stated the resident refused to eat or drink due to nausea. CNA #2 removed the tray cover, and the resident began retching and vomited a small amount of clear substance. The resident was weak, pale, and her lips were dry.

Interview with CNA #2 on 2/12/24 at 8:35 AM, revealed she had worked at the facility for three (3) weeks and that the resident had been refusing to eat or drink since then. She explained that the resident had been nauseated, dry heaving, and

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vomiting for the three (3) weeks since she had been employed, and she had reported it to the medication nurse every day that she worked.

Interview with CNA #1 on 2/15/24 at 8:35 AM revealed Resident #20 refused breakfast due to nausea and she had notified the nurse each time that she witnessed the resident with nausea and vomiting or refusing to eat and drink.

Record review of Resident #20's "Progress Notes" from 11/01/23 through 2/11/24, revealed there was not any documentation that the resident had nausea and vomiting or that she refused meals.

Record review of the "Occupational Therapy Progress Notes" dated 2/01/24 revealed, "Patient refused: pt (patient) is refusing to eat and has poor appetite. pt (patient) c/o (complains of) nausea almost every day, but is not eating even with max encouragement and assist from therapist." ... Also revealed under, "Assessment and Summary of Skilled Services: ... therapist encouraging pt (patient) daily to eat and providing assist, but pt (patient) refuses to eat and c/o (complains of) nausea." ...

Record review of the "Order Summary Report" for Resident #20 revealed an order dated 2/11/24 at 1827 (6:27 PM), "Ondansetron HCL (Hydrochloride) (Zofran) Tablet 4 (four) MG (milligrams) Give 1 (one) tablet by mouth every 6 (six) hours as needed for Nausea and Vomiting" ...

Record review of Resident #20's January and February 2024 "Medication Admission Record" (MAR) revealed, there was not a physician's order for nausea/vomiting medication before the

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new order for Zofran started on 2/11/24, which indicated the resident's symptoms of prolonged nausea and vomiting were left untreated.

Record review of the "Meal Intake Documentation Report" completed by the Certified Nurse Aides (CNAs) revealed, Resident #20 refused eighteen (18) meals from 12/18/23 through 12/31/23. She refused thirty-one (31) meals in the month of January 2024, with a total of thirty-nine (39) meals consumed at 0-25% (percent), and she refused sixteen (16) meals from 2/01/24 through 2/11/24, with a total of fourteen (14) meals consumed at 0-25% (percent).

Record review of Resident #20's weights revealed a significant weight loss of 13.9% (percent) in one (1) month, 21.6% (percent) in three (3) months, and 26.2% (percent) in six (6) months.

Record review of the "Dietary Recommendations" dated 12/27/23, for Resident #20 revealed the RD (Registered Dietician) recommended, "Med Pass 2 oz (ounces) BID (twice daily), weekly weights x (times) 4 (four) weeks, and add Fortified Pudding BID (twice daily) at lunch and dinner" ...

Record review of the "Consultant Registered Dietician (RD) Note" dated 1/5/24, for Resident #20 revealed, "Resident w/(with) significant wt (weight) loss x (times) 1 (one) mo (month) (-9%) and x (times) 6 (six) mo (months) (13.7%) (percent). Po (by mouth) intake likely not meeting nutritional needs. Resident is at risk for skin breakdown and wt (weight) loss d/t (due to) decreased appetite ... NO N/V/c/D (nausea, vomiting, complaints of diarrhea) documented." ... Also revealed under REC (recommendations): "Resident may benefit from an appetite stimulant,

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please document % (percentage) of supplement consumed daily, add fortified pudding BID (twice daily) at lunch and dinner, weekly weights x (times) 4 (four) weeks to assure stable weight" ...

Record review of the "Consultant Registered Dietician (RD) Note) dated 2/10/24, for Resident #20 revealed, "Resident w/(with) significant wt (weight) loss x times 1 (one) mo (month), x (times) 3 (three) mo (months) and x (times) 6 (six) mo (months) ... consuming <25% w/(with) refusals of meals ... Po (by mouth) intake likely not meeting nutritional needs ... NO N/V/c/D (nausea, vomiting, complaints of diarrhea) documented." ... Also revealed under REC (recommendations): "Resident may benefit from an appetite stimulant, please document % of supplement consumed daily, weekly weights x 4 weeks to assure stable weight, if po (by mouth) intake and wt (weight) status does not improve, resident may benefit from an alternate means of nutrition support."

Record review of the "Order Summary Report" for Resident #20 revealed there was not a physician's order for fortified pudding at lunch and supper or a medication to stimulate appetite per Registered Dietician (RD) recommendations.

Telephone interview with Medical Director on 2/12/24 at 6:05 PM, revealed the staff had contacted him last night regarding Resident #20 having nausea and vomiting, and he had ordered Zofran as needed. He confirmed that the staff had not contacted him or made him aware of the residents' decline in condition or her refusal to eat or drink. He stated that he was not notified of her significant weight loss (40.5 pounds in 6 months) or the Registered Dietician (RD) recommendations. He confirmed Resident #20's

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current condition was serious and stated what you have relayed screamed neglect.

Record review of Resident #20's Physician Nursing Home Visit dated 1/26/24 revealed, "No concerns reported by the nursing staff ...." The physician progress note did not identify any documentation to support the resident's nausea and vomiting or weight loss.

Interview with Licensed Practical Nurse (LPN) #2 on 2/13/24 at 7:45 AM, revealed Resident #20 was not drinking the med pass supplement, and was refusing meals. She stated that the resident had been refusing meals for several weeks. She revealed that the resident's family was highly involved with her care, and the resident would report nausea to them, and they would come and notify her.

Interview with the Dietary Manager (DM) on 2/13/24 at 8:13 AM, revealed that the RD was consulted on Resident #20 in January 2024, but confirmed that she had not seen any RD recommendations. She stated that the resident had never received fortified pudding, and to her knowledge, had never started on an appetite stimulate. She explained that the facility had trouble getting the RD recommendations. The DM stated she just realized last week on Friday 2/9/24 that the RD recommendations were going to her spam email. She revealed that she tried to open the email and the email read it was quarantined. She revealed that she told the DON that she was not receiving anything from the RD, and she thought the DON had texted her. She revealed that the administrator had been going into all the residents' progress notes and printing out the recommendations to make sure they were being implemented. She confirmed that lack of

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implementation of the RD recommendations could cause the resident to have weight loss and malnourishment.

Telephone interview with the Registered Dietician (RD) on 2/13/24 at 9:56 AM, the RD stated she was notified in late December that Resident #20 needed to be seen due to a significant change. She revealed that she recommended med pass 2 ounces twice daily as a supplement, weekly weights and fortified pudding added with lunch and dinner. She revealed that she also did a consultation on Resident #20 on 1/5/24 and 2/10/24 and recommended that the resident would benefit from an appetite stimulant. She explained that she emailed all her recommendations to the ADM, DON, DM, and the Regional Nursing Consultant (RNC). She explained that she marked on the recommendations if the resident's physician needed to be contacted for a physician order. She stated that she had not been contacted by anyone from the facility reporting that they had not received Resident #20's dietary recommendations.

Interview with the DON on 2/13/24 at 10:38 AM. she confirmed after reviewing the progress notes, she observed there was no documentation to support Resident #20's decline, nausea, and vomiting or food refusal. She confirmed that the facility should have notified the physician immediately when the decline came about, and verbalized that was a failure on their part. The DON stated that the facility did not reach out to the physician to inquire about drawing labs or starting any Intravenous fluids (IV) throughout these months of the resident refusing to eat or drink. She stated that she did report the weight loss to the physician while he was inside the

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facility. She stated, "I do not recall the date or month I notified him." She confirmed that she did not have documentation to support her notification. She stated the RD recommendations were not implemented because the facility was not receiving any of them, and the DM determined that the emails were going to her junk folder. She explained that the Administrator was going into the resident notes and printing them out to ensure they were all implemented. She revealed she was unsure if an audit was conducted to ensure all the recommendations were implemented. The DON stated that the RD would also add notes into the Electronic Medical Record (EMR) and would not tell anyone. She revealed that she had texted the RD to tell her that the recommendations were not received, and the RD would reply that she would resend them. The DON stated she had never received any emails from the RD, and confirmed that she had not gone into her junk email to search and see if they came to her that way. The DON stated, "I have over 700 junk emails and I do not have time to do that."

Interview with the Administrator (ADM) on 2/13/24 at 2:10 PM, revealed that the facility usually communicates with the current RD through email or text messages. The ADM stated the last RD recommendation she had received by email was in August 2023 and that the Dietary Manager (DM) had received some, but they went to her spam folder encrypted. She explained that she had not reached out to the RD herself to follow up and confirmed that the facility had not started an audit and stated they tried to go over the recommendations in the High-Risk meetings. She stated that Resident #20 had been discussed in January 2024 during a PAR (patients at risk) meeting. The ADM confirmed that the Dietary

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Recommendations for Resident #20 had not been implemented and that the facility failed to document the significant changes that occurred in the resident's condition. She stated, "I know the documentations not there." She revealed that she was told the DON had reached out to the physician and stated, "It looks bad on our part."

Record review of Resident #20's Order Summary Report revealed an order dated 1/02/24, "Norco Oral Tablet 7.5 -325 MG (milligrams) (Hydrocodone-Acetaminophen) Give 7.5 mg (milligrams) by mouth every 6 (six) hours related to Pain ..."

Record review of Resident #20's Order Summary Report revealed an order dated 12/13/23, "Tramadol HCL (Hydrochloride) Tablet 50 MG (milligrams) Give 1 tablet by mouth every 12 (twelve) hours as needed for pain. Also revealed an order dated 12/13/23, "Tramadol HCL (Hydrochloride)Tablet 50 MG (milligrams) Give 2 (two) tablets by mouth every 12 (twelve) hours as needed for pain ..."

Record review of Resident #20's Pain Care Plan revealed under, "Interventions/Tasks: ... Observe/document for side effects of pain medication. Observe for constipation; ... nausea; vomiting; ... Report occurrences to the physician." ...

Record review of Resident #20's BM (bowel movement) Report dated 1/29/24 through 2/13/24 revealed one (1) medium BM documented on 2/04/24. All other days documented as "None" or "Not Applicable" ...

Interview with the Assistant Director of Nursing (ADON) on 2/13/24 at 5:10 PM, revealed the

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aides were responsible for documenting the bowel movements every shift. She revealed if a resident did not have a bowel movement in 3 days, it will trigger the charting system dashboard and will alert the DON. She revealed that the dashboard was checked every morning by the DON after the daily stand-up meeting to identify which residents had not had a BM. She explained that the DON would then check with the nurses and the aides on the floor to identify if a resident had a BM, and maybe it was not documented. If a resident had not had a BM, a process was followed through with pulling a standing order for a laxative. She revealed that Resident #20's BM report was not firing to the dashboard to alert the staff of no BM.

Interview with the DON on 2/13/24 at 5:36 PM, confirmed the facility did not have a monitoring tool in place for the residents receiving high doses of opioid pain medication to monitor for the common side effects of constipation, nausea, and vomiting. She revealed that Resident #20's BM Report was not firing to the charting system database to alert the staff of no BM. She confirmed that Resident #20 had not had a documented BM since 2/4/24. She explained that the resident was incontinent, so if she did have a bowel movement, the staff would have known. She stated that the physician had not been notified at this point. She revealed that she was going to tell Resident #20's nurse to administer a laxative, and she would follow up with the resident in the morning.

Interview with the Director of Nursing (DON) on 2/14/34 at 9:20 AM, revealed she was unsure if Resident #20 had a bowel movement (BM) overnight. She revealed that with everything going on in the facility yesterday, she forgot to notify the

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nurse caring for the resident last night that she needed a laxative. She explained if a laxative had been administered it would be documented on the Medication Administration Record (MAR) and it was not. She stated," I will get someone to do it now."

Interview with the Director of Nursing (DON) on 2/14/24 at 2:55 PM, revealed she had not notified the nurse on the floor caring for Resident #20 to give her a laxative and confirmed the physician had not been made aware.

Interview with the Regional Nursing Consultant (RNC) and Regional Director of Operations (RDO) on 2/14/24 at 3:05 PM, confirmed they were not aware Resident #20 had not had a bowel movement (BM) since 2/04/24. They both revealed that a situation such as that should be taken seriously, and the physician should have already been notified and that they would take care of it right away.

Record review of the progress Notes for Resident #20 dated 2/14/24 at 15:52 (3:52 PM) revealed, "Note Text: Resident has not had a bm since 2/04/24. This nurse notified (Proper Name of Doctor) and he gave a one time order for lactulose. He also gave an order for xray flat and upright. This was ordered by the nurse."

Record review of Resident #20's Abdominal X-Ray report dated 2/14/24 revealed under, "Impression: 1. No free air or bowel obstruction. 2. Moderate stool in colon compatible with constipation." ...

Record review of the "Transfer/Discharge Report" revealed the facility admitted Resident #20 on 1/24/22 with medical diagnoses that included

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M 030	Continued From page 16 Alzheimer's disease, Rheumatoid Arthritis, and Wedge compression fracture of T 11-T 12 vertebra, subsequent encounter for fracture with delayed healing. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/10/24 revealed a Brief Interview for Mental Status (BIMS) score of 03 which indicated the resident had severe cognitive impairment. Prior MDS's dated 09/18/23 revealed a BIMS of 11, MDS dated 12/11/23 revealed a BIMS of 9. Resident #13 Cross reference F600, F692, F580, F684 Interview on 2/14/24 at 11:40 AM, the DON revealed Resident #13 had a significant weight loss which was not reported to the physician for interventions, therefore, her weight continued to decrease. She confirmed the facility neglected to recognize, evaluate, and address the resident's weights, failed to notify the physician of the weight decline, and failed to consult the RD, therefore, appropriate evaluations and interventions were not ordered or initiated which put the resident at risk for a continued weight loss. She confirmed these failures of the facility's administration led to a significant weight loss of 6.92% during Resident #13's first month at the facility and to a 17.52% weight loss during her first four months at the facility. InterIview with the facility's Regional Nurse Consultant on 2/15/24 at 8:45 AM, revealed the physician nor the nurse practitioner were notified of Resident #13's significant weight loss and therefore, no interventions were initiated and weight continued to decline. She confirmed the facility's Administration was responsible for	M 030		

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overseeing the residents' care and ensuring the needed services were available and received, but the facility's administration failed to do this. She confirmed the facility neglected to identify, evaluate, and intervene for nutritional concerns and, therefore, an avoidable weight loss occurred due to the facility Administration's failure to appropriately manage the resident's nutritional needs.

Record review of Resident #13's Admission Record revealed she was admitted to the facility on 10/2/23. Diagnoses included Stevens-Johnson Syndrome, Non-pressure Ulcers, Anxiety Disorder, Major Depressive Disorder.

Record review of Resident #13's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/12/23 revealed a Brief Interview for Mental Status (BIMS) of 12 which indicated the resident had moderate cognitive impairment.

