STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255247	A. BUILDING _____ B. WING _____	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN HEALTH AND REHABILITATION	103 CUNNINGHAM DRIVE RIPLEY, MS 38663

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and a complaint investigation (CI) MS #24539 at the facility from 4/23/24 through 4/25/24. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F584, F656, F677, F689, F695, F761, F867 and F880. The SA found the facility to be in compliance related to CI MS #24539 and no deficiencies were cited. The census at the time of survey was 42 and the facility was licensed for 60 beds.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		5/18/24

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

Electronically Signed | 05/17/2024

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F 584	Continued From page 1 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interviews the facility failed to provide a safe clean environment as evidenced by a wheelchair with a torn armrest, a dirty oxygen concentrator, an overbed table with tattered and torn edging and overbed tables with a thick black substance on the metal base for three (3) of 44 residents rooms observed. Resident #13, Resident #31, and Resident #39 Findings include: An interview with the Administrator on 4/25/24 at 9:23 AM, revealed the facility did not have a policy addressing repairing and cleaning equipment. Resident #13	F 584	F584 SS=D SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT CFR(s) 1 On 04/23/24, the overbed table for Resident #13 was removed immediately from the resident□s room. The wheelchair armrest for Resident #39 was removed and replaced with a new armrest immediately. The oxygen concentrator for Resident #31 was cleaned immediately by the License Practical Nurse(LPN). 2. On 04/24/2024, The Facility Administrator noted that all residents have the potential to be affected by this deficient practice of allegation of failure to provide a home-like environment. 3. A 100% audit of the facility was completed by the Facility Administrator	

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F 584	Continued From page 2 An observation and interview on 4/23/24 at 6:50 AM, revealed Resident #13 lying in bed with her overbed table pulled up to her. The overbed table edging was off around the table with exposed chipped wood. The metal base of the overbed table had a thick black substance. Resident #13 stated, "I need a new table. It's been like this for a long time." During an interview and observation on 4/24/24 at 9:00 AM, Licensed Practical Nurse (LPN) #3 confirmed Resident #13's overbed table needed to be replaced because the edging around the table was tattered and torn and revealed the torn edging could cause a skin tear. Resident #31 An observation on 4/23/24 at 7:25 AM and again at 3:45 PM, revealed Resident #31's oxygen concentrator sitting by her bed with a brown and gray substance down the front and on top of the oxygen concentrator. Resident #31's overbed table had a thick brown and black substance on the metal base. During an observation and interview on 4/24/24 at 9:05 AM, LPN #3 revealed the cleaning of the oxygen concentrators is the responsibility of the nursing department but stated, "really anyone who sees it can clean it." She confirmed that the oxygen concentrator was dirty and needed to be cleaned and that the metal base on the overbed table needed to be cleaned and revealed housekeeping usually does that. She revealed the metal base "looks like it has rust, but it does need cleaning."	F 584	and the Director of Nursing on 04/24/2024. It was noted that 3 out of 42 residents were affected by this deficient practice of overbed tables being in poor conditions. It was noted that 1 out of 38 residents were affected by this deficient practice of wheelchairs in poor condition. Lastly, it was noted that 1 out of 7 residents were affected by this deficient practice of oxygen concentrators being dirty. On 04/30/24, the facility replaced 45 overbed tables with 45 new overbed tables. On 4/29/24, the housekeeping supervisor was in-serviced by the Facility Administrator on routine cleaning found in the Focus Round Standard and the Housekeeping Standard. On 4/29/24, the housekeeping supervisor provided an in-service to 5 of 5 housekeeping staff on routine cleaning found in the Focus Round Standard and the Housekeeping Standard. On 05/03/2024, the Interdisciplinary Team, Clinical, and Ancillary staff were in-serviced by Nurse Educator (NE)on proper cleaning of resident equipment and how to report any damages to TEL□s. 4. The Medical Records Coordinator, Nurse Educator, Dietary Manager, Activity Director, and MDS Coordinator will conduct weekly focus rounds on bedside tables, wheelchairs, and oxygen concentrators beginning on 04/29/2024 for one month and then monthly for three months ending on 07/29/2024. The findings of the focus rounds will be reported to the Quality Assurance (QA) Committee beginning 5/16/2024 and then monthly for three	

