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	255142	A. BUILDING _____ B. WING _____	04/18/2024

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OCEAN SPRINGS HEALTH & REHABILITATION CENTER	1199 OCEAN SPRINGS ROAD OCEAN SPRINGS, MS 39564

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey along with five (5) Compliant Investigations (CI MS #22889, CI MS #24211, CI MS #24345, CI MS #24347, and CI MS #24717), at the facility from 4/15/24 through 4/18/24. The SA investigated CI MS #24717 related to abuse, resident's rights, and quality of care, CI MS #24347 related to resident's rights and CI MS #22889 related to resident records and there were no deficiencies cited related to those complaints. CI MS #24211 was a Facility Reported Incident (FRI) related to abuse and there were no deficiencies cited related to the FRI. The SA investigated CI MS #24345 related to pressure sores and cited F656 and F686. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of the participation in Medicare and Medicaid and cited F550, F656, F689, F690, F851, F865, and F880. The facility had a census of 104 and had 115 certified beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 550		5/16/24

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

Electronically Signed | 05/09/2024

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F 550	Continued From page 1 her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right for a dignified dining experience when the staff did not provide incontinence care for a resident which resulted in odors in the resident's room, causing the meal to be unappetizing, for one (1) of 22 sampled residents. Resident #38	F 550	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the State of Deficiencies. This Plan of Correction is prepared solely because of the provisions of State and Federal Laws. 1) On 04/15/2024, Resident #38 was	

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F 550	Continued From page 2 Findings include: A review of the facility's policy "Resident's Rights and Responsibilities", effective 01/07 revealed " ...Each nursing facility resident has a right to a dignified existence ...A facility must protect and promote the rights of each resident ..." On 4/15/24 at 12:17 PM, during an observation in the hallway, Resident #38's call light was lit up above the door. Certified Nurse Aide (CNA) #2 walked into the resident's room, explained to the resident that it would be a minute because she was passing out meal trays, and she exited the room. There were no meal trays being served on the hall at that time. On 4/15/24 at 1:10 PM, during an interview and observation, Resident #38 was lying in bed. There was a strong odor in the room. Resident #38 explained her brief was soiled before lunch and she had asked the staff to change her. She stated the staff told her that she had to wait because the lunch trays were being passed out. She said she had to eat her lunch while wearing a soiled brief and she was uncomfortable with the odor. On 4/15/24 at 1:35 PM, in an interview and observation of Resident #38, CNA #10 and CNA #1 came into the resident's room to check on her. The resident reported to both to the CNAs that she had been sitting in a soiled brief for over an hour and had to eat lunch while she was dirty. Both reported they were not aware that the resident needed assistance before lunch trays were served. Resident #38 expressed to both CNAs that she wanted to be changed. During the incontinence care, there was a dark brown ring	F 550	assessed for adverse signs and symptoms resulting form failure to receive incontinent care during dining experience by Director of Nursing, no adverse findings noted. On 04/22/2024 Certified Nursing Assistant (CNA) #1, #2 and #10 were inserviced on residents rights and perineal care, by Director of Nurses. On 04/18/2024 CNA #1 and #10 provided perineal care to Resident #38. 2) Current Residents that receive incontinent care have the potential to be affected by this alleged deficient practice. 3) All Nursing Staff inserviced on 04/22/2024 in regards to residents rights and perineal care during meal times by the Director of Nurses. 4) Unit Managers will observe perineal care for five (5) residents that require incontinent care weekly x 4 weeks, then monthly x 3 months to ensure resident receives timely incontinent care, beginning 04/15/2024. Audits will be given to the Director of Nursing. The Director of Nursing will bring audits to the Quality Assurance Performance Improvement Committee Meeting on 05/16/2024, and continue monthly for three (3) months to determine the effectiveness and make necessary changes.	

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F 550	Continued From page 3 on the incontinence pad and the resident's brief was heavily soiled. On 4/15/24 at 2:35 PM, during an interview with CNA #2, she explained that she did not tell anyone that Resident #38 had requested and needed to have her brief changed because she had forgotten. On 04/16/24 at 4:00 PM, during an interview with the Director of Nursing (DON), she explained that any staff member, including a CNA or a nurse, could assist with changing a resident and expressed that it was not acceptable for a resident to have to wear a soiled brief while eating lunch or any other time for a long period of time. She explained she expected the staff to assist the residents when they request it and to provide care every two (2) hours and as needed. On 04/18/24 at 3:30 PM, during an interview with the Administrator, he explained he expected all staff to do their job and to treat residents with dignity and respect. He would expect staff to never allow a resident to stay in a soiled brief during lunch. A record review of the "Admission Record" revealed the facility admitted Resident #38 on 1/12/21 with current diagnoses including Spinal Stenosis. A record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/13/24, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact.	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		5/16/24