The facility submitted the following removal plan:

On 02/13/2024 at 4:30 PM the Mississippi State Department of Health (MSDH) state survey team notified the Administrator of an Immediate Jeopardy for failing to ensure processes were in place to review and implement Registered Dietician (RD) recommendations, notify the physician of weight loss, and implement interventions to address weight loss for Resident #20, who had lost 40.5 lbs in the last six months. Resident #20 also had nausea and vomiting and was not eating or drinking adequately for the last three weeks and the facility had failed to notify the physician of the significant change. The facility failed to follow care plan interventions to identify weight loss and address weight loss for Resident

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M 030	Continued From page 18 #20. The facility failed to have an effective Quality Assurance and Performance Improvement (QAPI) meeting to ensure all recommendations from the Registered Dietician were addressed in a prompt manner. Review of facility processes revealed that the recommendations from the registered dietician was being sent to the Dietary Manager via email and the emails were not received and not presented to the interdisciplinary team and reviewed by the provider and implemented. Interview with staff indicates that resident has had poor appetite since January, and it was not documented in the medical record. On 02/11/2024 at 6:27 PM, the facility nurse notified the provider and obtained orders for anti-emetic. On 2/12/2024 at 9:27 am, the facility attempted to transfer resident to the emergency room for evaluation and treatment as indicated. The Responsible Party refused for resident to be sent to the emergency room on this date. The facility obtained a physician's order for hospice services. On 02/13/2024 5:00 PM, In-services began on Abuse and Neglect for all staff by the Assistant Director of Nursing. All staff will be trained prior to returning to work. In-services began by Assistant Director of Nursing on Documentation, Provider Notification, and Change of Condition. All staff will be trained prior to returning to work. On 02/13/2024 at 5:15 PM, Social Services and Medical Records Nurse interviewed all residents regarding Nausea and Vomiting to ensure all significant changes of conditions were reported to the providers. It was noted upon interview that nine (9) residents reported recent complaints of nausea and vomiting, one (1) resident noted to	M 030		

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have yellow discharge from mouth and nose, 1 resident was unable to recall when nausea or vomiting occurred with no staff being knowledgeable of nausea or vomiting, two (2) residents reported nausea or vomiting after eating, 2 residents reported not having appetite or eating, 1 resident reported nausea but did not report to nurse, 2 residents reported nausea and medications received.

On 02/13/2024 at 5:30 PM, all residents were audited for weight loss by the Director of Nursing, Regional Nurse Consultant, and Minimum Data Set Nurse. Results of weight loss audit were reviewed by the medical director (15 unplanned weight losses, 1 planned) and new orders and diagnoses were provided by the medical director. All nutrition care plans audited by Minimum Data Set Nurse on 02/13/2024 with 5 residents whose registered dieticians' recommendations were not on care plans, dietary recommendations reviewed with providers and orders received per providers.

On 02/13/2024 at 6:05 PM, the Director of Nursing notified the physician of all 9 residents, notified the Institutional Specialized Needs Plan (ISNP) nurse practitioner of all residents (4) and hospice of all residents (1) with Nausea and Vomiting with new orders received from provider. 1 resident reviewed with new orders for chest x-ray due to cough, congestion, and yellow discharge from mouth and nose, 2 residents were ordered medications for reflux, 1 resident noted to be receiving antibiotics and has orders in place for anti-emetic medications, 1 resident reported abdominal pain and MD was notified and seen resident on 02/12/2024 with new orders for stool softener, 1 resident noted to have diarrhea and has been antibiotics new orders received for Zofran and anti-diarrheal, 1 resident noted to

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have weight loss and nausea and vomiting new orders received on 2/11/2024 to start Zofran and start peri-actin the family was not agreeable to start peri-actin and wanted to wait to speak to hospice on 02/14/2024, 2 residents did not report nausea to nurses at time of occurrence.

On 02/13/2024 at 6:59 PM, Social Services and Medical Records nurse interviewed residents with BIMS 10 or higher to ensure feeling of safe and are free of health concerns, no health or safety concern during interviews.

On 02/13/2024 at 8:30 PM, all Registered Dietician recommendations for last 90 days audited by Dietary Manager and Minimum Data Set Nurse with 5 residents whose registered dietician recommendations were not addressed. All Dietary recommendations reviewed with the Medical Director (5) and subsequent providers as appropriate Hospice (2 residents who have been on hospice services prior to survey entrance) and Institutional Special Needs Program nurse practitioner (1), new orders received from providers as appropriate.

On 02/13/2024 at 8:40 PM, All nutrition care plans audited by Minimum Data Set Nurse with 5 residents whose registered dieticians' recommendations were not on care plans, dietary recommendations reviewed with providers and orders received per providers and care plans updated.

On 02/13/2024 at 9:00 PM, all residents noted with weight loss were reviewed with the Medical Director, the Medical Director performed medication review on all residents with weight loss.

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M 030	Continued From page 21 Ad Hoc QAPI was held on 02/13/2024 at 10:15 PM with the Medical Director via phone, Administrator, Director of Nursing, Social Services, Minimum Data Set Nurse, Life Connections Coordinator, Regional Nurse Consultant, Regional Director of Operations, Assistant Director of Nursing, Registered Nurse Supervisor, Dietary Manager, and Medical Records Nurse. The Minimum Data Set Nurse has been designated as the Quality Assurance Nurse with responsibility reviewing all audits, Performance Improvement Plans, Quality Measures, and actively participating in the Quality Assurance and Performance Improvement meetings. All areas of deficiencies were reviewed in Ad-Hoc Quality Assurance and Performance Improvement meeting. Medical Records nurse or Assistant Director of Nursing will be responsible for receiving Registered Dietician recommendations, reviewing with providers, entering orders, and progress notes. New processes for Medical Director to review facility weight losses each week on visit, Registered Dietitian recommendations to be reviewed weekly with the Interdisciplinary Team and the Medical Director by Friday, in the event Registered Dietician recommendations are not received, the medical director will be notified. The Dietary Manager will review the weight and vital sign exception report and present findings in the clinical meeting. The Director of Nursing will review weights and registered dietician recommendations. The Director of Nursing will review progress notes daily. The administrator will review the audit findings weekly. All results will be reviewed in Quality Assurance and Performance Improvement meetings. On 02/13/2024 at 10:00 PM, One-on-one Inservice conducted with Administrator by the	M 030		

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Regional Director of Operations for weights, care plans, Quality Assurance and Performance Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation, and Administration Processes. The Regional Nurse Consultant conducted one-on-one in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records Nurse, and Minimum Data Set Nurse regarding weights, care plans, Quality Assurance and Performance Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation and Administration Processes. One-on-one in-service conducted with the Dietary Manager by the Administrator regarding Communication of Dietary Recommendations, Review of Recommendations, and reporting any identified areas of concerns with Dietary Recommendations. All nurses who provided care to resident #20 for the previous 3 weeks were provided One-on-one in-services regarding reporting changes of condition to provider, documentation, and following plan of care then were provided with a post-test to confirm understanding of one-on-one in-services.

As of 02/14/2024, the facility alleges compliance and all corrective action completed on 02/13/2024.

The Survey Agency (SA) validated the facility's Corrective Actions on 2/20/24:

The SA validated through record review that Resident #20 was ordered an anti-emetic for nausea/vomiting.

The SA validated through interview and record review that in-services were conducted for Abuse and neglect, documentation, provider notification,

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and change of condition. No staff can return to work until they have received in-services.

The SA validated through record review that all residents were interviewed and screened for symptoms of nausea and vomiting and the physician was notified of the findings with physician orders if appropriate.

The SA validated through record review and staff interview that all residents were audited for weight loss and the Medical Director was updated. All nutrition care plans were audited and updated with dietary recommendations.

The SA validated through record review that all residents with a Brief Interview for Mental Status (BIM's) of 10 or higher were interviewed to ensure feeling safe in their environment and free from health concerns.

The SA validated through record review that all Registered Dietician (RD) recommendations were audited and addressed with the provider as appropriate.

The SA validated the Medical Director reviewed the resident with weight loss and performed medication review.

The SA validated through staff interview and record review on 2/20/24 that an Emergency Quality Assurance and Performance Improvement (QAPI) meeting was conducted on 2/13/24 with all members in attendance.

The SA validated through record review and staff interview that one-on-one in-services were conducted on weights, care plans, Quality Assurance and Performance Improvement

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M 030	Continued From page 24 (QAPI), notifying physicians, reporting changes, Registered Dietician Recommendations, Documentation, and Administrative Processes. No staff can return to work until they have received in-services. The SA validated that all corrective actions were completed on 2/13/24 and the IJ was removed as of 2/14/24.	M 030		
M 175	45.2.30 Qualified Dietary Manager 1. A Dietetic Technician who has successfully graduated from a Dietetic Technician program accredited by the American Dietetic Association Commission on Accreditation and Approval of Dietetic Education and earns 15 hours of continuing education units every year approved by the Dietary Manager's Association or the American Dietetic Association. 2. A person who has successfully graduated from a didactic program in Dietetics approved by the American Dietetic Association Commission on Accreditation and Approval of Dietetic Education and earns 15 hours of continuing education units every year approved by the Dietary Manager's Association or the American Dietetic Association. 3. A person who has successfully completed a Dietary Manager's Course approved by the Dietary Manager's Association and who passes the credentialing examination and earns 15 hours of continuing education units every year approved by the Dietary Manager's Association or the American Dietetic Association. 4. A person who has successfully completed a Dietary Manager's Course approved by the Dietary Manager's Association and earns 15	M 175		3/19/24

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COURTYARDS COMM LIVING CENTER	907 EAST WALKER STREET FULTON, MS 38843

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M 175	Continued From page 25 hours of continuing education units every year approved by the Dietary Manager's Association or the American Dietetic Association. This Statute is not met as evidenced by: Level II Based on staff interview, record review, and facility policy review, the facility failed to ensure qualifying certifications were held by the Dietary Manager during ten (10) of 10 days of survey. Findings include: Record review of facility policy titled "Dietary Manager", dated 12/21/17, revealed, " ...Procedure: 1. The Dietary Manager is a qualified dietetic service supervisor licensed by this state in accordance with the American Dietetic Association's rules, regulations, and guidelines; ..." During an interview on 2/13/24 at 10:45 AM, the Dietary Manager revealed she had worked as Dietary Manager at the facility for approximately six months and stated she was not certified and was not enrolled in a program to become certified. She revealed corporate did not have a Certified Dietary Manager come into facility to assist the facility's dietary staff. She revealed the Registered Dietician (RD) met remotely for consults and in the time she had worked at the facility, she had not had an in-person visit with the RD. An interview with the Administrator on 2/14/24 at 4:45 PM, revealed she was unaware a certification for the Dietary Manager position was required and she thought the facility had one year from the hire date for the Dietary Manager to obtain certification and the Dietary Manager's hire	M 175	1. On 02/23/2024, Dietary Manager registered and paid for a course of study in Nutrition and Foodservice Professional Training through the University of North Dakota. The course is preparation for the national Certifying Board for Dietary Managers Credentialing Exam. 2. The alleged deficient practice has the potential to affect all residents. 3. On 02/23/2024, the Regional Director of Operations in-serviced the Administrator and Dietary Manager on the requirement to meet the qualifications as listed in 483.60(a)(2). The Registered Dietician will oversee the Dietary Manager Duties through routine visits and calls. The target completion date for the Dietary Manager is 12/15/2024. 4. The Administrator will meet with Dietary Manager weekly starting 03/05/2024 to review progress toward completion of the Nutrition and Foodservice Professional Training Course until the course is completed. Any issues will be immediately addressed. The Administrator will report results of the progress to Quality Assurance Performance Improvement Committee (QAPI) on 03/19/2024, for 9 months or until course completed and as needed for	

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M 175	Continued From page 26 date was 6/19/23. She confirmed the facility's Dietary Manager was not certified or enrolled in a certification program and there was no corporate staff member that served as a consultant for the Dietary Manager.	M 175	review/revision.	
M 190	45.2.33 Restraint Restraint. The term "restraint" shall include any means, physical or chemical, which is intentionally used to restrict the freedom of movement of a person. This Statute is not met as evidenced by: Level II Based on observation, staff and family interview, record review, and facility policy review, the facility failed to identify a bed rail as a physical restraint and restricted a resident's freedom of movement for one (1) of 28 sampled residents. Resident #15 Findings Include: Record review of the facility policy titled "Physical Restraints" dated 4/23/12 revealed "Policy: It is the policy of this facility that residents have the right to be free of physical restraints not required to treat the resident's medical symptoms. Physical restraints are not to be used for the convenience of the staff or as punishment of the resident. Physical restraints or safety devices are only used to enable and/or promote functional independence of the resident after consultation with a physical or occupational therapist, upon order of physician, and discussion with the resident's responsible party ..."	M 190	1. On 2/12/24, the bed rails were removed from Resident #15□s bed by the Maintenance Director. 2. The alleged deficient practice has the potential to affect all residents with side rails. 3. Starting 02/27/2024 and completed by 03/18/2024 by Director of Nurses, licensed staff will be in-serviced on ensuring residents are free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the residents medical symptoms. Starting 02/27/2024 and completed by 03/18/2024 by Director of Nurses, Licensed staff will be in-serviced that physical restraints or safety devices are only used to enable and/or promote functional independence of the resident after consultation with a physical or occupational	3/19/24

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M 190	Continued From page 27 A telephone interview on 02/12/24 at 09:40 AM, with a family member of Resident #15 revealed that the facility had not contacted her regarding the application of bed rails. An observation of Resident #15 on 2/12/24 at 2:30 PM, revealed the resident lying in bed with her eyes open, she was alert, but confused. Three-quarter (¾) side rails up on both sides of the bed were observed and the resident was trying to get up and scooted herself to the end of the opening of the bed rail, toward the footboard, and sat up on the end of the bed. Record review of the Order Summary Report for Resident #15 revealed an order dated 9/27/23, "1/2 (one-half) Side Rails X (times) 2 (two) as an enabler..." An interview with Licensed Practical Nurse (LPN) #1 on 2/12/24 at 2:40 PM revealed that Resident #15 had the side rails to prevent her from getting up due to falls. She confirmed that Resident #15 would not be able to lower the rails on her own and explained that the resident could get herself up and down from the bed into a wheelchair. She revealed that the resident usually scooted herself to the end of the bed, and sat between the rail opening when she wanted to get up. She stated she was unsure what the risks were associated with the bed rails. An interview and observation with the Director of Nursing (DON) on 2/12/24 at 2:50 PM, revealed she was unsure why Resident #15 had the three-quarter (3/4) bed rails. She confirmed that the bed rails kept the resident from getting up on her own and were a barrier for her safely getting up. The DON explained the resident could possibly crawl over the top of the rails or become	M 190	therapist, upon order of physician, and discussion with the residents responsible party. Starting 02/27/2024 and completed by 03/18/2024 by Director of Nurses, Licensed staff will be in-serviced on completing a signed consent from the family, a bed rail assessment, and a physicians order for the applied bed rails must be completed prior to applying side rails. Side rail evaluation form was modified on 3/12/24 to include a signature line for informed consent. Starting 02/27/2024, the Administrator and Director of Nurses reviewed siderail use and performed siderails evaluations for all residents, consents obtained for all applicable residents. Starting 03/13/2024, Maintenance Director will complete monthly inspection of side rails for proper functioning, proper measurements. 4. Starting 02/27/2024, the Director of Nurses (DON) will conduct walking rounds on five residents with side rails weekly times 4 weeks, bi-weekly times 4 weeks and monthly times 2 months. The Maintenance Director will complete monthly inspection of the side rails for proper functioning and proper measurements. The Maintenance Director and Director of Nursing will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly, starting 03/19/2024, for 3 months and as needed for review/revision.	