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F 584	Continued From page 3 Resident #39 Observation on 4/23/24 at 8:05 AM, revealed Resident #39 sitting in the dining room in a wheelchair with the left side armrest vinyl tattered and torn with jagged edges exposed where the resident's arm rested on the armrest Observation on 4/23/24 at 9:44 AM, revealed Resident #39's overbed table had a thick black substance scattered on the metal base. An interview and observation on 4/24/24 at 9:25 AM, Certified Nurse Aide (CNA) #1 revealed it is the CNA's responsibility to report any wheelchairs that are in disrepair to the Maintenance Director. She confirmed Resident #39's left armrest on his wheelchair needed to be repaired and revealed she had not reported the wheelchair to anyone. She confirmed the metal base on his overbed table was dirty and needed to be cleaned. She revealed housekeeping is responsible for cleaning the rooms. An observation and interview on 4/24/24 at 9:30 AM the Housekeeping Supervisor revealed that the nursing department is usually responsible for cleaning the oxygen concentrators and the housekeeping department is responsible for cleaning the overbed tables. She confirmed that the overbed tables for Resident #13, Resident #31, and Resident #39 had a thick substance on the metal base and the edging on Resident #13's overbed tabletop was torn and needed to be replaced. She revealed we can try and clean the metal bases on the overbed tables, but I think it's thick rust or old paint peeling. She confirmed the overbed tables looked bad and she would see what she could do to clean them.	F 584	months. The Focus rounds will be reviewed by the Interdisciplinary Team and Quality Assurance(QA) Committee which consists of the Administrator, Director of Nursing, RN Supervisors, Dietary Manager, Nurse Educator, Medical Records Nurse, Social Service Director, Activity Director, and Medical Director to ensure compliance with the Facility Focus Round standard. The QA Committee will make necessary recommendations as needed.	

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F 584	Continued From page 4 An observation and interview on 4/24/24 at 10:09 AM, the Administrator confirmed the left armrest on Resident #39's wheelchair was torn and tattered and needed to be repaired. He confirmed the overbed tables for Resident #13, Resident #31 and Resident #39 were in disrepair and needed to be either be cleaned, resurfaced, or replaced. He confirmed the tables did not look good.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		5/18/24

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F 656	Continued From page 5 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to implement a comprehensive care plan for a resident with an elopement bracelet (Resident #1) and a resident requiring nail care (Resident #24) for two (2) of 15 sampled residents reviewed during survey. Findings Include: Review of the facility policy titled "Comprehensive Care Plan" with a revision date of 3/2019 revealed under, "Standard: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental	F 656	F656 SS=D Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) 1. On 04/24/2024, an order was entered for Resident #1 for a Wander guard for safety to include the monitoring and function on the Medication Administration Record (MAR)/Treatment administration Record (TAR). On 05/09/2024, the care plan for Resident #1 was updated to include the monitoring and functioning of the wander guard. On 04/23/24, the Registered Nurse provided nail care for Resident #24 nails. 2. On 05/09/2024, The Director of Nursing and Minimum Data Nurse(MDS) noted that all residents have the potential	

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F 656	Continued From page 6 and psychosocial needs that are identified in the resident's comprehensive assessment." Record review of Resident #1's "Care Plans", undated revealed "Focus: (Proper name of Resident #1) is an elopement risk/wanderer ...Interventions ...Wanderguard at all times for safety ..." The care plan did not include any interventions to monitor the residents wanderguard bracelet. An observation on 04/23/24 at 12:49 PM revealed Resident #1 was wearing a wander guard bracelet on his left wrist. Record review of Resident #1's "Elopement Evaluation" dated 3/11/24 revealed the resident has a history of elopement or attempted elopement and wanders. Record review revealed that there was not any monitoring of the wander guard each shift on the Treatment Administration Record (TAR) or Medication Administration Record (MAR). Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/11/24 revealed in Section P the resident was coded for a wander/elopement alarm that was used daily. During an interview on 4/23/24 at 1:30 PM, with Registered Nurse (RN) #1 revealed Resident #1 wears a wanderguard because he has dementia and gets confused sometimes. She stated he says he wants to go home and does wander, but he has never eloped. During an interview on 4/25/24 at 8:20 AM, with the Director of Nurses (DON) revealed that it was	F 656	to be affected by this allegation of the deficient practice of failure to update and follow care plans. 3. A 100% care plan audit was completed on 05/09/2024 of 42 of 42 care plans by the Director of Nursing and MDS coordinator. It was noted that 1 of 2 residents was affected by this deficient practice of missing information in the care plan. It was noted that 1 of 42 residents were affected by this deficient practice of failure to follow through with the care plan. On 05/03/2024, the Nurse Educator in-serviced 15 of 15 nursing staff and 17 of 17 CNA staff on the Wandering/Elopement Standard and the Activity of Daily Living(ADL) Care Standard. All new hires will be in serviced on the Wandering/Elopement Standard and the Activity of Daily Living(ADL) Care Standard before beginning patient assignments. 4. The Director of Nursing or Minimum Data Nurse to audit the wander guard documentation on the MAR/TAR weekly to ensure the monitoring and functioning of the wander guard for one month beginning on 04.29.2024, then monthly for 3 months ending on 7.29.2024. The findings of this audit will be brought before the Quality Assurance(QA) committee on 05.16.2024 and monthly following for three months. The findings will be reviewed by the Interdisciplinary Team and the QA committee which consists of which consists of the Administrator, Director of Nursing, RN Supervisors, Dietary Manager, Nurse Educator, Medical	

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F 656	Continued From page 7	F 656		

her expectation that Resident #1's care plan would be implemented correctly because the purpose of the care plan was for staff to know what care the resident needs. She stated that the resident had gone out to the hospital and had returned and she thinks that the monitoring of the wander guard "just got left off of his TAR."