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F 656	Continued From page 4 CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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F 656	Continued From page 5 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review, the facility failed to develop care plan interventions for a resident with a Urinary Tract Infection (UTI) (Resident #55) and for a resident with Substance Use Disorder (SUD) (Resident #57), and failed to implement a care plan intervention related to a low air loss mattress (Resident #261) for three (3) of 22 resident care plans reviewed. Findings include: A record review of the facility's policy "Plans of Care" with revision date 09/25/17 revealed " ... An individual person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative (s) to the extent practicable and updated in accordance with state and federal requirements ..." Resident #55 On 4/15/24 at 10:55 AM, during an interview, Resident #55 explained he had a UTI and was taking medication for the UTI. Record review of the "Admission Record" revealed the facility admitted Resident #55 on	F 656	1) Care Plan for Resident #55 was updated by Minimum Data Set (MDS) nurse, on 04/17/2024. Resident #261 discharged from the facility on 02/07/2024. Care Plan for Resident #57 was updated by MDS Nurse, to include substance abuse disorder and interventions on 05/07/2024. 2) All Residents with Urinary Tract Infections (UTI), history of substance abuse and that require a low air mattress have the potential to be affected by this alleged deficient practice. 3) MDS Nurse inservced on 04/22/2024 regarding completing and updating care plans accurately by Director of Nurses. MDS Nurse reviewed residents with UTI, history of substance abuse and use of a low air loss mattress to audit resident care plan for accuracy beginning on 04/22/2024 and continuing to 05/07/2024. Director of Nurses will audit daily orders to ensure care plan updates, beginning 04/22/2024 to 05/07/2024 4) The Director of Nurses will bring the audits to the Quality Assurance	

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F 656	Continued From page 6 9/1/22 and had current diagnoses including Hemiplegia and Hemiparesis following Unspecified Cerebrovascular Disease. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/29/24 revealed Resident #55 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Section GG revealed he required total dependence for toileting hygiene and Section H revealed he was always incontinent of bowel and bladder Record review of the "Order Summary Report" with active orders as of 04/16/24, revealed Resident #55 had a Physician's Order, dated 4/12/24, for Bactrim DS (an oral antibiotic) for UTI until 4/26/24. Further review revealed a Physician's Order, dated 4/4/24, for Macrobid (an oral antibiotic) for acute cystitis (bladder infection) with hematuria (blood in the urine). Record review of Resident #55's Comprehensive Care Plan revealed there was no care plan with interventions developed related to the diagnosis of UTI. At 03:00 PM on 4/17/24, during an interview and review of the comprehensive care plan, the Director of Nursing (DON) confirmed Resident #55 did not have a care plan in place for UTI and that care plans should be updated when new physician orders are received. The care plan should remain in place until the issue is resolved. She stated she expected care plans to be developed to ensure residents are receiving proper care.	F 656	Performance Improvement Committee on 05/16/2024. On 04/22/2024, the audits will continue daily times two (2) weeks, then three (3) times a week for two weeks and then weekly for three (3) months. Audits will be brought to the Quality Assurance Performance Improvement Committee monthly for 3 months beginning 05/16/2024, and necessary as indicated.	

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F 656	Continued From page 7	F 656		

On 04/17/24 at 3:45 PM, during an interview with Licensed Practical Nurse (LPN) #1, she stated she was responsible for resident care plans. She confirmed there was no care plan developed for Resident #55 related to his UTI and she confirmed he was currently taking antibiotic medication related to UTI. She explained the purpose of the care plan was for staff to know how to take care of the residents and she expected the staff to follow all resident care plans.

Resident #57

On 4/16/24 at 9:00 AM, an interview with Resident #57's family member revealed Resident #57 had a history of alcohol abuse since he had an accident which caused him to become paralyzed from the waist down. The family member commented that the resident has been drinking more lately and felt as if he needed some help with substance abuse. The family member stated the facility had not recommended any programs or behavioral health services related to SUD.

During an interview on 4/16/24 at 10:00 AM, with License Practical Nurse (LPN) #2 states, she explained that she was the care plan nurse. She confirmed Resident #57 had an alcohol abuse problem and the facility had not developed a care plan or had thought about putting interventions into place to assist the resident with SUD.