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M 190	Continued From page 28 entrapped. She stated she had no idea how long the rails had been on the bed, and the facility had not performed a restraint assessment that would indicate a need for them. The DON explained that to her knowledge, a bed rail consent had not been signed by the family. An interview with the Regional Nurse Consultant (RNC) on 2/14/24 at 9:02 AM, revealed that after searching, she could not locate a signed consent by the family, a bed rail assessment, or a physician's order for the applied bed rails. Record review of the Quarterly Evaluation for Resident #15 dated 9/05/23 revealed, "Summary Findings... 2. Type of rail in use: Half rail 3. Rails in use: Bilateral ... 5. Bed rails are indicated and serve as an enabler to promote independence: yes..." Record review of the "Admission Record" for Resident #15 revealed the facility admitted Resident #15 on 9/02/23 with diagnoses that included Unspecified dementia, Other seizures and Repeated falls.	M 190		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and	M 500		3/19/24

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M 500	Continued From page 29	M 500		

private property of other residents;

2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;

3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his

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M 500	Continued From page 30 period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;	M 500		

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M 500	Continued From page 31 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse	M 500		

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M 500	Continued From page 32 practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level IV Pattern Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to protect a residents right to be free from neglect for two (2) of three (3) residents sampled for abuse, Resident #13 and Resident #20 as evidence by: 1) neglected to recognize, communicate, evaluate, and address a resident's nutritional needs, which resulted in an unintended significant weight loss of 6.92% (percent) in one (1) month, which further led to a significant weight loss of 17.52% (percent) in four (4) months. Resident #13. The facility's failure to consult a Registered Dietician (RD), notify the attending physician of a significant change in condition, and act upon the residents' weight loss, placed the resident, and all other residents residing in the facility at risk for serious serious harm, serious injury, serious impairment, or possibly death. 2) neglected to identify, communicate, and address a resident at risk for malnutrition due to prolonged nausea and vomiting, and failure to identify a decrease in food intake due to pain and nausea resulted in an unintended significant weight loss of 40.5 pounds in six (6) months. Resident #20. The facility's failure to implement a	M 500	1. On 02/11/2024, antiemetic medication was ordered for resident #20. On 2/13/2024, In-service for Abuse and Neglect for staff began by the Assistant Director of Nursing. On 02/13/2024, Social Services and Medical Records Nurse interviewed all residents for nausea and vomiting and reported it to the provider. On 02/13/2024, the Director of Nursing notified providers of residents with complaints of nausea and vomiting. On 02/13/2024, all residents were audited for weight loss by the Director of Nursing, Regional Nurse Consultant, and Minimum Data Set Nurse. On 02/13/2024, Providers for all residents with weight loss were notified by the Director of Nursing, Assistant Director of Nursing, and Medical Records Nurse. On 02/13/2024, a medication review for all residents with weight loss was conducted by the medical director. On 02/13/2024, Dietary Manager and Minimum Data Set Nurse audited all Registered Dietician Recommendations for the last 90 days were reviewed with provider and new orders and implemented. On 02/13/2024, all nutrition care plans were audited by the Minimum Data Set Nurse and updated to reflect dietary recommendations. Ad Hoc Quality	

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M 500	Continued From page 33 Registered Dietician (RD) recommendation, notify the attending physician of a significant change in condition, and address the residents' prolonged symptoms of nausea and vomiting, and decreased food intake placed the resident and all other residents residing in the facility at risk for serious harm, serious injury, serious impairment, or possibly death. The facility's neglect also resulted in a functional decline for Resident #20, which potentially resulted in the resident's admission to hospice services on 2/14/24. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 11/02/23 when the facility failed to recognize, evaluate, and address Resident #13's nutritional needs, which resulted in an unintended significant weight loss of 6.92% (percent) in one (1) month, which further led to a significant weight loss of 17.52% (percent) in four (4) months. The facility's failure to consult a Registered Dietician (RD), notify the attending physician of a significant change in condition, and act upon the residents' weight loss, placed the resident, and all other residents residing in the facility at risk for serious negative outcomes. The IJ and SQC existed at: Rule 45.17.2 Resident Rights M500 Level IV The facility Administrator was notified of the IJ and SQC on 2/13/24 at 4:30 PM and provided the IJ Template. The facility provided an acceptable Removal Plan on 2/14/24, in which they alleged all corrective actions to remove the IJ were completed on 2/13/24 and the IJ removed on 2/14/24.	M 500	Assurance and Performance Improvement meeting was held on 02/13/2024. On 02/13/2024, One-on-One in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records Nurse, and Minimum Data Set Nurse regarding weights, care plans, notifying physician, Quality Assurance and Performance Improvement meetings, Registered Dietitian Recommendations, Documentation, and Administration were conducted by the Regional Nurse Consultant. On 02/13/2024, the Regional Director of Operations conducted and One-on-One in-service with the Administrator regarding weights, care plans, notifying physician, Quality Assurance and Performance Improvement meetings, Registered Dietitian Recommendations, Documentation, and Administration. On 02/13/2024, nurses who provided care to resident # 20 for previous three weeks were provided one-on-one for reporting changes of condition to provider, documentation, and following plan of care and provided posttest to confirm understanding by the Director of Nursing and Assistant Director of Nursing. On 02/13/2024, Social Services and Medical Records nurse interviewed residents with a BIMS of 10 or higher to ensure residents were feeling safe in the environment and are free of health and safety concerns. On 02/14/2024, resident #20 was ordered appetite stimulant. On 02/14/2024, Resident #20 was admitted to hospice services. On 2/15/2024, resident #13 was ordered fortified cereal and fortified mashed potatoes.	

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M 500	Continued From page 34 The SA validated the Removal Plan on 2/20/24 and determined the IJ was removed on 2/14/24. Therefore, the scope and severity for Rule 45.17.2 Resident Rights M 500 was lowered from a Level IV to a Level II while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Review of the facility policy titled "Abuse, Neglect, Exploitation and Misappropriation Prevention Program" with a revision date of 10/22 revealed, "Policy Statement: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not used to treat the resident ' s symptoms...Policy Interpretation and Implementation: The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to a. facility staff; ... 2. Develop and implement policies and protocols to prevent and identify:... neglect of residents;..." Resident #20 Cross reference F580, F656, F692 During an observation and interview with Resident #20 on 2/11/24 at 3:19 PM, revealed her lying in a fetal position at the foot of the bed. Upon entrance to the room the door was closed, the room was dark and it was observed that a	M 500	2. All residents in the facility have the potential to be affected by the alleged negligent practices. 3. A new Registered Dietician (RD) was placed in the facility on 03/07/2024. Meal intake percentages will be monitored by Medical Records starting on 02/13/2024 in clinical meeting weekly. Beginning on 02/13/2024 all dietary recommendations will be reviewed by the Dietary Manager and the Director of Nurses weekly. Starting 02/13/2024, Medical Records will ensure that all dietary recommendations are completed and followed though. Staff were in-serviced with a post test on abuse, neglect and misappropriation beginning on 02/13/2024 and completed on 03/18/2024 by Assistant Director of Nurses. Starting 02/13/2024 and completed on 03/18/2024, licensed nurses educated on notifying provider of changes in condition with posttest to confirm understanding by Director of Nurses. Starting 03/07/2024 and completed on 03/08/2024, the Rehab Director in-serviced therapy staff to notify nurse of changes in resident conditions and concerns promptly. 4. Starting 02/13/2024, the Medical Records Nurse will review dietary recommendations weekly and ensure follow through weekly x 4 weeks then monthly x 3 months. The Medical Records Nurse will report the findings to the Quality assurance and performance improvement committee (QAPI) for review and or revision monthly starting 03/19/2024. Starting 03/04/2024, the Administrator will	

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M 500	Continued From page 35 garbage can was located on the floor beside the resident. The resident stated she was sick to her stomach and she had a washcloth in her hand and was wiping her face. The resident 's color was pale, lips were dry, and she was thin in appearance. During an observation and interview with Resident #20 on 2/11/24 at 6:07 PM, revealed her lying on her right side in bed. The resident stated she was nauseated and could not eat dinner and stated, "I'm just sick." During an observation of Resident #20 on 2/12/24 at 8:29 AM, revealed her lying on her right side in bed. The garbage can was located on the floor, close by the resident. The breakfast tray was located on the bedside table untouched. CNA #2 entered the resident's room, and stated the resident refused to eat or drink due to nausea. CNA #2 removed the tray cover, and the resident began to retch and vomited a small amount of clear substance into the garbage can. The resident was observed as weak and pale, and her lips were dry. During an interview with CNA #2 on 2/12/24 at 8:35 AM, revealed she had worked at the facility for three (3) weeks and Resident #20 had refused to eat or drink everyday since then. She explained that the resident had been nauseated, dry heaving, and vomiting for the past three (3) weeks, that she had been employed at the facility. She confirmed that she had reported the symptoms to the medication nurse every day that she worked. Record review of Resident #20's "Progress Notes" from 11/01/23 through 2/11/24, revealed there was not any documentation that the	M 500	interview 5 (five) alternating residents weekly to ensure that residents feel safe and are free of health and safety concerns for 8 weeks, then bi-weekly for 2 months, then monthly for 2 months. The administrator will take immediate corrective action as needed and notify appropriate authorities as needed. The Administrator will report the findings to the Quality assurance and performance improvement committee (QAPI) for review and or revision monthly, starting on 03/19/2024 for 6 months then as needed.	

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resident had nausea and vomiting or that she refused meals.

Record review of the "Occupational Therapy Progress Notes" dated 2/01/24 revealed, "Patient refused: pt (patient) is refusing to eat and has poor appetite. pt (patient) c/o (complains of) nausea almost every day, but is not eating even with max encouragement and assist from therapist." ... Also revealed under, "Assessment and Summary of Skilled Services: ... therapist encouraging pt (patient) daily to eat and providing assist, but pt (patient) refuses to eat and c/o (complains of) nausea..."

Record review of the "Order Summary Report" for Resident #20 revealed an order dated 2/11/24 at 1827 (6:27 PM), "Ondansetron HCL (Hydrochloride) Tablet (Zofran) 4 (four) MG (milligrams) Give 1 (one) tablet by mouth every 6 (six) hours as needed for Nausea and Vomiting" ...

Record review of Resident #20's January and February "Medication Admission Record" (MAR) revealed, there was not a physician ' s order for nausea/vomiting medication before the new order for Zofran started on 2/11/24, which indicated the resident's symptoms of prolonged nausea and vomiting were left untreated.

Record review of the "Meal Intake Documentation Report" completed by the Certified Nurse Aides (CNAs) revealed, Resident #20 refused eighteen (18) meals from 12/18/23 through 12/31/23. She refused thirty-one (31) meals in the month of January 2024, with a total of thirty-nine (39) meals consumed at 0-25% (percent), and she refused sixteen (16) meals from 2/01/24 through 2/11/24, with a total of fourteen (14) meals

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M 500	Continued From page 37 consumed at 0-25% (percent). Record review of Resident #20's "Order Summary Report" revealed an order dated 1/08/24, "Weekly weights x (times) 4 (four) weeks one time a day every 7 day(s)" ... Record review of Resident #20's weights revealed a significant weight loss of 13.9% (percent) in one (1) month, 21.6% (percent) in three (3) months, and 26.2% (percent) in six (6) months. Record review of the" Order Summary Report" for Resident #20 revealed an order dated 1/04/24, "Regular diet Regular texture, Regular consistency" ... Also revealed an order dated 1/04/24, "Med Pass 2.0 two times a day for supplement." During an interview with the Director of Nursing (DON) on 2/11/24 at 3:55 PM revealed Resident #20's condition had declined over the past couple of months. She explained that the resident had a significant decline after she fell in December 2023, and received a fracture of the T-12 vertebrae and had to be placed on strong pain medications. She stated, to her knowledge, the resident had not experienced any nausea and vomiting until yesterday when the Survey Agent brought it to her attention. She stated none of the staff had reported it to her and that she should be aware of what was happening with the resident. She revealed she was aware that the resident was not eating or drinking and had been refusing meals and that she had made the physician aware of the resident's decline, and the significant weight loss, and the Registered Dietician (RD) had evaluated her.	M 500		

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M 500	Continued From page 38 An interview with Licensed Practical Nurse (LPN) #3 on 2/11/24 at 4:20 PM, revealed Resident #20 had a decline over the past several weeks. She explained that the resident would not eat or drink anything, including the med pass supplement. She stated that usually they cannot get her to take her medications. She revealed that the resident would eat crushed ice chips, but that's about it. LPN #3 explained that she noticed a change after the resident fell and hurt her back and was in a lot of pain. She confirmed that she had not notified the resident's physician of the change in condition. During a telephone interview with Medical Director on 2/12/24 at 6:05 PM, revealed the staff had contacted him last night regarding Resident #20 having nausea and vomiting, and he had ordered Zofran as needed. He confirmed that the staff had not contacted him or made him aware of the residents' decline in condition or her refusal to eat or drink. He stated that he was not notified of her significant weight loss (40.5 pounds in 6 months) or the Registered Dietician (RD) recommendations. He confirmed Resident #20's current condition was serious and stated "What you have relayed screams neglect." Record review of Resident #20's Order Summary Report revealed an order dated 1/08/24, "RD (Registered Dietician) consult" ... Record review of the "Consultant Registered Dietician (RD) Note" dated 12/27/23, for Resident #20 revealed the RD (Registered Dietician) recommended, "Med Pass 2 oz (ounces) BID (twice daily), weekly weights x (times) 4 (four) weeks, and add Fortified Pudding BID (twice daily) at lunch and dinner" ...	M 500		

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M 500	Continued From page 39 Record review of the "Consultant Registered Dietician (RD) Note" dated 1/5/24, for Resident #20 revealed, "Resident w/(with) significant wt (weight) loss x (times) 1 (one) mo (month) (-9%) and x (times) 6 (six) mo (months) (13.7%) (percent). Po (by mouth) intake likely not meeting nutritional needs. Resident is at risk for skin breakdown and wt (weight) loss d/t (due to) decreased appetite ... NO N/V/c/D (nausea, vomiting, complaints of diarrhea) documented." ... Also revealed under REC (recommendations): "Resident may benefit from an appetite stimulant, please document % (percentage) of supplement consumed daily, add fortified pudding BID (twice daily) at lunch and dinner, weekly weights x (times) 4 (four) weeks to assure stable weight" ... Record review of the "Consultant Registered Dietician (RD) Note) dated 2/10/24, for Resident #20 revealed, "Resident w/(with) significant wt (weight) loss x times 1 (one) mo (month), x (times) 3 (three) mo (months) and x (times) 6 (six) mo (months) ... consuming <25% w/(with) refusals of meals ... Po (by mouth) intake likely not meeting nutritional needs ... NO N/V/c/D (nausea, vomiting, complaints of diarrhea) documented." ... Also revealed under REC (recommendations): "Resident may benefit from an appetite stimulant, please document % of supplement consumed daily, weekly weights x 4 weeks to assure stable weight, if po (by mouth) intake and wt (weight) status does not improve, resident may benefit from an alternate means of nutrition support." Record review of the "Order Summary Report" for Resident #20 revealed there was not a physician's order for fortified pudding at lunch and supper or a medication to stimulate appetite per Registered Dietician (RD) recommendations.	M 500		

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Record review of Resident #20's Physician Nursing Home Visit dated 1/26/24 revealed, "No concerns reported by the nursing staff ...." The physician progress note did not identify any documentation to support the resident's nausea and vomiting or weight loss.