An interview on 4/25/24 at 9:00 AM, with Registered Nurse #1 confirmed Resident #1's care plan was not followed because the wander guard was not being monitored.

Resident #24

Record review of Resident #24's care plan with an initiated date of 2/9/24 revealed "Focus The resident has an ADL (Activities of Daily Living) self care performance deficit r/t (related to Dementia ...Interventions ... Personal Hygiene/Oral Care: The Resident requires (1) staff participation with personal hygiene and oral care ..."

During an observation of Resident #24, on 4/23/2024 at 9:50 AM, revealed long thick discolored fingernails on the left hand that measured approximately three-eights (3/8) inch in length from the tip of the fingers. Also observed, the right fingernails measured approximately one-fourth (1/4) inch in length.

During an observation and interview on 4/23/2024 at 2:39 PM, with Registered Nurse (RN) #1, confirmed Resident #24's nails were long and needed cutting.

During an interview with the Director of Nursing (DON) on 4/25/2024 at 8:16 AM, revealed the

Records Nurse, Social Service Director, Activity Director, and Medical Director.

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F 656	Continued From page 8 purpose of the care plan was for the staff to know how to care for the resident. She revealed the personal hygiene care plan covered nail care and confirmed it was not done.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and facility policy review, the facility failed to perform nail care for a resident that needed assistance, as evidence by long thick fingernails for one (1) of two (2) residents reviewed for activities of daily living (ADLs). Resident #24 Findings Include: Review of the facility policy titled "Care of Fingernails/Toenails" with a revision date of 06/2022 revealed under, "Purpose: The purpose of this procedure is to clean the nail bed, to keep nails trimmed and to prevent infections. Nail care includes cleaning and trimming as needed. Proper nail care can aid in the prevention of skin problems around the nail bed. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his/her skin (unless medically contraindicated)". Resident #24 An observation and interview on 4/23/2024 at	F 677	F677 SS=D ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) 1. On 04.23.2024, Registered Nurse provided nail care for Resident #24 nails. 2. On 04/29/2024, The facility Administrator and Director of Nursing noted that 42 out of 42 residents who reside in the facility had the potential to be affected by this allegation of deficient practice of not providing nail care. 3. On 05.03.24, the Director of Nursing completed an audit of 42 of 42 residents. 16 out of 16 Diabetic residents had an order updated for a Licensed Nurse to complete nail care. 26 of 26 non-diabetic residents' nail care is to be provided by a Certified Nursing Assistant(CNA) in the shower and documented on Point Of Care(POC). On 05.03.2024, the Nurse Educator provided an in-service to 15 of 15 nurses and 17 of 17 CNAs on the Activity of Daily Living(ADL) Care Standard.	5/18/24

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F 677	Continued From page 9 9:50 AM, with Resident #24, revealed long thick discolored fingernails on the left hand that measured approximately three-eights (3/8) inch in length from the tip of the fingers. The nails on the right hand measured approximately one-fourth (1/4) inch in length. The resident expressed he "would like his nails cut." An observation and interview with Licensed Practical Nurse (LPN) #6 on 4/23/2024 at 2:20 PM, confirmed Resident #24's nails needed cutting. She revealed a Registered Nurse (RN) must cut his nails because he was a diabetic. An observation and interview with Registered Nurse (RN) #1 on 4/23/2024 at 2:39 PM, revealed she was responsible for trimming the diabetic nails. She confirmed Resident #24's nails were long, and he could scratch himself and cause skin concerns. An interview with the Director of Nursing (DON) on 4/24/2024 at 8:14 AM revealed the Registered Nurse (RN) on duty was responsible for doing nail care for the diabetics every Tuesday, and it should be documented on the Medication Administration Record (MAR). She confirmed Resident #24 did not have this task on his MAR. She confirmed that the long nails were an infection and a personal hygiene concern.	F 677	4. The Director of Nursing is to monitor Medication Administration Record(MAR)/ Treatment Administration Record(TAR) documentation and Point Of Care documentation weekly for 30 days beginning on 04.29.24 and monthly for three months ending on 07.29.24 to ensure completion of documentation. The Medical Records Coordinator, Nurse Educator, Dietary Manager, Activity Director, and Minimum Data Set(MDS) Coordinator to complete weekly rounds on Thursdays beginning 04.29.24 and then monthly for 3 months with completion on 07.29.24. The findings from these audits will be brought to our Quality Assurance Performance Improvement(QAPI) meeting on 05.16.2024 and then monthly for three months. The findings will be reviewed by the Interdisciplinary Team and the Quality Assurance(QA) committee which consists of which consists of the Administrator, Director of Nursing, RN Supervisors, Dietary Manager, Nurse Educator, Medical Records Nurse, Social Service Director, Activity Director, and Medical Director.	
F 689 SS=E	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	F 689		5/18/24