A record review of the "Admission Record" revealed the facility admitted Resident #57 on 8/2/23 with current diagnoses including Quadriplegia and Unspecified Injury at C1 Level of Cervical Spinal Cord.

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F 656	Continued From page 8	F 656		

A record review of the Annual MDS with an ARD of 3/20/24 revealed Resident #57 had a BIMS score of 15, which indicated he was cognitively Intact.

A review of the medical record for Resident #57 revealed there was no comprehensive care plan developed with interventions related to Substance Use Disorder (SUD).

Resident #261

Record review of the comprehensive care plan for Resident #261 with an initiation date of 12/08/23, revealed a Focus (Proper Name) has self-care deficits r/t (related to) needs assistance ...Intervention/Tasks ...THERAPEUTIC MATTRASS (mattress) ..."

On 4/16/24 at 1:00 PM, in an interview with a family member of Resident #261, she explained she attended a care plan meeting with the facility and the Medical Doctor (MD) apologized to her during the meeting because the Resident #261 was moved from the skilled unit to the long term care (LTC) unit in January of 2024 and the facility did not move his air mattress to the new bed.

On 4/17/24 at 10:00 AM, in an interview with the Director of Nursing (DON), she confirmed that when Resident #261 moved from the skilled unit to the LTC unit, the low air loss mattress that was ordered for him was not moved to his new bed.

Record review of the "Admission Record" revealed the facility admitted Resident #261 on 9/26/23 with current diagnosis including Injury of Cervical Spinal Cord.

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F 656	Continued From page 9 Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/2/2024 revealed Resident #261 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated he was cognitively intact.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to ensure a resident's safety by not assessing for the risk of substance use and not developing interventions for a resident with known substance use disorder (SUD) for one (1) of 22 sampled residents. (Resident # 57) Findings include: During an interview on 4/15/24 at 1:00 PM, Resident #57 stated that he frequently signed himself out of the facility to visit a friend that lived down the street. He confirmed he used his electric wheelchair to travel beside the road to his friend's home. He commented that the facility was trying to discharge him from the facility because he enjoyed visiting his friends outside of the facility. The resident confirmed he would drink a couple of beers while visiting his friends	F 689	1) On 05/07/2024, Resident #57 was offered to attend Alcoholics Anonymous (AA) by RN Supervisor. 2) Current Residents with substance abuse disorders have the potential to be affected by this alleged deficient practice. 3) 6 other Residents were identified that had alcohol dependent and other psychoactive substance abuse on 04/22/2024. The monitoring will make sure that they do not want to participate in Alcoholics Anonymous. All Nurses were inserviced on "How to recognize Residents that suffer from substance abuse", on 04/22/2024. 4) On 04/22/2024, the Director of Nurses	5/16/24

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F 689	Continued From page 10 sometimes but denied bringing alcohol or tobacco back into the facility. During an interview on 4/16/24 at 9:00 AM, Resident #57's family member revealed Resident #57 had a history of alcohol abuse since he had an accident which caused him to become paralyzed from the waist down. The family member commented that the resident has been drinking more lately and felt as if he needed some help with substance abuse. The family member stated the facility had not recommended any programs or behavioral health services related to SUD. On 4/16/24 at 10:00 AM, during an interview with License Practical Nurse (LPN) #2 states, she explained that she was the care plan nurse. She confirmed Resident #57 had an alcohol abuse problem and the facility had not developed a care plan or had thought about putting interventions into place to assist the resident with SUD. During an interview on 4/16/24 at 11:00 AM with the Director of Nursing (DON), she stated Resident #57 enjoyed leaving the facility two or three times a week on his electric scooter. The DON confirmed that he signed himself out and traveled along the side of the highway and visited his friends. During these visits, he would drink alcohol and returned to the facility impaired. The DON explained that because the resident was cognitively intact, he could make his own decisions. The DON stated Resident #57 brought alcohol and tobacco products back into the facility when he returned and would give tobacco products to the other residents. The DON confirmed the facility has not assessed or developed interventions related to the resident's	F 689	will begin to audit Residents identified with Alcohol and Substance Abuse daily for two (2) weeks, then three (3) times a week for two (2) weeks, then weekly for three (3) months. These Audits will ensure they do not want to participate in Alcoholics Anonymous. Results of the Audits will be presented to the Quality Assurance Performance Improvement Committee by the Director of Nurses monthly for three months starting 05/16/2024 to determine effectiveness and make necessary changes as indicated.	