An interview with Licensed Practical Nurse (LPN) #2 on 2/13/24 at 7:45 AM, revealed Resident #20 was not drinking the med pass supplement, and was refusing meals. She stated that the resident had been refusing meals for several weeks and that the resident's family was highly involved with her care, and the resident would report nausea to them, and the family would come and let us know when they were there for a visit. LPN #2 confirmed that there was no documentation in the nurses notes to indicate that the resident had nausea or vomiting.

During an interview with the Dietary Manager (DM) on 2/13/24 at 8:13 AM, revealed that she was new to the role and had been in the position since June 2023. She revealed that the facility had weekly PAR (Patients at Risk) meetings where the weights of the residents were discussed and stated all the department heads attend the meetings. The DM revealed, if a resident should need a RD (Registered Dietician) consult, she would notify the RD after the weekly PAR meeting by texting or calling. She stated that the RD would usually text her back to let her know she had the resident down on her list. She revealed that the RD did not come to the facility and did all her consultations remotely. She explained that the RD was consulted on Resident #20 in January 2024, but confirmed that she had not seen any RD recommendations since that time. She stated that the resident had never

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received fortified pudding, and to her knowledge, had never started on an appetite stimulate. She explained that the facility had trouble getting the RD recommendations and that she just realized last week on Friday 2/9/24 that the RD recommendations were going to her spam email. She revealed that she tried to open the email and the email read it was quarantined. She revealed that she told the Director of Nursing (DON) that she was not receiving anything from the RD, and she thought the DON had texted her and took care of it. She confirmed that lack of implementation of the RD recommendations could cause the resident to have further weight loss and malnourishment.

During a telephone interview with the Registered Dietician (RD) on 2/13/24 at 9:56 AM, she stated she was notified in late December that Resident #20 needed to be seen due to a significant weight change. She confirmed that she recommended med pass 2 ounces twice daily as a supplement, weekly weights and fortified pudding added with lunch and dinner. She revealed that she also did a consultation on Resident #20 on 1/5/24 and 2/10/24 and recommended that the resident would benefit from an appetite stimulant. She explained that she emailed all her recommendations to the Administrator (ADM), Director of Nursing (DON), Dietary Manager (DM), and the Regional Nursing Consultant (RNC). She explained that she marked on the recommendations if the physician needed to be contacted for a physician order and confirmed that Resident #20's recommendation was marked to contact the physician for an appetite stimulant and adding the fortified pudding. She stated that she was unable to contact the doctor or write orders because she did not have the authority with her contract with the facility. She stated that

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she had not been contacted by anyone from the facility reporting that they had not received Resident #20's dietary recommendations

During an interview with the DON on 2/13/24 at 10:38 AM, revealed Resident #20 functional status had declined since her fall. She confirmed after reviewing the progress notes, she observed there was no documentation to support a decline, nausea, and vomiting or food refusal. She revealed before the fall the resident was ambulatory, rarely in bed, and she took herself to the bathroom. She revealed that she would sit up in a chair in her room. She stated after the fall the resident required more help with her Activities of Daily Living (ADLs), stayed in bed, became incontinent, had more falls, and required the staff to assist with eating. She confirmed that the facility should have notified the physician immediately when the decline came about, and verbalized that was a failure on their part. She explained that the facility had spoken with the son about placing the resident on hospice today, and he had agreed. She explained that she knew it looked bad that they had consulted hospice, but she stated we had talked to the son before, and he thought she might recover. The DON stated that the facility did not reach out to the physician to inquire about drawing labs or any intravenous fluids throughout these months of the resident refusing to eat or drink and experiencing significant weight loss. She stated that she did report the weight loss to the physician while he was inside the facility. She stated, "I do not recall the date or month I notified him," and confirmed that she did not have documentation to support her notification. She stated that the facility was not receiving any of the dietary recommendations, and the Dietary Manager (DM) determined that the emails were going to her junk

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folder. The DON stated that the RD would also add her notes to the Electronic Medical Record (EMR) and would not tell anyone. The DON revealed that she had never received any emails from the RD, and confirmed that she had not gone into her junk email to search and see if they came to her that way. The DON stated, "I have over 700 junk emails and I do not have time to do that." The DON confirmed that with 60 residents in the facility she should have noticed when she was not getting anything from the RD each month but confirmed that she hadn't noticed.

During an interview with the ADM on 2/13/24 at 2:10 PM, revealed the Registered Dietician (RD) worked remotely, and she had seen her in the facility twice. She revealed that the facility usually communicates with the current RD through email or text messages and confirmed that the last RD recommendation she had received by email was in August 2023. She stated that the Dietary Manager (DM) had received some, but they went to her spam folder encrypted. She revealed in November 2023 she started going into the resident notes and printing out the recommendations. She explained that she had not reached out to the RD herself to follow up. The ADM stated they tried to go over the recommendations in the High-Risk meetings and that Resident #20 had been discussed in January 2024 during a PAR (patients at risk) meeting. The ADM confirmed that the Dietary Recommendations for Resident #20 had not been implemented and that the facility failed to document the significant changes that occurred in the resident's condition. She stated, "I know the documentations not there. It looks bad on our part."

During an interview with Social Services (SS) on

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M 500	Continued From page 44 2/13/24 at 3:00 PM, revealed she had reached out to the family of Resident #20 about the functional decline on 1/10/24. She revealed that the son did not want to do hospice at that time and was hoping the resident would perk up. She explained that since then, she followed up with the family and explained that the resident continued to decline and asked them to reconsider hospice services again. The SS confirmed that she was unaware that the physician had not been notified of the significant changes with the resident. Record review of the "Progress Notes" for Resident #20 dated 2/14/24, "Proper Name Hospice consulted per md (medical doctor) order and family request ... for declining condition related to Alzheimer's disease ..." During an interview with the Minimum Data Set (MDS) Nurse on 2/14/24 at 5:23 PM, revealed that she did a significant change MDS after Resident #20 fell in December 2023, and after it was identified in the facility's clinical meeting that the resident had a significant weight loss in January 2024. She revealed that after the fall, the resident declined in her ability to get out of bed, and she was no longer able to sit in a chair, which was what the resident liked to do. She explained that the resident experienced increased pain, worsening incontinence and was required to wear a back brace when she was out of the bed. She confirmed that the documentation was absent to support a decline in the resident's condition, and stated she went off what was discussed in the High-Risk meetings. She revealed that she was aware that the resident did not have a physician order for the fortified pudding or an appetite stimulant that was recommended by the Registered Dietician (RD).	M 500		

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M 500	Continued From page 45 Record review of the "Transfer/Discharge Report" revealed the facility admitted Resident #20 on 1/24/22 with medical diagnoses that included Alzheimer's disease, rheumatoid arthritis, primary open-angled glaucoma, and wedge compression fracture of T 11-T 12 vertebra, subsequent encounter for fracture with delayed healing. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/10/24 revealed a Brief Interview for Mental Status (BIMS) of 03 which indicated the resident had severe cognitive impairment. Prior MDS's dated 09/18/23 revealed a BIMS of 11, MDS dated 12/11/23 revealed a BIMS of 9. Resident #13 Cross reference F580, F656, F692 An observation and interview on 2/13/24 at 11:05 AM, Resident #13, lying in bed, stated she had lost weight while in the facility. She revealed there were times she did not eat well and she was not on supplements. An interview on 2/14/24 at 11:40 AM, the Director of Nursing (DON) revealed Resident #13 had a significant weight loss which was not reported to the physician for interventions, therefore, her weight continued to decrease. She stated the Registered Dietician (RD) had not been consulted concerning the significant weight loss. She confirmed that due to the physician and the RD not being notified, the resident had a weight loss that could have possibly been avoided if interventions had been put in place for the resident's nutritional well-being. She confirmed each resident has the right to appropriate care, and the facility failed to provide the needed nutritional care. She confirmed the facility	M 500		

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neglected to recognize, evaluate, and address the resident's weights, failed to notify the physician of the weight decline, and failed to consult the RD, therefore, appropriate evaluations and interventions were not ordered or initiated which put the resident at risk for a continued weight loss. She confirmed these failures led to a significant weight loss of 6.92% during Resident #13's first month at the facility and to a 17.52% weight loss during her first four months at the facility.

An interview with the facility's Regional Nurse Consultant on 2/15/24 at 8:45 AM, revealed the physician nor the nurse practitioner were notified of Resident #13's significant weight loss and therefore, no interventions were initiated and weight continued to decline. She stated the initial consult with the Registered Dietician (RD) was on admission due to her wounds and once her weight was trending down, no additional consults were made. She confirmed each resident has the right to receive appropriate care and the facility failed to provide the needed nutritional care for this resident. She confirmed the facility neglected to identify, evaluate, and intervene for nutritional concerns and, therefore, an avoidable weight loss occurred due to the facility's failure to appropriately manage the resident's nutritional needs.

An interview on 2/15/24 at 12:00 PM, the Dietary Manager confirmed she was unaware of the resident's significant weight loss and failed to ensure the Registered Dietician was notified of the weight loss concern.

Record review of "Weights and Vitals Summary" revealed Resident #13's admission weight on 10/3/23 was 166.1 pounds and a weight on

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M 500	Continued From page 47 11/2/23 was 154.6 pounds which listed a comparison weight of an 11.5 pound decrease and a 6.9% weight loss. Resident #13's weight on 2/5/24 was 137 pounds and compared to the admission weight 4 months previously of 166.1 pounds on 10/3/23 listed a comparison weight of a 29.1 pound decrease and a 17.5% weight loss. Record review of Resident #13's Admission Record revealed she was admitted to the facility on 10/2/23. Diagnoses included Stevens-Johnson Syndrome, Non-pressure Ulcers, Anxiety Disorder, Major Depressive Disorder. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/12/23 revealed a Brief Interview for Mental Status (BIMS) of 12 which indicated the resident had a moderate cognitive impairment. The facility submitted the following removal plan: On 02/13/2024 at 4:30 PM the Mississippi State Department of Health (MSDH) state survey team notified the Administrator of an Immediate Jeopardy for failing to ensure processes were in place to review and implement Registered Dietician (RD) recommendations, notify the physician of weight loss, and implement interventions to address weight loss for Resident #20, who had lost 40.5lbs in the last six months. Resident #20 also had nausea and vomiting and was not eating or drinking adequately for the last three weeks and the facility had failed to notify the physician of the significant change. The facility failed to follow care plan interventions to identify weight loss and address weight loss for Resident #20. The facility failed to have an effective Quality Assurance and Performance Improvement	M 500		

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M 500	Continued From page 48 (QAPI) meeting to ensure all recommendations from the Registered Dietician were addressed in a prompt manner. Review of facility processes revealed that the recommendations from the registered dietician was being sent to the Dietary Manager via email and the emails were not received and not presented to the interdisciplinary team and reviewed by the provider and implemented. Interview with staff indicates that resident has had poor appetite since January, and it was not documented in the medical record. On 02/11/2024 at 6:27 PM, the facility nurse notified the provider and obtained orders for anti-emetic. On 2/12/2024 at 9:27 am, the facility attempted to transfer resident to the emergency room for evaluation and treatment as indicated. The Responsible Party refused for resident to be sent to the emergency room on this date. The facility obtained a physician's order for hospice services. On 02/13/2024 5:00 PM, In-services began on Abuse and Neglect for all staff by the Assistant Director of Nursing. All staff will be trained prior to returning to work. In-services began by Assistant Director of Nursing on Documentation, Provider Notification, and Change of Condition. All staff will be trained prior to returning to work. On 02/13/2024 at 5:15 PM, Social Services and Medical Records Nurse interviewed all residents regarding Nausea and Vomiting to ensure all significant changes of conditions were reported to the providers. It was noted upon interview that nine (9) residents reported recent complaints of nausea and vomiting, one (1) resident noted to have yellow discharge from mouth and nose, 1 resident was unable to recall when nausea or	M 500		

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M 500	Continued From page 49 vomiting occurred with no staff being knowledgeable of nausea or vomiting, two (2) residents reported nausea or vomiting after eating, 2 residents reported not having appetite or eating, 1 resident reported nausea but did not report to nurse, 2 residents reported nausea and medications received. On 02/13/2024 at 5:30 PM, all residents were audited for weight loss by the Director of Nursing, Regional Nurse Consultant, and Minimum Data Set Nurse. Results of weight loss audit were reviewed by the medical director (15 unplanned weight losses, 1 planned) and new orders and diagnoses were provided by the medical director. All nutrition care plans audited by Minimum Data Set Nurse on 02/13/2024 with 5 residents whose registered dieticians' recommendations were not on care plans, dietary recommendations reviewed with providers and orders received per providers. On 02/13/2024 at 6:05 PM, the Director of Nursing notified the physician of all 9 residents, notified the Institutional Specialized Needs Plan (ISNP) nurse practitioner of all residents (4) and hospice of all residents (1) with Nausea and Vomiting with new orders received from provider. 1 resident reviewed with new orders for chest x-ray due to cough, congestion, and yellow discharge from mouth and nose, 2 residents were ordered medications for reflux, 1 resident noted to be receiving antibiotics and has orders in place for anti-emetic medications, 1 resident reported abdominal pain and MD was notified and seen resident on 02/12/2024 with new orders for stool softener, 1 resident noted to have diarrhea and has been antibiotics new orders received for Zofran and anti-diarrheal, 1 resident noted to have weight loss and nausea and vomiting new orders received on 2/11/2024 to start Zofran and	M 500		

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start peri-actin the family was not agreeable to start peri-actin and wanted to wait to speak to hospice on 02/14/2024, 2 residents did not report nausea to nurses at time of occurrence.