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F 689	Continued From page 10 §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 observation, staff interview, record review and facility policy review the facility failed to prevent the possibility of accidents and hazards for a resident who was an elopement risk by failing to monitor placement and function of a wander guard (Resident #1) and failure to secure smoking supplies for one (1) of three (3) days of survey. Findings Include Record review of the facility policy titled, "Wandering/Elopement Risk" with a revision date of 11/2017 revealed "STANDARD It is the standard of this facility to identify those residents at risk for wandering/elopement and to take the appropriate steps to minimize the risk of elopement ... The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering ..." of 10/2017 revealed "STANDARD This facility provides a safe and healthy environment for residents ...including safety as related to smoking. Safety protections apply to smoking and non-smoking residents ...Standard Explanation and Compliance Guidelines ...13. Smoking material will be maintained and secured by nursing staff ..." Resident #1 An observation on 04/23/24 at 12:49 PM,	F 689	F689 SS=E Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) 1. On 04/24/24, an order was entered for Resident #1 for a wander guard for safety to include the monitoring and function on the MAR/TAR. On 05/09/2024, the care plan for Resident #1 was updated to include the monitoring and functioning of the wander guard. On 04/29/2024, an automatic locking doorknob was placed on the door of the smoking closet. 2. On 04/29/2024, The Facility Administrator and Director of Nursing noted that 42 of 42 residents who reside in the facility had the potential to be affected by this allegation of deficient practice of failure to keep residents free of accident hazards/supervision/devices. 3. All staff were in-serviced on 5/3/2024 by the facility Nurse educator on the facility standard Wandering/Elopement Standard and the facility Smoking Standard. 47 of 47 staff received in-service on the Wandering/Elopement Standard and the facility Smoking Standard. All new hires will receive training upon hire in the orientation process. All new hires will be in serviced on the Wandering/Elopement Standard and the Activity of Daily Living (ADL) Care Standard before beginning patient assignments. All new hires will be	

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F 689	Continued From page 11 revealed Resident #1 was wearing a wander guard bracelet on his left wrist. Record review of Resident #1's "Elopement Evaluation" dated 3/11/24 revealed the resident has a history of elopement or attempted elopement and wanders. Record review of Resident #1's "Order Summary Report" with active orders as of 4/24/24 revealed there was not an order for a wander guard bracelet. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/11/24 revealed in Section P the resident was coded for a wander/elopement alarm that was used daily. An interview on 4/23/24 at 1:30 PM, with Registered Nurse (RN) #1 revealed that Resident #1 wears a wander guard because he has dementia and gets confused sometimes. She stated he says he wants to go home and does wander, but he has never eloped. An interview, observation, and record review on 4/24/24 at 4:30 PM, with Licensed Practical Nurse (LPN) #7 confirmed that Resident #1 had a wander guard bracelet on his left wrist. She stated he had worn it for a long time. She stated that anyone that has a wander guard bracelet should have an order and then it will show on either the Electronic Medication Administration Record (EMAR) or Electronic Treatment Administration Record (ETAR) to monitor it every shift. A record review of the resident's physician's orders with LPN #7 confirmed that Resident #1 did not have an order for a wander guard, and it	F 689	in serviced on the Wandering/Elopement Standard and the facility Smoking Standard before beginning assignments. 4. The Director of Nursing or Minimum Data Nurse to audit the wander guard documentation on the Medication Administration Record (MAR)/Treatment Administration Record (TAR) weekly to ensure the monitoring and functioning of the wander guard for one month beginning on 04.29.2024, then monthly for 3 months ending on 7.29.2024. Maintenance will ensure the smoking closet doorknob is functioning appropriately through audits beginning weekly on 04/29/2024 for thirty days and then monthly for three months. The findings from these audits will be brought to our QAPI meeting on 05.16.2024 and then monthly for three months. The findings will be reviewed by the Interdisciplinary Team and the Quality Assurance(QA) committee which consists of which consists of the Administrator, Director of Nursing, Register Nurse Supervisors, Dietary Manager, Nurse Educator, Medical Records Nurse, Social Service Director, Activity Director, and Medical Director. The Quality Assurance (QA) Committee will make necessary recommendations as needed.	