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F 689	Continued From page 11 alcohol abuse. The DON also stated the resident has been seen by behavioral health services previously, but those visits were not related to substance use disorder. In an interview on 4/17/24 at 2:00 PM with the Medical Director (MD), he confirmed Resident #57 should be referred to a program because he needed help dealing with alcohol abuse. The MD stated the facility did not have interventions in place to assist the resident with his behavior. A record review of the "Admission Record" revealed the facility admitted Resident #57 on 8/2/23 with current diagnoses including Quadriplegia and Unspecified Injury at C1 Level of Cervical Spinal Cord. A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/20/24 revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively Intact.	F 689		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		5/16/24

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F 690	Continued From page 12 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to provide incontinence care in a timely manner for six (6) of 22 sampled residents and resulted in Resident #57 having skin excoriations and Resident #55 free from wearing two (2) incontinence briefs with a current diagnosis of Urinary Tract Infection (UTI). (Residents #57, #55, #1, #8, #14, and #38) Findings include: Resident #57 On 4/15/24 at 10:00 AM, during an observation,	F 690	1) On 04/15/2024, Resident #1, 8, 38 and 55 were provided incontinent care by Certified Nursing Assistants (CNA)# 3, 4 and 5. The Brief was removed and incontinent care was provided to Resident #57 by CNA# 7, 12 and 13 on 04/16/2024. 2) Residents that require assistance with bowel and bladder care have the potential to be affected by this alleged deficient practice. 3) The Director of Nurses inserviced all Nurses and CNAs on bowel and bladder and perineal care on 04/18/2024.	

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F 690	Continued From page 13 staff were transferring Resident #57 from the bed to an electric wheelchair using a mechanical lift. On 4/15/24 at 4:00 PM, during an observation and interview, Resident #57 was in his electric wheelchair and stated that he had been up in his chair since 10:00 AM and the staff had not changed his brief since then. He explained that he usually wears two (2) incontinence briefs during the day to hold his urine because it takes several staff members to transfer him with the lift and to change him. On 4/15/24 at 4:15 PM, during an observation of incontinence care for Resident #57, Certified Nurse Assistants (CNAs) #3, # 4 and #5 assisted the resident to bed. The CNAs removed two (2) briefs that were saturated with urine and soiled with bowel movement (BM). The resident's perineal area and lower buttocks were red and excoriated. During an interview on 4/15/24 at 4:30 PM, with CNA # 3, CNA #4 and CNA # 5, they explained Resident #57 requested two (2) briefs on dayshift staff did not want to change him and get him back up. The CNAs said they normally assist the resident to bed around 9:00 PM, provide incontinence care, and use a barrier cream on his perineal area and buttocks. An observation on 4/16/24 at 1:00 AM of incontinence care with CNA #7, CNA #12, and CNA #13, revealed Resident #57's brief was saturated with urine. He had redness and excoriations to the perineal area and his lower buttocks had excoriated areas that were bleeding. During an interview on 4/16/24 at 1:30 AM with	F 690	4) The Director of Nurses began monitoring bowel and bladder care on 04/18/2024. Findings of the monitoring will be brought to the Quality Assurance Performance Improvement Committee on 05/16/2024. Director of Nurses will monitor bowel and bladder care for four (4) residents weekly for three (3) weeks, then monthly for three (3) months. Findings will be brought to the Quality Assurance Performance Improvement Committee beginning on 05/16/2024, then monthly for the next three months to determine effectiveness and make necessary changes as indicated.	

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CNA #7, CNA # 12 and CNA #13 confirmed Resident #57 had excoriated areas and that the nurses had advised them to use a barrier cream.

On 4/17/24 at 9:00 AM, during an interview with the Medical Director, he confirmed he had been made aware of the excoriations to Resident #57's perineal and buttock areas. The staff were in the process of transferring him to his wheelchair when he went to the resident's room to observe the areas and he was only able to see the redness and excoriations to the perineal area. He asked the wound care nurse to follow up with the excoriated areas.

During an interview on 4/18/24 at 10:33 AM with the Director of Nursing (DON), she stated she was unaware Resident #57 had excoriated areas.

A record review of the "Admission Record" revealed the facility admitted Resident #57 on 8/2/23 and he had current diagnoses including Quadriplegia.

A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/20/24 revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Review of section GG revealed Resident #57 required substantial/maximal assistance with toileting hygiene.

Resident #55

On 04/16/24 at 1:10 AM, during an observation and interview, Resident #55 was wearing two incontinence briefs. Licensed Practical Nurse (LPN) #2 confirmed he was wearing two briefs.