On 02/13/2024 at 6:59 PM, Social Services and Medical Records nurse interviewed residents with BIMS 10 or higher to ensure feeling of safe and are free of health concerns, no health or safety concern during interviews.

On 02/13/2024 at 8:30 PM, all Registered Dietician recommendations for last 90 days audited by Dietary Manager and Minimum Data Set Nurse with 5 residents whose registered dietician recommendations were not addressed. All Dietary recommendations reviewed with the Medical Director (5) and subsequent providers as appropriate Hospice (2 residents who have been on hospice services prior to survey entrance) and Institutional Special Needs Program nurse practitioner (1), new orders received from providers as appropriate.

On 02/13/2024 at 8:40 PM, All nutrition care plans audited by Minimum Data Set Nurse with 5 residents whose registered dieticians' recommendations were not on care plans, dietary recommendations reviewed with providers and orders received per providers and care plans updated.

On 02/13/2024 at 9:00 PM, all residents noted with weight loss were reviewed with the Medical Director, the Medical Director performed medication review on all residents with weight loss.

Ad Hoc QAPI was held on 02/13/2024 at 10:15 PM with the Medical Director via phone,

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M 500	Continued From page 51 Administrator, Director of Nursing, Social Services, Minimum Data Set Nurse, Life Connections Coordinator, Regional Nurse Consultant, Regional Director of Operations, Assistant Director of Nursing, Registered Nurse Supervisor, Dietary Manager, and Medical Records Nurse. The Minimum Data Set Nurse has been designated as the Quality Assurance Nurse with responsibility reviewing all audits, Performance Improvement Plans, Quality Measures, and actively participating in the Quality Assurance and Performance Improvement meetings. All areas of deficiencies were reviewed in Ad-Hoc Quality Assurance and Performance Improvement meeting. Medical Records nurse or Assistant Director of Nursing will be responsible for receiving Registered Dietician recommendations, reviewing with providers, entering orders, and progress notes. New processes for Medical Director to review facility weight losses each week on visit, Registered Dietitian recommendations to be reviewed weekly with the Interdisciplinary Team and the Medical Director by Friday, in the event Registered Dietician recommendations are not received, the medical director will be notified. The Dietary Manager will review the weight and vital sign exception report and present findings in the clinical meeting. The Director of Nursing will review weights and registered dietician recommendations. The Director of Nursing will review progress notes daily. The administrator will review the audit findings weekly. All results will be reviewed in Quality Assurance and Performance Improvement meetings. On 02/13/2024 at 10:00 PM, One-on-one Inservice conducted with Administrator by the Regional Director of Operations for weights, care plans, Quality Assurance and Performance	M 500		

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M 500	Continued From page 52 Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation, and Administration Processes. The Regional Nurse Consultant conducted one-on-one in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records Nurse, and Minimum Data Set Nurse regarding weights, care plans, Quality Assurance and Performance Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation and Administration Processes. One-on-one in-service conducted with the Dietary Manager by the Administrator regarding Communication of Dietary Recommendations, Review of Recommendations, and reporting any identified areas of concerns with Dietary Recommendations. All nurses who provided care to resident #20 for the previous 3 weeks were provided One-on-one in-services regarding reporting changes of condition to provider, documentation, and following plan of care then were provided with a post-test to confirm understanding of one-on-one in-services. As of 02/14/2024, the facility alleges compliance. All corrective action completed on 02/13/2024. The Survey Agency (SA) validated the facility's Corrective Actions on 2/20/24: The SA validated through record review that Resident #20 was ordered an anti-emetic for nausea/vomiting. The SA validated through interview and record review that in-services were conducted for Abuse and neglect, documentation, provider notification, and change of condition. No staff can return to work until they have received in-services.	M 500		

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M 500	Continued From page 53 The SA validated through record review that all residents were interviewed and screened for symptoms of nausea and vomiting and the physician was notified of the findings with physician orders if appropriate. The SA validated through record review and staff interview that all residents were audited for weight loss and the Medical Director was updated. All nutrition care plans were audited and updated with dietary recommendations. The SA validated through record review that all residents with a Brief Interview for Mental Status (BIM's) of 10 or higher were interviewed to ensure feeling safe in their environment and free from health concerns. The SA validated through record review that all Registered Dietician (RD) recommendations were audited and addressed with the provider as appropriate. The SA validated the Medical Director reviewed the resident with weight loss and performed medication review. The SA validated through staff interview and record review on 2/20/24 that an Emergency Quality Assurance and Performance Improvement (QAPI) meeting was conducted on 2/13/24 with all members in attendance. The SA validated through record review and staff interview that one-on-one in-services were conducted on weights, care plans, Quality Assurance and Performance Improvement (QAPI), notifying physicians, reporting changes, Registered Dietician Recommendations, Documentation, and Administrative Processes.	M 500		

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M 500	Continued From page 54 No staff can return to work until they have received in-services. The SA validated on 02/20/24 that all corrective actions were completed on 2/13/24 and the IJ (Immediate Jeopardy) was removed as of 2/14/24.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observations, staff and resident interviews, record review, and facility policy review, the facility failed to ensure residents who required assistance with Activities of Daily Living (ADLs) were assisted with personal hygiene as evidenced by long, jagged nails with brown substance underneath nails and unshaven facial hair for three (3) of eighteen residents sampled. Resident #11, Resident #26, and Resident #54 Findings include: Record review of the facility policy titled "Shaving	M 610	1. On 02/12/2024, Resident #11 was offered to be shaved by Certified Nursing Aide and agreed. On 02/13/2024, Residents #26 and #54 were provided nail care by Registered Nurse Supervisor. 2. This alleged deficient practice has the potential to affect all residents. 3. Licensed staff in-serviced by Director of Nurses and Administrator on ADL care including nail care and shaving starting on 02/13/2024 and completed by 03/18/2024. On 02/12/2024 all nail care orders were audited by Assistant Director of Nurses to	3/19/24

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The Resident" dated 8/25/14, revealed "Purpose: The purpose of this procedure is to promote cleanliness and to provide skin care ..."

Record review of facility policy titled, "A.M. Care (Day Tour of Duty) with a revision date of August 25, 2014 revealed "Purpose: 1. To refresh the resident. 2. To provide cleanliness, comfort and neatness .... Equipment: See specific procedures for: Care of nails. ...Documentation 1. Date, time, care provided ... 4. Signature, title and date..."

Resident #11

An observation and interview with Resident #11 on 2/11/24 at 3:26 PM, revealed the resident was up in his chair in the hallway. The resident was observed with one-eighth (1/8) inch of white facial hair.

An interview with Resident #11 on 2/11/24 at 3:31 PM, revealed he would like to be shaved on his shower days that were scheduled on Tuesday, Thursday, and Saturday. He stated that he did not get shaved yesterday and explained that he was not sure why.

An observation and interview of Resident #11 on 2/12/24 at 3:05 PM, with the Administrator (ADM), confirmed that the resident needed shaving. The resident explained to the ADM that he had not been shaved since last Tuesday (2/06/24). The ADM revealed that they have a shower team that worked Monday through Friday and were responsible for shaving the residents. She revealed on Saturday's, it was the assigned aide's responsibility. She revealed that shaving was expected to be done with the showers.

Record review of the Minimum Data Set (MDS)

ensure that nail care was on the treatment administration record. Any residents who did not have orders in place were immediately put into place.
4. Starting 03/04/2024, the Director of Nurses will make weekly walking rounds and
audit five residents a week to ensure that residents have appropriate nail care and are
offered to be shaved weekly times 4 weeks, bi-weekly times 4 weeks, then monthly times 2 months. The
Director of Nurses will take immediate corrective action as needed. Starting 03/04/2024, the Medical Records Nurse will audit five residents per week to ensure that orders are in place and documented on the Treatment Administration Record weekly times 4 weeks, bi-weekly times 4, and then monthly times 2 months. The Director of
Nurses and Medical Records nurse will present audit findings to the Quality Assurance and Performance Improvement Committee monthly starting 03/19/2024 for 3 months then as needed for review and revision.

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with an Assessment Reference Date (ARD) of 1/29/24 revealed, under section GG, Resident #11 required partial/moderate assistance with personal hygiene.

Record review of the "Admission Record" revealed the facility admitted Resident #11 on 10/05/20 with medical diagnoses that included peripheral vascular disease, acquired absence of unspecified leg above knee, gout, heart failure, and essential (primary) hypertension.

Resident #26

An observation and interview on 02/11/24 at 5:55 PM, Resident #26's fingernails on both hands were approximately one-half (1/2) inch long and jagged with a brown substance underneath the nails. Resident #26 revealed he would like his nails to be cut because they are too long.

An observation and interview on 02/12/24 at 2:50 PM, with Certified Nursing Assistant (CNA) #6 confirmed that Resident #26's nails were long and uneven and had a brown substance under them and needed to be cleaned and trimmed. She stated, "I'll check with the nurse to see if the resident is diabetic or not, the aides aren't allowed to do diabetic nails and I'm not sure if he is or not."

On 02/12/24 at 2:55 PM, an interview and record review with Licensed Practical Nurse (LPN) #2 revealed Resident #26 is a diabetic and his nails must be cut by a Registered Nurse (RN). She stated the LPNs are not allowed to cut diabetic nails. During a review of Resident #26's Treatment Administration Record (TAR), LPN #2 confirmed it was not listed on his TAR for the RN's to do nail care and there was no place for

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the nurses to document.

An interview and observation on 02/12/24 at 3:10 PM, the Director of Nurses (DON) revealed the RNs are responsible for providing diabetic nail care. She revealed it should show up on the Treatment Administration Record (TAR) and the RN would sign off that it has been done. She confirmed that Resident #26's fingernails were long and jagged with a brown substance under them, and stated, "The resident could scratch himself and cause a skin tear or infection."

Record review of Resident #26's Admission Record revealed the resident was admitted to the facility on 09/13/2023 with medical diagnoses that included Parkinsonism, Chronic obstructive pulmonary disease, and Type 2 Diabetes Mellitus with hyperglycemia.

Record review of Resident #26's MDS an ARD of 12/19/23, revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated the resident is severely cognitively impaired.

Resident #54

An interview and observation on 02/12/24 at 9:30 AM, revealed Resident #54's fingernails were noted to be approximately one-half (1/2) inch from the nail bed and extending over the tips of his fingers with a dark brown/black substance noted under each nail. Resident #54 stated he preferred his nails to be kept short and he would like for them to be trimmed today.

During an observation and interview with Licensed Practical Nurse (LPN) #3 on 2/12/24 at 3:00 PM, she observed Resident #54 had scratch marks on his abdomen and arms and the dark

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substance under his nails appeared to be dried blood. She confirmed his nails were long and dirty and needed to be cleaned and trimmed to protect his skin and to honor his preference for short nails. She stated the CNAs were to do residents' nail care on bath days and it was her responsibility to make sure this was done. She confirmed nail care for this resident had not been done recently.

On 2/12/24 at 3:20 PM, the Assistant Director of Nursing (ADON) confirmed Resident #54's nails were long and dirty and scratches on his abdomen and arms were noted. The ADON confirmed the resident's nails were long and dirty with a substance that appeared to be old dried blood from scratching his skin and this resident's nails were not kept clean and trimmed to the length the resident preferred. She confirmed the facility failed to provide the resident's ADL nail care assistance for his nail care needs.

During an interview on 2/12/24 at 4:55 PM, the DON confirmed the facility failed to ensure adequate ADL nail care for a dependent resident was done. She confirmed the resident's nails were not kept clean and short as preferred by the resident.

Record review of Resident #54's Admission Record revealed the resident was admitted to the facility on 11/9/23. Diagnoses included Muscle Weakness and Lack of Coordination.

Record review of Resident #54's MDS with an ARD of 1/5/24, Section GG revealed for personal hygiene, Resident #54 required partial/moderate assistance. Resident #54's BIMS score was 11 which indicated the resident had moderate cognitive impairment.

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M 645	45.21.9 Nutrition Nutrition. Residents shall maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless residents ' clinical condition indicates that this is unavoidable. All residents shall receive diets as orders by their physician or nurse practitioner/physician assistant. Residents identified with significant nutritional problems shall receive appropriate medical nutrition therapy based on current professional standards. This Statute is not met as evidenced by: Level IV Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to maintain acceptable parameters of nutrition for two (2) of six (6) residents sampled for nutrition as evidence by: Resident #13 and Resident #20 1) failed to recognize, evaluate, and address a resident's nutritional needs, which resulted in an unintended significant weight loss of 6.92% (percent) in one (1) month, which further led to a significant weight loss of 17.52% in four (4) months. Resident #13. The facility's failure to consult a Registered Dietician (RD), notify the attending physician of a significant change in condition, and act upon the residents' weight loss, placed the resident, and all other residents residing in the facility at risk for serious harm, serious injury, serious impairment, and possibly death. 2) failed to identify and address a resident at risk for malnutrition due to prolonged nausea and vomiting, and failure to identify a decrease in food intake due to pain and nausea resulted in an	M 645	1. On 02/11/2024, antiemetic medication was ordered for resident #20. On 2/13/2024, Inservice for Abuse and Neglect for staff began by the Assistant Director of Nursing. On 02/13/2024, Social Services and Medical Records Nurse interviewed all residents for nausea and vomiting and reported to provider. On 02/13/2024, the Director of Nursing notified providers of residents with complaints of nausea and vomiting. On 02/13/2024, all residents were audited for weight loss by the Director of Nursing, Regional Nurse Consultant, and Minimum Data Set Nurse. On 02/13/2024, Providers for all residents with weight loss were notified by the Director of Nursing, Assistant Director of Nursing, and Medical Records Nurse. On 02/13/2024, a medication review for all residents with weight loss was conducted by the medical director. On 02/13/2024, Dietary Manager	3/19/24