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F 689	Continued From page 12	F 689		

was not triggered on the residents EMAR or ETAR to check for functioning or placement of the wander guard bracelet each shift.

An interview and record review on 4/24/24 at 4:40 PM, with LPN #3 confirmed that Resident #1's "wander guard" bracelet had not been monitored each shift to make sure it was still on the resident and functioning.

An interview on 4/25/24 at 8:20 AM with the Director of Nurses (DON), revealed it was her expectation that Resident #1's physicians order would have been put in the resident's record and triggered for the staff to monitor the resident's wander guard placement and function. She stated the residents order for a wander guard dropped off in December 2023 after he returned from a hospital stay. She confirmed a residents wander guard needs to be monitored for placement and function to prevent an elopement.

Record review of Resident #1's "Admission Record" revealed the resident was admitted to the facility on 4/12/18 with medical diagnoses that included Schizoaffective Disorder, Bipolar Type.

Smoking:

An observation on 4/23/24 at 6:38 AM, revealed the smoking supply closet on the resident hall that held residents smoking supplies was unlocked. Observed a sign on the smoking supply closet door "Keep this door locked at all times".

An interview and observation on 4/23/24 at 6:45 AM, with Housekeeping Staff #2 confirmed the smoking supply closet was unlocked and stated "they are supposed to keep that door locked at all

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F 689	Continued From page 13 times." Housekeeping Staff #2 stated the key is kept behind the nurse's desk. An interview and observation on 4/23/24 at 6:50 AM, with Licensed Practical Nurse (LPN) #6 confirmed that the resident smoking supply closet was unlocked, held resident's smoking supplies including at least one lighter and that it was supposed to always be locked for safety. An interview on 4/23/24 at 6:55 AM, with Registered Nurse (RN) #1 confirmed that the residents smoking supply closet was supposed to be locked at all times and the key is kept behind the nurse's station. She revealed that the purpose of keeping the smoking supply closet locked was to prevent residents from having access to the smoking supplies and the lighter. She stated "there is at least one lighter in there. If the residents got a hold of the supplies they'd be smoking in the rooms and we have oxygen in the building, so it's a safety issue." Record review of the "List of Resident on Designated Smoking list" undated, revealed there were 9 active smokers listed. An interview with Administrator on 4/25/24 at 11:00 AM, confirmed that the smoking supplies should always be locked up to prevent the residents from having access to the smoking supplies including the lighter for safety issues and that was the facilities policy.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		5/18/24

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F 695	Continued From page 14 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide appropriate care and services for respiratory care, as evidenced by, failing to label and store an aerosol nebulizer mask device for one (1) of three (3) nebulizers in the facility. Resident #28 Findings Include: This citation is cross reference to: F867 Record review of the facility policy titled "Respiratory System Management" with a revision date of 1/2003 revealed "Procedure, In Order: ... 17. Rinse the nebulizer and mouthpiece. Shake to air dry and store in a plastic bag that is labeled with the resident's name and room number. Nebulizer and mouth piece may also be stored in the machine if storage shelf is available. 18. Change nebulizer set up-weekly." An observation and interview with Resident #28 on 4/23/2024 at 9:04 AM, revealed he was sitting on the edge of the bed. A nebulizer machine was sitting on a bedside table, with the nebulizer mask lying across the lower bed. The tubing and mask were undated, and the mask was unbagged. The	F 695	F695 SS=D Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) 1. On 04.23.24, a licensed practical nurse provided a plastic bag for storage and new tubing and mask to Resident #28. 2. On 04/29/2024, the Facility Administrator and Director of Nursing identified 8 of 42 residents with had the potential to be affected by this allegation of deficient practice of not providing a plastic bag for storage of nebulizer tubing and mask. 3. On 05.01.24, the Director of Nursing completed an audit of 8 of 8 residents with an order for nebulizer treatments. An order was entered for each resident to change tubing and plastic bag weekly on Sunday evening. An order was also added to the Medication Administration Record (MAR)/Treatement Administrator Record(TAR) every shift to ensure that tubing and mask are in a dated plastic bag for storage when not in use. On 05.03.24, the Nurse Educator provided an in-service on the infection control policy, specifically the respiratory management section, for 15 of 15 nurses and 17 of 17 Certified Nursing	