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Resident #55 reported sometimes the CNAs will put four (4) or five (5) briefs on him so they will not have to change him during the night. LPN #2 explained residents should not wear two briefs unless there is a specific care plan intervention to do so. She explained that wearing two briefs could cause skin breakdown and moisture associated skin damage. The CNAs should round every two hours to check on the residents, but she did not check behind them to be sure they were completing their rounds.

At 1:45 AM on 04/16/24, during an interview with CNA #8, she explained she had not checked on Resident #55 this shift and the 3-11 must have applied two briefs to the resident. She reported she usually started her rounds at 12 AM but had not checked Resident #55 yet.

On 04/17/24 at 11:30 AM, during an interview with Registered Nurse #2/Infection Preventionist Nurse, she explained that being left in a soiled brief for long periods of time increased the risk for UTIs and skin breakdown.

Record review of the "Admission Record" revealed the facility admitted Resident #55 on 9/1/22 and had current diagnoses including Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease.

Record review of the Quarterly MDS with an ARD of 03/29/24 revealed Resident #55 had a BIMS score of 15, which indicated he was cognitively intact. Section GG revealed he required total dependence for toileting hygiene and Section H revealed he was always incontinent of bowel and bladder.

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Record review of the "Order Summary Report" with active orders as of 04/16/24, revealed Resident #55 had a Physician's Order, dated 4/12/24, for Bactrim DS (an oral antibiotic) for UTI until 4/26/24. Further review revealed a Physician's Order, dated 4/4/24, for Macrobid (an oral antibiotic) for acute cystitis (bladder infection) with hematuria (blood in the urine).

Resident #1

On 04/15/24 at 12:17 PM, during an observation and interview, Resident #1's call light was lit up and sounding. CNA #2 went into the resident's room, explained that it would be a minute because the staff were passing meals trays, and turned the light off. There were two (2) nurses sitting at the nurse's station and there were no meal trays observed on the hall. CNA #2 explained it was the policy of the facility not to change residents while meal trays were being passed out on the floor.

At 12:30 PM on 04/15/24, during an observation and interview, Resident #1 was eating lunch and he stated that he needed to be changed.

At 1:15 PM on 04/15/24, during an observation and interview, Resident #1 was sitting in his wheelchair in his room and reported that he had not been changed.

On 04/15/24 at 01:25 PM, during an observation and interview, Resident #1 left his room and went down the hallway. CNA #10 explained no one had told her that Resident #1 requested to be changed.

A record review of the "Admission Record"

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revealed the facility admitted Resident #1 on 12/01/2014 and he had current medical diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction.

A record review of the Annual MDS with an ARD of 01/16/24 revealed Resident #1 had a BIMS score of 15, which indicated he was cognitively intact. Section GG revealed he required maximal assistance for toileting hygiene and Section H revealed he was frequently incontinent of bowel and bladder.

Resident #8

On 04/16/24 at 1:15 AM, during an observation and interview, Resident #8 was wearing two (2) incontinence briefs that were wet with urine. LPN #2 explained there should be no residents wearing two briefs at any time unless the resident has been care planned to have them. LPN #2 stated that residents wearing two incontinence briefs could cause skin breakdown or infection.

On 04/16/24 at 1:45 AM, during an interview with CNA #8, she explained she had not checked on Resident #1 since the beginning of her shift at 11 PM and the double briefs must have come from the 3-11 shift. She stated she usually started her rounds at 12 AM, but she must have forgotten to check on Resident #1.

Record review of the "Admission Record" revealed the facility admitted Resident #8 on 1/15/20 and had current diagnoses including Acute on Chronic Systolic (Congestive) Heart Failure.

Record review of the Quarterly MDS with an ARD

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of 3/6/24 revealed Resident #8 had a BIMS score of 00, which indicated his cognition was severely impaired. Section GG revealed he required maximal assistance with toileting hygiene and Section H revealed he was always incontinent of bowel and bladder.

Resident #14

On 04/16/24 at 1:05 AM, during an observation and interview, Resident #14's brief was torn off and there was BM noted on the resident. The incontinence pad underneath the resident had a brown ring. CNA #8 reported it was not unusual for the resident to tear off the brief and explained that she completed rounds on the residents at 12 AM, 2AM, 4 AM, and 6 AM. CNA #8 stated that she did not think she had checked Resident #14's brief earlier because the resident was asleep. She confirmed there was a brown ring noted to the incontinence pad and that Resident #14 had not been changed for a long period of time.