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M 645	Continued From page 60 unintended significant weight loss of 40.5 pounds in six (6) months. Resident #20. The facility's failure to implement a Registered Dietician (RD) recommendation, notify the attending physician of a significant change in condition, and address the residents' prolonged symptoms of nausea and vomiting, and decreased food intake placed the resident and all other residents residing in the facility at risk for serious harm, serious injury, serious impairment, and possibly death. The facility's neglect also resulted in a functional decline for Resident #20, which possibly resulted in the resident's admission to hospice services on 2/14/24. The State Agency (SA) identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 11/02/23 when the facility failed to recognize, evaluate, and address Resident #13's nutritional needs, which resulted in an unintended significant weight loss of 6.92% (percent) in one (1) month, which further led to a significant weight loss of 17.52% (percent) in four (4) months. The facility's failure to consult a Registered Dietician (RD), notify the attending physician of a significant change in condition, and act upon the residents' weight loss, placed the resident, and all other residents residing in the facility at risk for serious negative outcomes. The IJ and SQC existed at: Rule 45.21.9 Nutrition M 645 Level IV The facility administrator was notified of the IJ and SQC on 2/13/24 at 4:30 PM and provided the IJ Template. The facility provided an acceptable Removal Plan on 2/14/24, in which they alleged all corrective	M 645	and Minimum Data Set Nurse audited all Registered Dietician Recommendations for the last 90 days were reviewed with provider and new orders and implemented. On 02/13/2024, all nutrition care plans were audited by the Minimum Data Set Nurse and updated to reflect dietary recommendations. Ad Hoc Quality Assurance and Performance Improvement meeting was held on 02/13/2024. On 02/13/2024, One-on-One in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records Nurse, and Minimum Data Set Nurse regarding weights, care plans, notifying physician, Quality Assurance and Performance Improvement meetings, Registered Dietitian Recommendations, Documentation, and Administration were conducted by the Regional Nurse Consultant. On 02/13/2024, the Regional Director of Operations conducted and One-on-One in-service with the Administrator regarding weights, care plans, notifying physician, Quality Assurance and Performance Improvement meetings, Registered Dietitian Recommendations, Documentation, and Administration. On 02/13/2024, the nurses who provided care to resident # 20 for previous three weeks were	

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M 645	Continued From page 61 actions to remove the IJ were completed on 2/13/24 and the IJ removed on 2/14/24. The SA validated the Removal Plan on 2/20/24 and determined the IJ was removed on 2/14/24. Therefore, the scope and severity for Rule 45.21.9 Nutrition M 645 Level IV, was lowered from a Level IV to a Level II while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: Review of the facility policy titled "Weight Assessment and Intervention" with a review date of 8/2003 revealed, "Policy Statement: Resident weights are monitored for undesirable or unintended weight loss or gain .... Weight Assessment: 1. Residents are weighed upon admission and at intervals weekly or monthly or as ordered by the physician .... 3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. a. If the weight is verified, nursing will immediately notify the dietician in writing. ... 5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria ... a. 1 month- 5% weight loss is significant; greater than 5% is severe. b. 3 months- 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months- 10% weight loss is significant; greater than 10% is severe ...." Under, "Evaluation: ... 2. The physician and the multidisciplinary team identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss." Review of the facility policy titled "Nutritional	M 645	provided one-on-one for reporting changes of condition to provider, documentation, and following plan of care and provided posttest to confirm understanding by the Director of Nursing and Assistant Director of Nursing. On 02/13/2024, Social Services and Medical Records nurse interviewed residents with a BIMS of 10 or higher to ensure residents were feeling safe in the environment and are free of health and safety concerns. On 02/14/2024, resident #20 was ordered appetite stimulant. On 02/14/2024, Resident #20 was admitted to hospice services. On 2/15/2024 resident #13 was ordered fortified cereal and fortified mashed potatoes. 2. All residents in the facility have the potential to be affected by the alleged negligent practices. 3. On 02/13/2024, appropriate staff were educated on nutritional status, care plans, reporting, documentation, and notifying provider by Assistant Director of Nurses. Starting on 03/07/2024 and completed on 03/08/2024, the Rehab Director in-serviced therapy staff to notify nurse of changes in resident conditions and concerns promptly. Beginning on 02/13/2024, the Medical Records nurse will review the nutritional report in the electronic health record for any residents with decreased meal intake	

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M 645	Continued From page 62 Assessment" with a review date of 7/24/23 revealed, "Policy Statement: As part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident...Policy interpretation and Implementation: 1. The dietician, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change that places the resident at risk for impaired nutrition. ... 4. The multidisciplinary team shall identify, upon the resident's admission and upon his or her change of condition, the following situations that place the resident at increased risk for impaired nutrition. ... d. Medication changes - includes changes resulting in loss of appetite, nausea, constipation, lethargy, decreased absorption, swallowing difficulties., etc .... h. Fluid and nutrient loss-prolonged fluid and nutrient loss secondary to diarrhea and/or vomiting that may increase nutritional requirements..." Resident #20 Cross reference F580, F692, F656 An observation and interview with Resident #20 on 2/11/24 at 3:19 PM, revealed her lying in a fetal position at the foot of the bed with a garbage can located on the floor beside the resident. The resident stated she was sick to her stomach and had a washcloth in her hand and was wiping her face. The resident's color was pale, lips were dry, and she was thin in appearance. An observation and interview with Resident #20 on 2/11/24 at 6:07 PM, revealed her lying on her right side in bed. The resident stated she was nauseated and could not eat dinner. She stated,	M 645	percentage in clinical meetings. The Medical Records nurse will ensure that concerns are communicated to the provider, interventions are put in place and the plan of care is updated at this time. Beginning on 02/13/2024, the dietary recommendations will be reviewed weekly by the DON and Dietary manager. The recommendations will be reviewed in clinical meetings for completion and documented in the resident's chart with the plan of care updated. 4. Starting 02/14/2024, the Director of Nurses will review the progress notes 5 times per week for changes in resident condition for 4 weeks, then weekly for 4 weeks, then biweekly for 2 months, then monthly for 2 months. The Director of Nursing will take immediate corrective action as needed. Starting 03/04/2024, the Administrator will interview 5 alternating residents weekly to ensure that residents feel safe and are free of health and safety concerns for 8 weeks, then bi-weekly for 2 months, then monthly for 2 months. The administrator will take immediate corrective action as needed and notify appropriate authorities as needed. The Administrator will report findings to the Quality assurance and performance improvement committee (QAPI) monthly for review and or revision of the plan. Starting 02/13/2024, the Minimum	

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M 645	Continued From page 63 "I'm just sick." An interview on 2/11/24 at 6:12 PM, with Certified Nurse Aide (CNA) #7 revealed Resident #20 refused her dinner tray due to nausea and vomiting. She stated she was unsure how long the resident had been sick. An observation of Resident #20 on 2/12/24 at 8:29 AM, revealed her lying on her right side in bed. The garbage can was located on the floor, close by the resident. The breakfast tray was located on the bedside table untouched. CNA #2 entered the resident's room, and stated the resident refused to eat or drink due to nausea. CNA #2 removed the tray cover, and the resident began to retch and vomited a small amount of clear substance. The resident was weak, pale, and her lips were dry. An interview with CNA #2 on 2/12/24 at 8:35 AM, revealed she had worked at the facility for three (3) weeks and Resident #20 had refused to eat or drink since then. She explained that the resident had been nauseated, dry heaving, and vomiting for the past three (3) weeks since she had been employed at the facility. CNA #2 confirmed that she had reported the symptoms to the medication nurse every day that she worked. An interview with CNA #1 on 2/15/24 at 8:35 AM, revealed Resident #20 refused breakfast due to nausea. She stated that she had notified the nurse each time that she witnessed the resident with nausea and vomiting or refusing to eat and drink. Record review of Resident #20's "Progress Notes" from 11/01/23 through 2/11/24, revealed there was not any documentation that the	M 645	Data Set Nurse will audit nutrition care plans weekly times 4 weeks, then bi- weekly times 2 months, then monthly times 3 months for appropriate interventions. The Minimum Data Set Nurse will take immediate corrective action as needed. The MDS nurse will report findings to the Quality assurance and performance improvement committee (QAPI) monthly for review and or revision of the plan. Starting 02/13/2024 the Medical Records Nurse and the Dietary Manager will audit the dietary recommendations to ensure receipt, provider notification, documentation, and implementation weekly times 4, then bi-weekly times 2 months, then monthly times 3 months. The Medical Records Nurse and the Dietary Manager will take immediate corrective action as needed. The Dietary Manager will report findings to the Quality assurance and performance improvement committee (QAPI) monthly for review and or revision of the plan. The Director of Nurses will review weights five (5) times a week times 2 months for changes. The DON will take immediate corrective action as needed. The DON, Administrator, Minimum Data Set Nurse, Dietary Manager, and Medical Records Nurse will report findings to the Quality assurance and performance improvement committee	

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M 645	Continued From page 64 resident had nausea and vomiting or that she refused meals. Record review of the "Occupational Therapy Progress Notes" dated 2/01/24 revealed, "Patient refused: pt (patient) is refusing to eat and has poor appetite. pt (patient) c/o (complains of) nausea almost every day, but is not eating even with max encouragement and assist from therapist." ... Also revealed under, "Assessment and Summary of Skilled Services: ... therapist encouraging pt (patient) daily to eat and providing assist, but pt (patient) refuses to eat and c/o (complains of) nausea." ... Record review of the "Order Summary Report" for Resident #20 revealed an order dated 2/11/24 at 1827 (6:27 PM), "Ondansetron HCL (Hydrochloride) Tablet 4 (four) MG (milligrams) Give 1 (one) tablet by mouth every 6 (six) hours as needed for Nausea and Vomiting" ... Record review of Resident #20's January and February "Medication Admission Record" (MAR) revealed, there was not a physician's order for nausea/vomiting medication before the new order for Ondansetron HCL started on 2/11/24, which indicated the resident's symptoms of prolonged nausea and vomiting were left untreated. Record review of the "Meal Intake Documentation Report" completed by the Certified Nurse Aides (CNAs) revealed, Resident #20 refused eighteen (18) meals from 12/18/23 through 12/31/23. She refused thirty-one (31) meals in the month of January 2024, with a total of thirty-nine (39) meals consumed at 0-25% (percent), and she refused sixteen (16) meals from 2/01/24 through 2/11/24, with a total of fourteen (14) meals consumed at 0-25% (percent).	M 645	(QAPI) monthly, starting 03/19/2024, for 6 months for review and or revision of the plan then as needed.	

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M 645	Continued From page 65 Record review of Resident #20's "Order Summary Report" revealed an order dated 1/08/24, "Weekly weights x (times) 4 (four) weeks one time a day every 7 day(s)" ... Record review of Resident #20's "Weight Summary" revealed the following weights: 8/03/23 - 154.5 pounds 9/07/23 - 152.2 pounds 10/5/23 - 147.6 pounds 11/01/23 - 145.4 pounds 12/04/23 - 145 pounds 1/03/24 - 132.4 pounds 1/10/24 - 129.6 pounds 1/16/24 - 124 pounds 1/23/24 - 133.2 pounds 1/30/24 - 122.8 pounds 2/06/24 - 114 pounds 02/15/24 - 110 pounds Record review of Resident #20's weights revealed a significant weight loss of 13.9% (percent) in one (1) month, 21.6% (percent) in three (3) months, and 26.2% (percent) in six (6) months. Record review of the" Order Summary Report" for	M 645		

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M 645	Continued From page 66 Resident #20 revealed an order dated 1/04/24, "Regular diet Regular texture, Regular consistency" ... Also revealed an order dated 1/04/24, "Med Pass 2.0 two times a day for supplement." An interview with the Director of Nursing (DON) on 2/11/24 at 3:55 PM, revealed Resident #20's condition had declined over the past couple of months related to her diagnosis of dementia. She explained that the resident had a significant decline after she fell in December 2023, and received a fracture of the T-12 vertebrae and had to be placed on strong pain medications. She stated, to her knowledge, the resident had not experienced any nausea and vomiting until yesterday when the Survey Agency brought it to her attention. She stated none of the staff had reported it to her and confirmed that she should be aware of what was happening with the resident. She revealed she was aware that the resident was not eating or drinking and had been refusing meals. The DON stated she had made the physician aware of the resident's decline, and the significant weight loss, and the Registered Dietician (RD) had evaluated her. An interview with Licensed Practical Nurse (LPN) #3 on 2/11/24 at 4:20 PM, revealed Resident #20 had a decline over the past several weeks. She explained that the resident would not eat or drink anything, including the med pass supplement. She stated that usually they cannot get her to take her medications and that the resident would eat crushed ice chips, but that's about it. LPN #3 explained that she noticed a change after the resident fell and hurt her back and was in a lot of pain. She confirmed that she had not notified the resident's physician of the change in condition.	M 645		

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M 645	Continued From page 67 A telephone interview with Medical Director on 2/12/24 at 6:05 PM, revealed the staff had contacted him last night regarding Resident #20 having nausea and vomiting, and he had ordered Zofran (Ondansetron) as needed. He confirmed that the staff had not contacted him or made him aware of the resident's decline in condition or her refusal to eat or drink. He stated that he was not notified of her significant weight loss (40.5 pounds in 6 months) or the Registered Dietician (RD) recommendations. He confirmed Resident #20's current condition was serious and stated what you have relayed to me screams neglect. Record review of the "Emergency Room (ER) Report" dated 12/17/23, revealed Resident #20 was transported to the ER after suffering an unwitnessed fall at the facility with complaints of back pain. Findings of the CT (Cat Scan) of the Spine Lumbar without contrast dated 12/17/23 revealed," There is a T-12 vertebral fracture involving both the superior and inferior endplates as well as the posterior cortex." ... Record review of Resident #20's Order Summary Report revealed an order dated 1/08/24, "RD (Registered Dietician) consult" ... Record review of the "Consultant Registered Dietician (RD) Note" dated 12/27/23, for Resident #20 revealed the RD (Registered Dietician) recommended, "Med Pass 2 oz (ounces) BID (twice daily), weekly weights x (times) 4 (four) weeks, and add Fortified Pudding BID (twice daily) at lunch and dinner" ... Record review of the "Consultant Registered Dietician (RD) Note" dated 1/5/24, for Resident #20 revealed, "Resident w/(with) significant wt (weight) loss x (times) 1 (one) mo (month) (-9%)	M 645		

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and x (times) 6 (six) mo (months) (13.7%) (percent). Po (by mouth) intake likely not meeting nutritional needs. Resident is at risk for skin breakdown and wt (weight) loss d/t (due to) decreased appetite ... NO N/V/c/D (nausea, vomiting, complaints of diarrhea) documented." ... Also revealed under REC (recommendations): "Resident may benefit from an appetite stimulant, please document % (percentage) of supplement consumed daily, add fortified pudding BID (twice daily) at lunch and dinner, weekly weights x (times) 4 (four) weeks to assure stable weight" ...

Record review of the "Consultant Registered Dietician (RD) Note) dated 2/10/24, for Resident #20 revealed, "Resident w/(with) significant wt (weight) loss x times 1 (one) mo (month), x (times) 3 (three) mo (months) and x (times) 6 (six) mo (months) ... consuming <25% w/(with) refusals of meals ... Po (by mouth) intake likely not meeting nutritional needs ... NO N/V/c/D (nausea, vomiting, complaints of diarrhea) documented." ... Also revealed under REC (recommendations): "Resident may benefit from an appetite stimulant, please document % of supplement consumed daily, weekly weights x 4 weeks to assure stable weight, if po (by mouth) intake and wt (weight) status does not improve, resident may benefit from an alternate means of nutrition support."

Record review of the "Order Summary Report" for Resident #20 revealed there was not a physician's order for fortified pudding at lunch and supper or a medication to stimulate appetite per Registered Dietician (RD) recommendations.