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F 695	Continued From page 15 resident revealed he used the nebulizer mask "every day" for his breathing and was not aware of a storage bag for the nebulizer mask. An observation of Resident #28's room on 4/23/2024 at 2:10 PM, revealed a nebulizer machine sitting on top of a bedside table with the nebulizer mask secured in an upright position on the side. The mask was not bagged, and the tubing had a piece of tape attached with a date of 4/23/2024. Record review of the "Order Summary Report" with active orders as of 4/24/24 revealed orders dated 3/21/24 for Arformoterol Tartrate Inhalation Nebulization Solution and Ipratropium Bromide Inhalation Solution for Chronic obstructive pulmonary disease. An observation and interview with Licensed Practical Nurse (LPN) #6 on 4/23/2024 at 2:25 PM, confirmed the nebulizer mask did not have a cover to protect it. She revealed the mask should be placed in a bag to prevent it from getting contaminated. She revealed she just changed out the nebulizer set-up and dated it. An interview with Registered Nurse (RN) #1 on 4/23/2024 at 2:42 PM, revealed the nebulizer mask should be stored in a plastic bag to prevent the formation of bacteria in the mask and the bag, mask and tubing should be changed out weekly and dated. An interview with the Director of Nursing (DON) on 4/24/2024 at 8:12 AM, revealed the nebulizer mask was to be placed in a bag when not in use to prevent infection. She revealed the bag, tubing, and mask were changed out weekly on the night	F 695	Assistant(CNA). 4. . The Medical Records Coordinator, Nurse Educator, Dietary Manager, Activity Director, and Minimum Data Set (MDS) Coordinator will conduct weekly focus rounds on nebulizer tubing and mask to ensure they are in dated plastic bags when not in use on 04/29/2024 for one month and then monthly for three months ending on 07/29/2024. The findings of the focus rounds will be reported to the Quality Assurance(QA) Committee beginning 5/16/2024 and then monthly for three months. The Focus rounds will be reviewed by the Interdisciplinary Team and Quality Assurance(QA) Committee which consists of the Administrator, Director of Nursing, RN Supervisors, Dietary Manager, Nurse Educator, Medical Records Nurse, Social Service Director, Activity Director, and Medical Director to ensure compliance with the Facility Focus Round standard. The Quality Assurance(QA) Committee will make necessary recommendations as needed.	

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F 695	Continued From page 16 shift and her expectation was for staff to do this and apply the date. Record review of the "Admission Record" revealed the facility admitted Resident #28 on 1/27/23 with medical diagnoses that included Chronic obstructive pulmonary disease and Schizophrenia.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		5/18/24

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F 761	Continued From page 17 Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure medications were stored appropriately and not left in the resident's room for one (1) of 15 sampled residents. Resident #31 Findings include: A review of the facility policy, titled "4.1 Storage of Medication" with a date of 01/23 revealed, " 4.1 STORAGE OF MEDICATION Policy: ...The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications ... Procedures ... 1. Medications are to remain in these containers and stored in a controlled environment. This may include such containers as medication carts, medication rooms, medication cabinets, or other suitable containers ...." An observation and interview on 4/23/24 at 7:00 AM, revealed a prescription-labeled box of Latanoprost Solution eye drops and a prescription-labeled box of Cosopt Ophthalmic solution with medications inside of boxes sitting on Resident #31's overbed table. Licensed Practical Nurse (LPN) #1 entered the room and asked the resident, "Why are these medications lying on your bedside table?" Resident #31 revealed someone left them there. LPN #1 confirmed the medications were supposed to be locked up in the medication cart because the residents are not supposed to have medications in their rooms and revealed, the eye drop medication was given last night and should have been locked back up in the medication cart.	F 761	F761 SS=D Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) 1. On 04.23.24, the eye drops, and ophthalmic solution were immediately removed from the bedside table of Resident #31. 2. On 04/29/2024, the Facility Administrator and Director of Nursing identified that 42 of 42 residents who reside in the facility had the potential of being affected by this allegation of deficient practice of leaving medications at the bedside. 3. On 05.03.24, the Nurse Educator completed an in-service to 15/15 nurses on the Medication Standard. 4. The Medical Records Coordinator, Nurse Educator, Dietary Manager, Activity Director, and MDS Coordinator will conduct weekly focus rounds to ensure no medications are left at the bedside of any resident on 04/29/2024 for one month and then monthly for three months ending on 07/29/2024. The findings of the focus rounds will be reported to the Quality Assurance(QA) Committee beginning 5/16/2024 and then monthly for three months. The Focus rounds will be reviewed by the Interdisciplinary Team and Quality Assurance(QA) Committee which consists of the Administrator, Director of Nursing, RN Supervisors, Dietary Manager, Nurse Educator, Medical Records Nurse, Social Service Director, Activity Director, and Medical Director to ensure compliance with the Facility Focus Round standard. The	