On 04/16/24 at 1:23 AM, during an interview with LPN #2, she explained that when there was a brown ring on a resident's incontinent pad, then the resident had not been changed for a long period of time. She said the CNAs should complete rounds on the residents every two (2) hours, but she did not check behind the CNAs.

A record review of the "Admission Record" revealed the facility admitted Resident #14 on 9/3/13 with current medical diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction.

A record review of the Quarterly MDS with an ARD of 3/18/24 revealed Resident #14 had a

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BIMS score of 00, which indicated her cognition was severely impaired. Section GG revealed she required maximal assistance for toileting hygiene and Section H revealed she was always incontinent of bowel and bladder.

Resident #38

During an observation on 4/15/24 at 12:17 PM, Resident #38's call light was on and Certified Nurse Aide (CNA) #2 walked into the resident's room, explained to the resident that it would be a minute because she was passing out meal trays, and exited the room. There were no meal trays being served on the hall.

During an observation and interview on 4/15/24 at 1:10 PM, Resident #38 was lying in bed and there was a strong odor in the room. Resident #38 explained her brief was soiled before lunch and she had asked the staff to change her. She stated the staff told her that she had to wait because the lunch trays were being passed out.

During an observation and interview on 4/15/24 at 1:35 PM, Resident #38 reported to CNA #10 and CNA #1 that she had been sitting in a soiled brief for over an hour. Both reported they were not aware she needed assistance before lunch trays were served. During incontinence care, there was a dark brown ring on the incontinence pad and the resident's brief was heavily soiled.

During an interview on 4/15/24 at 2:35 PM, CNA #2 explained she did not tell anyone that Resident #38 had requested to have her brief changed because she had forgotten.

On 04/16/24 at 1:20 AM, during an interview and

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F 690	Continued From page 20 observation, Resident #38 reported that she had not been changed all night. LPN #2 confirmed Resident #38's brief was wet and soiled. A record review of the "Admission Record" revealed the facility admitted Resident #38 on 1/12/21 with current diagnoses including Spinal Stenosis. A record review of the Quarterly MDS with an ARD of 3/13/24, revealed Resident #38 had a BIMS score of 14, which indicated she was cognitively intact. During an interview with the Director of Nursing (DON), on 04/16/24 at 4:00 PM, she explained she was unaware that staff were applying two incontinence briefs on the residents. She reported that no residents should wear two briefs and she expected the staff to follow the standards of care for all residents. She explained there were enough staff on the units to assist with resident care if the CNAs were busy. She expected staff to keep residents from having to wait for long periods of time to receive assistance with incontinence care.	F 690		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by	F 851		5/16/24

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F 851	Continued From page 21 CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.	F 851		

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F 851	Continued From page 22 §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately submit direct care staffing information based on payroll data to the Centers for Medicare and Medicaid (CMS) as required for Quarter 1 of Fiscal Year (FY) 2023 (October - December 2023) for one (1) of five (5) quarters reviewed. Findings include: Record review of facility's policy "Staffing Requirements", effective 11/30/2014, revealed, " ...Purpose ...To provide a sufficient number of employees ..." A review of the Payroll Based Journal (PBJ) Staffing Data report from the Certification and Survey Provider Enhanced Reports (CASPER) database for FY Quarter 1 (October 1-December 31) revealed the "Metric" of "Excessively Low Weekend Staffing" was triggered related to " ...Submitted Weekend Staffing is excessively low." Record review of the facility PBJ Data entry report for October, November, and December of 2023 revealed PBJ Salaried Employee Hour	F 851	1) The Payroll Base Journal (PBJ) was reviewed for accuracy for reporting period October, November and December 2023. 2) All Residents had the potential to be affected by this alleged deficient practice. 3) The Administrator will be responsible for auditing the Payroll Base Journel for accuracy before the corporate office is allowed to submit. The Administrator will monitor any notices from Centers of Medicare and Medicaid Services to ensure no errors with submission. The audits will begin on 05/14/2024 and will be an ongoing process. 4) This will be audited before every submission starting on 04/18/2024. The Administrator will bring the audits of the Payroll Base Journal to the Quality Assurance Performance Improvement Committee on 05/16/2024. The Administrator will bring the audits quarterly after 05/16/2024 until the Quality Assurance Performance Committee until the facility is in compliant for 2 quarters.	

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Adjustments occurred for the Minimum Data Set (MDS) Staff RN and the adjustments did not occur on weekends or for any other facility salaried employees.