Record review of Resident #20's Physician Nursing Home Visit dated 1/26/24 revealed, "No concerns reported by the nursing staff ...." The

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physician progress note did not identify any documentation to support the resident's nausea and vomiting or weight loss.

An interview with Licensed Practical Nurse (LPN) #2 on 2/13/24 at 7:45 AM, revealed Resident #20 was not drinking the med pass supplement, and was refusing meals. She stated that the resident had been refusing meals for several weeks. She revealed that the resident's family was highly involved with her care, and the resident would report nausea to them, and they would come and notify her.

An interview with the Dietary Manager (DM) on 2/13/24 at 8:13 AM, revealed that she was new to the role and had been in the position since June 2023. She revealed that the facility had weekly PAR (Patients at Risk) meetings where the weights were discussed. She stated all the Department Heads attend the meetings. The DM revealed, if a resident should need a RD (Registered Dietician) consult, she would notify the RD after the weekly PAR meeting by texting or calling. She stated that the RD would usually text her back to let her know she had the resident down on her list. She revealed that the RD did not come to the facility and did all her consultations remotely. She explained that the RD was consulted on Resident #20 in January 2024, but confirmed that she had not seen any RD recommendations. She stated that the resident had never received fortified pudding, and to her knowledge, had never started on an appetite stimulate. She explained that the facility had trouble getting the RD recommendations. The DM stated she just realized last week on Friday 2/9/24 that the RD recommendations were going to her spam email. She revealed that she tried to open the email and the email read it was

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quarantined. She revealed that she told the Director of Nursing (DON) that she was not receiving anything from the RD, and she thought the DON had texted her. She revealed that the Administrator had been going into all the residents 'progress notes and printing out the recommendations to make sure they were being implemented. She confirmed that lack of implementation of the RD recommendations could cause the resident to have weight loss and malnourishment.

A telephone interview with the Registered Dietician (RD) on 2/13/24 at 9:56 AM, revealed that she worked remotely and tried to be onsite every 60-90 days. She revealed that her last visit to the facility was December 16, 2023. The RD explained that she had access to the Electronic Medical Record (EMR) and was able to chart under the residents' Progress Notes or under the Miscellaneous tab. She revealed that she was usually notified by the Director of Nursing (DON) or the Dietary Manager (DM) when a resident needed a dietary consultation. The RD stated she was notified in late December that Resident #20 needed to be seen due to a significant change. She revealed that she recommended med pass 2 ounces twice daily as a supplement, weekly weights and fortified pudding added with lunch and dinner. She revealed that she also did a consultation on Resident #20 on 1/5/24 and 2/10/24 and recommended that the resident would benefit from an appetite stimulant. She explained that she emailed all her recommendations to the Administrator (ADM), Director of Nursing (DON), Dietary Manager (DM), and the Regional Nursing Consultant (RNC). She explained that she marked on the recommendations if the physician needed to be contacted for a physician order. She confirmed

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that Resident #20's recommendation was marked to contact the physician for an appetite stimulant and adding the fortified pudding. She stated that she was unable to contact the doctor or write orders because she did not have the authority with her contract with the facility. She stated that she had not been contacted by anyone from the facility reporting that they had not received Resident #20's dietary recommendations.

An interview with the Director of Nursing (DON) on 2/13/24 at 10:38 AM, revealed Resident #20 functional status had declined since her fall and after reviewing the progress notes, she observed there was no documentation to support a decline, nausea, and vomiting or food refusal. She revealed before the fall the resident was ambulatory, rarely in bed, and she took herself to the bathroom. She revealed that she would sit up in a chair in her room. She stated after the fall the resident required more help with her Activities of Daily Living (ADLs), stayed in bed, became incontinent, had more falls, and required the staff to assist with eating. She confirmed that the facility should have notified the physician immediately when the decline came about, and verbalized that was a failure on their part. She explained that the facility had spoken with the son about placing the resident on hospice today, and he had agreed. She explained that she knew it looked bad that they had consulted hospice, but she stated we had talked to the son before, and he thought she might recover. The DON stated that the facility did not reach out to the physician to inquire about drawing labs or any intravenous fluids throughout these months of the resident refusing to eat or drink. She stated that she did report the weight loss to the physician while he was inside the facility. She stated, "I do not recall the date or month I notified him." She confirmed

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that she did not have documentation to support her notification. She stated that the facility was not receiving any of the dietary recommendations, and the Dietary Manager (DM) determined that the emails were going to her junk folder. She explained that the Administrator was going into the resident notes and printing them out to ensure they were all implemented. The DON stated that the RD would also add her notes to the Electronic Medical Record (EMR) and would not tell anyone. She revealed that she had texted the RD to tell her that the recommendations were not received, and the RD would reply that she would resend them. The DON revealed that she had never received any emails from the RD, and confirmed that she had not gone into her junk email to search and see if they came to her that way. The DON stated, "I have over 700 junk emails and I do not have time to do that."

An interview with the Administrator (ADM) on 2/13/24 at 2:10 PM, revealed the Registered Dietician (RD) worked remotely, and she had seen her in the facility twice. She explained that they were in the process of trying to find a RD onsite. She revealed that the facility usually communicates with the current RD through email or text messages and the last RD recommendation she had received by email was in August 2023. She stated that the Dietary Manager (DM) had received some, but they went to her spam folder encrypted. She explained that she had not reached out to the RD herself to follow up and that the facility had not started an audit and stated they tried to go over the recommendations in the High-Risk meetings. She stated that Resident #20 had been discussed in January 2024 during a PAR (patients at risk) meeting. The ADM confirmed that the Dietary

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M 645	Continued From page 73 Recommendations for Resident #20 had not been implemented and that the facility failed to document the significant changes that occurred in the resident's condition. She stated, "I know the documentations not there." She revealed that she was told the Director of Nursing (DON) had reached out to the physician and stated, "It looks bad on our part." An interview with Social Services (SS) on 2/13/24 at 3:00 PM, revealed she had reached out to the family of Resident #20 about the functional decline on 1/10/24. She revealed that the son did not want to do hospice at that time and was hoping the resident would perk up. She explained that since then, she followed up with the family and explained that the resident continued to decline and asked them to reconsider hospice services again. Record review of the "Progress Notes" for Resident #20 dated 2/14/24, "Proper Name Hospice consulted per md order and family request ... for declining condition related to Alzheimer's disease ..." An interview with the Minimum Data Set (MDS) Nurse on 2/14/24 at 5:23 PM, revealed that she did a significant change MDS after Resident #20 fell in December 2023, and after it was identified in the facility's clinical meeting that the resident had a significant weight loss in January 2024. She revealed that after the fall, the resident declined in her ability to get out of bed, and she was no longer able to sit in a chair, which was what the resident liked to do. She explained that the resident experienced increased pain, worsening incontinence and was required to wear a back brace when she was out of the bed. She stated that staff had identified the weight loss,	M 645		

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and, in her opinion, it was being addressed. She confirmed that the documentation was absent to support a decline in the residents' condition, and stated she went off what was discussed in the High-Risk meetings. She revealed that she was aware that the resident did not have a physician order for the fortified pudding or an appetite stimulant that was recommended by the Registered Dietician (RD).

Record review of the "Transfer/Discharge Report" revealed the facility admitted Resident #20 on 1/24/22 with medical diagnoses that included Alzheimer's disease, Rheumatoid Arthritis, Primary Open-angled Glaucoma, and Wedge Compression Fracture of T 11-T 12 vertebra, subsequent encounter for fracture with delayed healing.

Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/10/24 revealed a Brief Interview for Mental Status (BIMS) of 03 which indicated the resident had severe cognitive impairment. Prior MDSs dated 09/18/23 revealed a BIMS of 11, MDS dated 12/11/23 revealed a BIMS of 9.

Resident #13 Cross reference F580, F600, F656

During an observation and interview on 2/13/24 at 11:05 AM, Resident #13 appeared comfortable lying in bed and stated she had lost weight while in the facility. She revealed there were times she did not eat well and she was not on supplements.

During an interview on 2/14/24 at 11:40 AM, the Director of Nursing (DON) revealed Resident #13 had a significant weight loss which was not reported to the physician for interventions, therefore, her weight continued to decrease. She

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stated the Registered Dietician (RD) had not been consulted concerning the significant weight loss. She confirmed that due to the physician and the RD not being notified, the resident had a weight loss that could have possibly been avoided if interventions had been put in place for the resident's nutritional well-being. She confirmed the facility neglected to recognize, evaluate, and address the resident's weights, failed to notify the physician of the weight decline, and failed to consult the RD, therefore, appropriate evaluations and interventions were not ordered or initiated which put the resident at risk for a continued weight loss. She confirmed these failures led to a significant weight loss of 6.92% during Resident #13's first month at the facility and to a 17.52% weight loss during her first four months at the facility.

An interview with the facility's Regional Nurse Consultant on 2/15/24 at 8:45 AM, revealed the physician nor the nurse practitioner were notified of Resident #13's significant weight loss and therefore, no interventions were initiated and weight continued to decline. She stated the initial consult with the Registered Dietician (RD) was on admission due to her wounds and once her weight was trending down, no additional consults were made. She confirmed the facility neglected to identify, evaluate, and intervene for nutritional concerns and, therefore, an avoidable weight loss occurred due to the facility's failure to appropriately manage the resident's nutritional needs.

During an interview on 2/15/24 at 12:00 PM, the Dietary Manager confirmed she was unaware of Resident #13's significant weight loss and failed to ensure the Registered Dietician was notified of the weight loss concern.

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M 645	Continued From page 76 Record review of "Weights and Vitals Summary" revealed Resident #13's weight on 10/3/23 of 166.1 pounds and a weight on 11/2/23 of 154.6 pounds which listed a comparison weight of an 11.5 pound decrease and a 6.9% weight loss. Resident #13's weight on 2/5/24 was 137 pounds and compared to the admission weight 4 months previously of 166.1 pounds on 10/3/23 listed a comparison weight of a 29.1 pound decrease and a 17.5% weight loss. Record review of Resident #13's Admission Record revealed she was admitted to the facility on 10/2/23. Diagnoses included Stevens-Johnson Syndrome, Non-pressure Ulcers, Anxiety Disorder, Major Depressive Disorder. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/12/23 revealed a Brief Interview for Mental Status (BIMS) of 12 which indicated the resident had a moderate cognitive impairment. The facility submitted the following removal plan: On 02/13/2024 at 4:30 PM, the Mississippi State Department of Health (MSDH) state survey team notified the Administrator of an Immediate Jeopardy for failing to ensure processes were in place to review and implement Registered Dietician (RD) recommendations, notify the physician of weight loss, and implement interventions to address weight loss for Resident #20, who had lost 40.5 lbs in the last six months. Resident #20 also had nausea and vomiting and was not eating or drinking adequately for the last three weeks and the facility had failed to notify the physician of the significant change. The facility	M 645		

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M 645	Continued From page 77 failed to follow care plan interventions to identify weight loss and address weight loss for Resident #20. The facility failed to have an effective Quality Assurance and Performance Improvement (QAPI) meeting to ensure all recommendations from the Registered Dietician were addressed in a prompt manner. Review of facility processes revealed that the recommendations from the registered dietician was being sent to the Dietary Manager via email and the emails were not received and not presented to the interdisciplinary team and reviewed by the provider and implemented. Interview with staff indicates that resident has had poor appetite since January, and it was not documented in the medical record. On 02/11/2024 at 6:27 PM, the facility nurse notified the provider and obtained orders for anti-emetic. On 2/12/2024 at 9:27 am, the facility attempted to transfer resident to the emergency room for evaluation and treatment as indicated. The Responsible Party refused for resident to be sent to the emergency room on this date. The facility obtained a physician's order for hospice services. On 02/13/2024 5:00 PM, In-services began on Abuse and Neglect for all staff by the Assistant Director of Nursing. All staff will be trained prior to returning to work. In-services began by Assistant Director of Nursing on Documentation, Provider Notification, and Change of Condition. All staff will be trained prior to returning to work. On 02/13/2024 at 5:15 PM, Social Services and Medical Records Nurse interviewed all residents regarding Nausea and Vomiting to ensure all significant changes of conditions were reported to the providers. It was noted upon interview that	M 645		

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nine (9) residents reported recent complaints of nausea and vomiting, one (1) resident noted to have yellow discharge from mouth and nose, 1 resident was unable to recall when nausea or vomiting occurred with no staff being knowledgeable of nausea or vomiting, two (2) residents reported nausea or vomiting after eating, 2 residents reported not having appetite or eating, 1 resident reported nausea but did not report to nurse, 2 residents reported nausea and medications received.

On 02/13/2024 at 5:30 PM, all residents were audited for weight loss by the Director of Nursing, Regional Nurse Consultant, and Minimum Data Set Nurse. Results of weight loss audit were reviewed by the medical director (15 unplanned weight losses, 1 planned) and new orders and diagnoses were provided by the medical director. All nutrition care plans audited by Minimum Data Set Nurse on 02/13/2024 with 5 residents whose registered dieticians' recommendations were not on care plans, dietary recommendations reviewed with providers and orders received per providers.