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F 761	Continued From page 18 An interview on 4/23/24 at 7:20 AM, Resident #31 revealed "the nurse left the eye drops in here last night." In an interview on 4/23/24 at 2:22 PM, the Director of Nurses (DON) confirmed she was made aware of the eye medication left on the overbed table and revealed that is a "no no". The DON stated, " the nurses know that is not supposed to happen, all medication is to be kept locked up in the medication cart." She revealed a wandering resident could enter a resident's room and take the medications. A record review of Resident #31's Admission Record revealed the resident was admitted to the facility on 6/26/21 with diagnoses that included Heart Failure and Chronic Kidney Disease, Stage 3. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/14/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #31 was cognitively intact.	F 761	Quality Assurance (QA) Committee will make necessary recommendations as needed.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective	F 867		5/18/24

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systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and

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implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).
Improvement projects must include at least

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F 867	Continued From page 21 annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor the interventions the committee put in place following the recertification survey of 2/2/2023. This was for a deficiency recited during a recertification and complaint survey on 4/23/2024 in the area of F695 Respiratory/Tracheostomy Care and Suctioning. The continued failure of the facility during two State Surveys of record shows a pattern of the facility to sustain an effective QAA program. This was for one (1) of eight (8) deficient practice citations. Findings Included:	F 867	F867 SS=E QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) 1. On 04.23.24, licensed practical nurse provided a plastic bag for storage and new tubing and mask to Resident #28. 2. On 04/29/2024, the Facility Administrator and Director of Nursing identified 8 of 42 residents have the potential to be affected by this allegation of deficient practice of not providing a plastic bag for storage of nebulizer tubing and mask. 3. On 05.01.24, the Director of	

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F 867	Continued From page 22 This citation is cross-referenced to: F695 Review of the facility policy titled "Quality Assurance and Performance Improvement" with a revision date of 8/2023 revealed "Standard: It is the standard of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. Focused Rounds: Focused Rounds are intended to discover areas of concern before they become a problem for the facility. Focused Rounds take the form of short checklist devoted to specific practices and concerns and are conducted on a regular basis..." An interview with the Administrator (ADM) on 4/25/2024 at 9:05 AM, revealed he was not aware that the nebulizer mask was not being stored appropriately and was a concern for the facility again. He revealed the interdisciplinary team (IDT) did discuss this in QAPI (Quality Assurance and Performance Improvement) after the facility was cited on this in February 2023. He revealed they implemented measures to ensure this did not happen again. The ADM explained that they made rounds to ensure all the nebulizers were stored in a bag, and they did in-services with the staff. He revealed the plan failed because they have a lot of new staff. He revealed the nurses should have been trained on hire that respiratory equipment was to be placed in a bag. The ADM revealed his expectation was for that information to be relayed to the new staff, but he stated, "it must have fallen through." Record review of the Facility's Plan of Correction (POC) dated 3/10/2023 revealed under, "3.	F 867	Nursing completed an audit of 8 of 8 residents with an order for nebulizer treatments. An order was entered for each resident to change tubing and plastic bag weekly on Sunday evening. An order was also added to the Medication Administration Record(MAR)/Treatment Administration Record(TAR) every shift to ensure that tubing and mask are in a dated plastic bag for storage when not in use. On 05.03.24, the Nurse Educator provided an in-service on the infection control policy, specifically the respiratory management section, for 15 of 15 nurses and 17 of 17 CNA□s. 4. The Medical Records Coordinator, Nurse Educator, Dietary Manager, Activity Director, and MDS Coordinator will conduct weekly focus rounds on nebulizer tubing and mask to ensure they are in dated plastic bags when not in use on 04/29/2024 for one month and then monthly for three months ending on 07/29/2024. The findings of the focus rounds will be reported to the Quality Assurance(QA) Committee beginning 5/16/2024 and then monthly for three months. The Focus rounds will be reviewed by the Interdisciplinary Team and Quality Assurance(QA) Committee which consists of the Administrator, Director of Nursing, RN Supervisors, Dietary Manager, Nurse Educator, Medical Records Nurse, Social Service Director, Activity Director, and Medical Director to ensure compliance with the Facility Focus Round standard. The Quality Assurance(QA) Committee will make necessary recommendations as	

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F 867	Continued From page 23 Education on Respiratory Management was provided to Nursing staff in person by our Nurse Educator on 2/03/2023 and assigned via (proper name) on 2/03/2023 with a completion date of 2/10/2023. Education on Infection Control was provided to clinical staff in person on 2/03/2023 by Nurse Educator and Via (proper name) on 2/03/2023 with a completion date of 2/10/2023. 4. Unit Manager/register nurse Supervisors to make daily audits using the Oxygen/Nebulizer audit form for 30 days beginning 2/03/2023 to ensure of proper storage of respiratory equipment. The Director of nursing /Nurse Educator will complete 5 audits using the Oxygen/Nebulizer audit form weekly x 4 weeks beginning 2/10/2023 then 5 audits biweekly for 60 days to ensure proper storage of respiratory equipment. The monitoring we have in place for this deficiency will be discussed at our monthly Quality Assurance and Performance Improvement meeting on 3/9/23 and then monthly for 2 months completing on 5/9/23." Review of the facility's Quality Assurance and Performance Improvement (QAPI) "Meeting Notes" dated 3/9/2023 revealed "... Conclusions and Recommendations: ... Plan of correction discussed with audit tools in place to monitor with no issues noted."	F 867	needed.	
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	F 880		5/18/24