On 4/16/24 at 2:48 PM, the Human Resource Coordinator explained the corporate office was responsible for submitting PBJ staffing data for all the facilities in the corporation and she was unaware the PBJ staffing information was inaccurate until she had reviewed the audit spreadsheet provided by the corporate office. She stated the PBJ submitted as per the audit spreadsheet did not reflect the salaried employees who had worked hourly on the weekends. She confirmed the data submitted in the first quarter of FY 2024 was not accurate because the facility utilized salary staff on weekends for coverage and this inaccuracy in reporting led to excessively low weekend staffing being triggered. She confirmed that she would not have known this information since she received no feedback of the reported information.

During an interview on 4/16/24 at 2:48 PM, with Licensed Practical Nurse (LPN) #4, she stated that she was unaware the facility failed to electronically submit PBJ staffing data to CMS accurately in the first quarter of FY 2024. She confirmed that she was responsible for making the staffing schedules and during October, November, and December of 2023, salaried staff had helped to cover the schedule.

The Administrator stated in an interview on 04/18/24 at 1:51 PM, that he was not aware that the facility failed to electronically submit PBJ staffing data to CMS accurately in the first quarter of FY 2024. The Administrator stated that the

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F 851	Continued From page 24 corporate office was responsible for submitting the PBJ staffing data for all the facilities in the corporation. He confirmed that he was knowledgeable of the importance of accurately reporting PBJ information to CMS and that it was ultimately the responsibility of the facility to ensure accuracy.	F 851		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon	F 865		5/16/24

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request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is

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F 865	Continued From page 26 defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to ensure the program	F 865	1) The Administrator educated the interdisciplinary team on the Quality Assurance Performance Improvement Committee Process to include identifying,	

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F 865	Continued From page 27 was sustained during transitions in leadership and failed to maintain implemented procedures and monitor the interventions the committee put into place in April 2022. This was for two (2) recited deficiencies originally cited in April 2022 on an annual recertification survey. The deficiencies were in the area of residents' rights and wounds. The facility's continued failure during two surveys shows a pattern of the facility's inability to sustain an effective QAPI Committee for two (2) of eight (8) deficient practice citations. Findings Include: A record review of the facility's policy, "Quality Assurance Performance Improvement Program (QAPI)", with a revision date of 10/24/2022, revealed, "Policy: The Center and organization has a comprehensive, data-driven Quality Assurance Performance Improvement Program that focuses on indicators of the outcomes of care and quality of life ...Program Design and Scope ...Systematic Analysis and Action: The center will ensure systems and actions are in place to improve performance. 11. The Center will establish and utilize a systematic approach to identify underlying causes of problems ...12. The center will develop corrective actions based on the information gathered and review effectiveness of the actions ..." F550: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right for a dignified dining experience when the staff did not provide incontinence care for a resident which resulted in odors in the resident's room, causing the meal to be unappetizing, for one (1) of 22 sampled	F 865	correcting and monitoring of identified deficiencies to ensure compliance and quality are maintained. The education will be completed on 05/13/2024 2) All Residents have the potential of being affected by this alleged deficient practice. 3) The Administrator inserviced all key staff on Quality Assurance Program beginning on 05/09/2024 and ending on 05/13/2024. Regional Clinical Director inserviced Administrator on 05/13/2024 4) The Administrator will monitor 3 Residents for skin integrity on 04/18/2023 once a week for 3 weeks, and then monthly for 3 months to ensure skin integrity and Resident's Rights are met timely. On 04/18/2024, rounds will begin by Administrator and/or Director of Nurses before, during and after meals to ensure Resident's Rights are being respected. The Resident's Rights Audits will be once a week for 3 weeks, and then monthly for 3 months. The Administrator will monitor the Quality Assurance Performance Improvement meetings monthly for 4 months starting on 05/16/2024. The Administrator is responsible for implementing this plan and will report on the results of the quality monitoring to the Quality Assurance Performance Improvement Committee monthly. Findings will be brought to the Quality Assurance Performance Improvement Committee beginning on 05/16/2024 then monthly for three (3) months to determine	

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F 865	Continued From page 28 residents. Resident #38 F686: Based on interviews, record review, and facility policy review, the facility failed to ensure a Pressure Ulcer (PU) intervention related to an air mattress was continued after a room change for one (1) of three (3) residents reviewed for PUs. Resident #261 A record review of the Statement of Deficiencies and Plan of Correction (Form 2567) from the previous annual survey in April 2022, revealed F550 was cited due to not covering a resident during incontinence/catheter care and F686 was cited regarding failure to provide wound care within professional standards. On 04/18/24 at 3:40 PM, an interview with the facility's Administrator, he stated he was not working for the company at the time of the recertification survey that occurred in April 2022. The Administrator confirmed he had reviewed the Form 2567 and was aware of the facility's previous citations.	F 865	effectiveness and make necessary changes as indicated.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		5/16/24