On 02/13/2024 at 6:05 PM, the Director of Nursing notified the physician of all 9 residents, notified the Institutional Specialized Needs Plan (ISNP) nurse practitioner of all residents (4) and hospice of all residents (1) with Nausea and Vomiting with new orders received from provider. 1 resident reviewed with new orders for chest x-ray due to cough, congestion, and yellow discharge from mouth and nose, 2 residents were ordered medications for reflux, 1 resident noted to be receiving antibiotics and has orders in place for anti-emetic medications, 1 resident reported abdominal pain and MD was notified and seen resident on 02/12/2024 with new orders for stool softener, 1 resident noted to have diarrhea and

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M 645	Continued From page 79 has been antibiotics new orders received for Zofran and anti-diarrheal, 1 resident noted to have weight loss and nausea and vomiting new orders received on 2/11/2024 to start Zofran and start peri-actin the family was not agreeable to start peri-actin and wanted to wait to speak to hospice on 02/14/2024, 2 residents did not report nausea to nurses at time of occurrence. On 02/13/2024 at 6:59 PM, Social Services and Medical Records nurse interviewed residents with BIMS 10 or higher to ensure feeling of safe and are free of health concerns, no health or safety concern during interviews. On 02/13/2024 at 8:30 PM, all RegisteredDietician recommendations for last 90 days audited by Dietary Manager and Minimum Data Set Nurse with 5 residents whose registered dietician recommendations were not addressed. All Dietary recommendations reviewed with the Medical Director (5) and subsequent providers as appropriate Hospice (2 residents who have been on hospice services prior to survey entrance) and Institutional Special Needs Program nurse practitioner (1), new orders received from providers as appropriate. On 02/13/2024 at 8:40 PM, All nutrition care plans audited by Minimum Data Set Nurse with 5 residents whose registered dieticians' recommendations were not on care plans, dietary recommendations reviewed with providers and orders received per providers and care plans updated. On 02/13/2024 at 9:00 PM, all residents noted with weight loss were reviewed with the Medical Director, the Medical Director performed medication review on all residents with weight	M 645		

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M 645	Continued From page 80 loss. Ad Hoc QAPI was held on 02/13/2024 at 10:15 PM with the Medical Director via phone, Administrator, Director of Nursing, Social Services, Minimum Data Set Nurse, Life Connections Coordinator, Regional Nurse Consultant, Regional Director of Operations, Assistant Director of Nursing, Registered Nurse Supervisor, Dietary Manager, and Medical Records Nurse. The Minimum Data Set Nurse has been designated as the Quality Assurance Nurse with responsibility reviewing all audits, Performance Improvement Plans, Quality Measures, and actively participating in the Quality Assurance and Performance Improvement meetings. All areas of deficiencies were reviewed in Ad-Hoc Quality Assurance and Performance Improvement meeting. Medical Records nurse or Assistant Director of Nursing will be responsible for receiving Registered Dietician recommendations, reviewing with providers, entering orders, and progress notes. New processes for Medical Director to review facility weight losses each week on visit, Registered Dietitian recommendations to be reviewed weekly with the Interdisciplinary Team and the Medical Director by Friday, in the event Registered Dietician recommendations are not received, the medical director will be notified. The Dietary Manager will review the weight and vital sign exception report and present findings in the clinical meeting. The Director of Nursing will review weights and registered dietician recommendations. The Director of Nursing will review progress notes daily. The administrator will review the audit findings weekly. All results will be reviewed in Quality Assurance and Performance Improvement meetings.	M 645		

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M 645	Continued From page 81 On 02/13/2024 at 10:00 PM, One-on-one Inservice conducted with Administrator by the Regional Director of Operations for weights, care plans, Quality Assurance and Performance Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation, and Administration Processes. The Regional Nurse Consultant conducted one-on-one in-services with the Director of Nursing, Dietary Manager, Assistant Director of Nursing, Medical Records Nurse, and Minimum Data Set Nurse regarding weights, care plans, Quality Assurance and Performance Improvement, Notifying Physicians, Registered Dietician Recommendations, Documentation and Administration Processes. One-on-one in-service conducted with the Dietary Manager by the Administrator regarding Communication of Dietary Recommendations, Review of Recommendations, and reporting any identified areas of concerns with Dietary Recommendations. All nurses who provided care to resident #20 for the previous 3 weeks were provided One-on-one in-services regarding reporting changes of condition to provider, documentation, and following plan of care then were provided with a post-test to confirm understanding of one-on-one in-services. As of 02/14/2024, the facility alleges compliance and all corrective action completed on 02/13/2024. The Survey Agency (SA) validated the facility's Corrective Actions on 2/20/24: The SA validated through record review that Resident #20 was ordered an anti-emetic for nausea/vomiting.	M 645		

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M 645	Continued From page 82 The SA validated through interview and record review that in-services were conducted for Abuse and neglect, documentation, provider notification, and change of condition. No staff can return to work until they have received in-services. The SA validated through record review that all residents were interviewed and screened for symptoms of nausea and vomiting and the physician was notified of the findings with physician orders if appropriate. The SA validated through record review and staff interview that all residents were audited for weight loss and the Medical Director was updated. All nutrition care plans were audited and updated with dietary recommendations. The SA validated through record review that all residents with a Brief Interview for Mental Status (BIM's) of 10 or higher were interviewed to ensure feeling safe in their environment and free from health concerns. The SA validated through record review that all Registered Dietician (RD) recommendations were audited and addressed with the provider as appropriate. The SA validated the Medical Director reviewed the resident with weight loss and performed medication review. The SA validated through staff interview and record review on 2/20/24 that an Emergency Quality Assurance and Performance Improvement (QAPI) meeting was conducted on 2/13/24 with all members in attendance. The SA validated through record review and staff	M 645		

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M 645	Continued From page 83 interview that one-on-one in-services were conducted on weights, care plans, Quality Assurance and Performance Improvement (QAPI), notifying physicians, reporting changes, Registered Dietician Recommendations, Documentation, and Administrative Processes. No staff can return to work until they have received in-services. The SA validated that all corrective actions were completed on 2/13/24 and the IJ was removed as of 2/14/24.	M 645		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review, and facility policy review, the facility failed to follow the physicians order for continuous oxygen usage for one (1) of five (5) residents reviewed for continuous oxygen. Resident #15 Findings Include: Record review of the facility policy titled "Oxygen Administration" dated 8/25/14, revealed " ... Preparation: 1. Verify that there is a physician's order for this procedure... Documentation: After	M 655	1. On 02/12/2024, the resident was encouraged to apply oxygen. On 02/12/24 the provider was notified by Assistant Director of Nurses of resident□s refusals to wear oxygen with orders to discontinue. 2. The alleged deficient practice has the potential to affect all residents on oxygen. 3. On 03/04/2024 licensed nurses in-serviced by Director of Nursing on ensuring physician orders are accurately transcribed and documented including notifying provider of	3/19/24

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M 655	Continued From page 84 completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: ... 7. How the resident tolerated the procedure. 8. If the resident refused the procedure, the reason(s) why and the intervention taken. Reporting: 1. Notify the supervisor if the resident refuses the procedure ..." Record review of the "Order Summary Report" with active orders as of 2/12/24 for Resident #15 revealed an order dated 1/12/24, "O2 (oxygen) on continuously at 2ls (two liters) bnc. (by nasal cannula) every shift ..." An observation on 2/11/24 at 4:39 PM, of Resident #15 revealed her lying in bed with her eyes closed. She was unable to arouse to verbal stimuli. The resident's oxygen concentrator was observed by the bedside, with the oxygen cannula laying over the concentrator. An observation of Resident #15 on 2/12/24 at 2:35 PM, revealed the resident lying in bed. The resident was alert/verbal and confused. The oxygen cannula was observed laying over the oxygen concentrator at the bedside. An observation and interview with Licensed Practical Nurse (LPN) #1 on 2/12/24 at 2:43 PM, confirmed Resident #15 had not been wearing oxygen. LPN #1 explained she had applied the oxygen this morning, and the resident refused to keep it on. She revealed the resident had been refusing to wear the oxygen for a while. She confirmed she had not made the physician aware of the resident's refusal, and stated she should have. LPN #1 confirmed she should have documented that the resident refused, and instead she documented the oxygen as	M 655	refusals to meet professional standards of quality. On 02/13/2024 the Regional Nurse Consultant (RNC), in-serviced DON and ADON on ensuring physician orders are accurately transcribed and documented including notifying provider of refusals to meet professional standards of quality. 4. Starting 03/08/2024, the director of nursing will make weekly walking rounds of all residents with oxygen times 4 weeks, then bi-weekly times 4 weeks, then monthly times 2 months to ensure residents are receiving oxygen as ordered and that documentation of residents□ use of oxygen is correct. The Director of Nursing will take immediate corrective action if needed. The Director of Nursing will present the audit findings to Quality Assurance and Performance Improvement Committee monthly starting, 03/19/2024, 3 months then as needed.	

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M 655	Continued From page 85 administered, which indicated the resident was using it. She stated she was unsure how long a resident must refuse a medication before the physician was contacted. An observation and interview with the Director of Nursing (DON) on 2/12/24 at 2:57 PM, confirmed she was aware Resident #15 had not been wearing the oxygen that was ordered continuous. She revealed the resident had been refusing to wear the oxygen, and to her knowledge, none of the staff had reached out to the physician to make him aware. She confirmed the Medication Administration Record (MAR) should reflect the resident's refusal, and the facility should have reached out to the physician to notify. Record review of the February 2024, Medication Administration Record (MAR) revealed an order dated 1/12/24, "O2 (oxygen) on continuously at 2ls (two liters) bnc (by nasal cannula) every shift". The MAR was documented as oxygen having been administered 2/1/24 through 2/12/24, with no refusals documented. Record review of the "Progress Notes" for Resident #15 revealed there was not any documentation to support the refusal of oxygen. Record review of the "Admission Record" for Resident #15 revealed the facility admitted Resident #15 on 9/02/23 with diagnoses that included Unspecified dementia, Other seizures and Repeated falls.	M 655		
M1230	45.40.11 Call System Call System. A call system shall be in place at the nurses' station to receive resident calls through a	M1230		3/19/24

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M1230	Continued From page 86 communication system to include audible and visual signals from bedrooms, toilets, and bathing facilities. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, and facility policy review, the facility failed to ensure a resident had access to the call light system for (1) of 60 residents on initial tour. Resident #8. Findings include: Record review of facility policy titled, "Call System, Resident", undated, revealed, " ...Residents are provided with a means to call staff directly for assistance through a communication system that directly calls a staff member or a centralized work station. Policy Interpretation and Implementation: 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor..." An interview with the Director of Nursing (DON) on 2/11/24 at 4:30 PM, revealed Resident #8 was living in this room and when her son was discharged from the hospital and returned to the facility on 02/10/24, Resident #8 wanted her son to be in the room with her so she could take care of him. She stated this room was small and designed for one person, but the resident wanted to be with her son, so "we put them together in here to see how it works out". She stated one call light is shared since beds are close. On 2/11/24 at 5:10 PM, an observation of Resident #8's room and an interview with	M1230	1. Resident #8 and roommate were moved to another room on 02/12/2024 where both residents have their own separate call light. 2. The alleged deficient practice has the potential to affect all residents. 3. Resident #8□s previous room will be converted to a single resident room beginning 02/12/2024 due to only one call light outlet present in room. 100% call light audit completed on 02/12/2024 by Administrator to ensure all residents had access to their own call light and all call lights were working properly. 4. 03/04/2024 Maintenance Director will monitor all call lights to ensure they are working properly weekly times 4 weeks, then biweekly times 2 weeks, then monthly times 2 months. Maintenance Director will report audit findings to Quality Assurance and Performance Improvement Committee monthly starting on 03/19/2024 for 3 months and as needed	

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M1230	Continued From page 87 Resident #8 revealed her son had been in the hospital and when he was discharged from hospital and returned to facility, he moved into the room with her so she could take care of him. She stated her son had been sick and she wanted to be there to care for him since "he's not doing well". She stated her son had a call light but she did not have one and "they need to get me one, too". The observation revealed one call light/cord attached to the one call light outlet available in the room. During an interview on 2/12/24 at 4:00 PM, the Maintenance Director stated the room Resident #8 and her son were in was designed for one resident and had only one call light and one call light outlet. He stated in the past, he had an adapter cord that split one call light outlet into two call light cords, but this divider was not being used and the room only had one call light cord available. He confirmed there were two residents in the room and there was only one call light available for use by one resident and each resident should have access to a call light. An interview with the Director of Nursing (DON) on 2/12/24 at 4:20 PM, revealed Resident #8's room was designed for one resident, not two, and only one call light was available for use for one resident. The DON confirmed a call light must be available and within reach for each resident to use to contact staff when assistance was needed to ensure each resident could receive prompt care. The DON confirmed the facility failed to provide Resident #8 with a call light and therefore, she was unable to contact staff if assistance was needed. Record review of Resident #8's Admission Record revealed the resident was admitted to the	M1230		

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M1230	Continued From page 88 facility on 10/18/23. Her diagnoses included, Dementia, Polyneuropathy, Major Depressive Disorder, Anxiety Disorder, Dizziness. Record review of Resident #8's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 2/6/24, revealed the resident had a Brief Interview for Mental Status (BIMS) of 8, which indicated the resident was moderately cognitively impaired.	M1230		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.	M1570		3/19/24

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M1570	Continued From page 89 This Statute is not met as evidenced by: Level II Based on observation, staff interview, and facility policy review, the facility failed to ensure hand hygiene was performed during medication pass to prevent the spread of infection for four (4) of eleven residents observed during medication pass. Resident #20, Resident #48, Resident #55, and Resident #211 Findings Include: Record review of the facility policy titled "Handwashing" dated June 1, 2000, revealed "Policy Statement: It is the policy of this facility that handwashing be regarded as the single most important means of preventing the spread of infection. Procedure: 1. All personnel shall wash their hands to prevent the spread of infection and disease to other residents, personnel, and visitors .... 7. Alcohol gel may be used during med pass for three times before washing hands." During an observation of medication pass on 2/14/24 at 7:55 AM, Licensed Practical Nurse (LPN) #3 prepared medications for Resident #211, entered the resident's room and applied gloves, administered the medications, removed the gloves, and exited the resident's room without performing hand hygiene. She then prepared and administered medications for Resident #48 and Resident #55 without performing hand hygiene. Lastly, she prepared Resident #20's medication, entered the resident's room, applied gloves, administered eye drops in both eyes, and exited the room without using hand hygiene. She returned to the medication cart and began to prepare medications for another resident.	M1570	1. Nurse #3 was removed from the medication cart and sent home on 2/14/24. Residents were assessed by Director of Nursing on 02/14/2024. Medical Director was notified on 02/14/2024 with no new orders. 2. The alleged deficient practice has the potential to affect all residents. 3. Nurse #3 completed documentation in--service, hand hygiene check-offs, and medication administration in-service and check-offs on 02/15/2024 prior to returning to work. Nurse #3 was checked off by Assistant Director of Nursing. Starting on 02/14/2024, licensed staff were educated by Assistant Director of Nursing on hand hygiene with a post test to confirm understanding, and completed skills check off for hand hygiene with alcohol based rub and handwashing. 4. The Assistant Director of Nursing will observe medication administration weekly 4 weeks, biweekly times 4 weeks, then monthly times 2 months to ensure hand hygiene is conducted appropriately during medication administration starting 03/04/2024. The Assistant Director of Nursing will take immediate corrective action as needed. Licensed staff will complete hand hygiene check offs upon hire and annually beginning 2/14/2024. The Assistant Director of Nursing will report audit findings to	

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M1570	Continued From page 90 An interview with LPN #3 on 2/14/24 at 8:30 AM, confirmed that she administered medications to four (4) residents and did not perform hand hygiene. She revealed that the purpose of hand hygiene was to kill germs and prevent the spread of infection. She stated that she should have used hand sanitizer before and after each resident. An interview with the Regional Nurse Consultant (RNC) on 2/15/24 at 8:15 AM, revealed the purpose of hand hygiene was to reduce the risk of cross contamination and the spread of infection. She stated hand hygiene should be done before and after contact with a resident. Record review of a document titled "Med pass points", undated and unsigned, revealed, "...Infection control: Wash hands or use hand sanitizer in between each resident. Actually look at it more specifically as exiting and re-entering a room even if you are still working on the same person ..." Record review of the "Handwashing Training" dated 1/24/24 revealed under, "Hand hygiene with alcohol based hand rubs: In most situations, the preferred method of hand hygiene is with an alcohol based hand rub .... a. Before and after direct contact with residents ... d. Before preparing or handling medications ... j. After removing gloves" ... Licensed Practical Nurse (LPN) #3 was in attendance for the in-service.	M1570	Quality Assurance and Performance Improvement Committee monthly, starting on 03/19/2024 for 3 months and as needed.	