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diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

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

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a 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

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F 880	Continued From page 25 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review, the facility failed to prevent the possibility of the spread of infection as evidenced by failing to utilize proper hand hygiene and maintaining a clean barrier for one (1) of five (5) care observations. Resident #13 Findings include: Review of the facility policy titled, "Infection Control Standard" with a revised date of 05-2023 revealed," STANDARD It is our standard to assume that patients are potentially infected or colonized with an organism that could be transmitted during the course of providing patient care services and therefore our facility applies the "Standard Precautions" infection control practices... 1. Hand Hygiene: a. During the	F 880	F-880-SS-D INFECTION PREVENTION & CONTROL 1. On 04/29/24, Licensed Practical Nurse #4 completed an in-service with the Nurse Educator on wound care procedure and Infection Control Standard with emphasis on Hand Hygiene. 2. The Director of Nursing noted on 04.29.24 that 6 out of 42 residents with orders for wound care treatment had the potential to be affected by this allegation of deficient practice of not following infection control standard while providing wound care. 3. On 04/29/24, Licensed Practical Nurse #4 completed an in-service with the Nurse Educator on wound care procedure and Infection Control Standard with	

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F 880	Continued From page 26 delivery of patient care services, avoid unnecessary touching of surfaces in close proximity to the resident to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces... e. Staff must perform hand hygiene (even if gloves are used): iii ...After contact with...nonintact skin, or wound dressing, visibly contaminated surfaces or after contact with objects in the resident's room... v... If hands shall be moving from a contaminated-body site to a clean-body site during resident care..." Observation of wound care treatment for Resident #13 on 4/23/24 at 2:45 PM revealed Licensed Practical Nurse (LPN) #4 washed her hands applied clean gloves and assisted Certified Nurse Aide (CNA) #2 with turning Resident #13 to her left side. LPN #4 began removing the resident's brief and then cleaned the wound to her right buttock with wound cleanser and then applied the wound treatment without changing out her gloves and washing her hands. When the wound treatment to the right buttock was completed two unopened packages of abdominal (ABD) pads fell off the overbed table onto the floor, LPN #4 retrieved the unopened ABD packages off the floor while wearing her soiled gloves and placed the unopened ABD pads back on the clean barrier tray contaminating the clean barrier tray. LPN #4 then removed her gloves, washed her hands, and applied clean gloves. LPN #4 assisted CNA #2 with turning Resident #13 to her right-side, LPN #4 did not change her soiled gloves and proceeded to administer wound treatment to Resident #13's left outer thigh. An interview on 4/23/24 at 3:10 PM, LPN #4 confirmed she did not practice infection control	F 880	emphasis on Hand Hygiene. On 05.03.24, Nurse Educator provided in-service training on the infection control policy, specifically on Hand Hygiene, for 15 of 15 nursing staff. 4. The Director of Nursing will make rounds with License nurses to ensure compliance with wound care procedure weekly for 30 days beginning 04/29/2024 and then monthly for three months ending on 07/29/2024. The Director of Nursing will make rounds to ensure compliance with Hand Hygiene procedure weekly for 30 days beginning 04/29/2024 and then monthly for three months ending on 07/29/2024 The findings of this audit will be brought before the Quality Assurance (QA) committee monthly for three months beginning on 05/16/2024. The findings will be reviewed by the Interdisciplinary Team and the QA committee which consists of which consists of the Administrator, Director of Nursing, RN Supervisors, Dietary Manager, Nurse Educator, Medical Records Nurse, Social Service Director, Activity Director, and Medical Director.	

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measures by failing to change her gloves during wound treatment to both of the resident's wounds. She confirmed when she picked up the ABD packages from the floor while wearing her soiled gloves and laying them on the clean barrier that she contaminated her clean barrier. She confirmed that not practicing proper infection control measures could potentially cause an infection in the wound.

During an interview on 4/23/24 at 3:45 PM, the Director of Nurses (DON) with LPN #4 present confirmed their policy regarding wound treatment is to make sure and change gloves and wash hands between soiled dressing and clean dressing care and confirmed by not doing so is an infection control issue and could delay healing.

A record review of Resident #13's Admission Record revealed the resident was admitted to the facility on 6/12/2023 with diagnoses that included Pressure ulcer of right buttock and Type 2 Diabetes Mellitus with Hyperglycemia.