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and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

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F 880	Continued From page 30 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to prevent the possible spread of infection as evidenced by a nurse touching medications with her bare hand and Certified Nursing Assistants (CNAs) discarding soiled linens and briefs on the floor for three (3) of nine (9) medication and incontinence care observations. Findings include: Medication Administration Review of the facility's policy "Medication- Oral Administration Of", revised 8/15/2019, revealed, "Procedure ...Refrain from touching powders, capsules, or pills with hands ..." On 04/16/24 at 8:59 AM, during a medication administration observation, Registered Nurse (RN) #3 placed a resident's pill into her ungloved hand and placed it in a medication cup.	F 880	1) Registered Nurse (RN)# 3 was inserviced by the Director of Nurses on facility policy "Medication - Oral Administration". CNA# 8 was inserviced by the Director of Nurses on facility policy "Perineal Care" and "Infection Control" with an emphasis on discarding soiled linen and briefs in proper receptacle on 04/22/2024. Resident# 14's room was cleaned by Housekeeping Personnel on 04/16/2024. 2) All Residents have the potential to be affected by this alleged deficient practice. 3) The Director of Nurses inserviced all nurses on facility policy, "Medication - Oral Administration" regarding not physically touching pills during medication administration on 04/22/2024. The Director of Nurses inserviced all clinical staff on "perineal Care" regarding disposal of soiled linen and brief on 04/22/2024.	

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F 880	Continued From page 31 On 04/16/24 at 10:59 AM, during an interview with RN #3, she confirmed she had placed a resident's pill in her ungloved hand and then put it in a medication cup because it was easier that way. She said she knew that it was not right, and it was not the way she was trained to administer medications. She stated it was a break in infection control. On 04/17/24 at 9:45 AM during an interview with RN #2/Infection Preventionist, she revealed the facility policy on medication administration specifically speaks to not touching medications with your hands. Incontinence Care Review of the facility's policy "Perineal Care", revised 9/5/17 revealed " ... Procedure ... dispose of linen ..." On 4/16/24 at 1:05 AM, in an observation of incontinence care for Resident #14, CNA #8 removed a soiled brief, incontinence pad, and linens and placed them directly on the floor, without placing them in a bag. After CNA #8 completed the care, she went to retrieve a bag, and then placed all the soiled items from the floor into a bag and placed them in the dirty linen room. At 1:25 AM on 4/16/24, in an observation of incontinence care for Resident #38, CNA #8 was assisted by CNA #9. CNA #8 removed a soiled brief and discarded it directly onto the floor and not in a bag. After she completed the care, CNA #8 retrieved a bag and placed the dirty brief in a bag and placed it in the trash.	F 880	4) Registered Nurse/Unit Manager will monitor medication administration and infection control practices weekly two (2) times a week for three (3) weeks then monthly for two (2) months, beginning 04/22/2024. Register Nurses/Unit Manager will monitor bowel and bladder care to include proper disposal of soiled linen and briefs for 4 residents weekly for three (3) weeks then monthly for three (3) months, beginning 04/22/2024. All Findings will be brought to the Quality Assurance Committee Improvement Committee on 05/16/2024 and monthly for three (3) months to determine effectiveness and make necessary changes as indicated.	

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At 1:35 AM on 4/16/24, during an interview with Licensed Practical Nurse (LPN) #2, she explained that dirty or soiled linens and briefs should not be placed directly onto the floor and should be contained in a garbage bag to maintain proper infection control.

On 04/16/24 at 1:40 AM, during an interview with CNA #8, she confirmed she discarded dirty linens and briefs on the floor when providing care for Resident #14 and Resident #38. She explained she should have placed all the dirty linen in a bag while, but she got nervous and tried to hurry up and clean the residents.

On 04/16/24 at 4:00 PM, during an interview with the Director of Nursing (DON), she explained she was informed of the dirty linen being placed on the floor during care and the CNA received disciplinary action. She reported that CNA #8 had been trained and had competency skills check off related to incontinence care and infection control. The DON stated that she expected the staff to follow standard practices related to infection control.

On 04/17/24 at 11:30 AM, during an interview with Registered Nurse #2/Infection Preventionist Nurse, she explained that discarding soiled briefs and linens directly onto the floor was an infection control issue and even though the CNA and picked up the soiled items from the floor, the concerns were still present on the floor.