STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255306	A. BUILDING _____ B. WING _____	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRACE EXTENDED CARE & REHABILITATION	1000 EAST MADISON STREET HOUSTON, MS 38851

(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 at the facility from 3/18/24 through 3/21/24. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F558, F578, F580, F582, F583 F636, F640, F641, F656, F658, F677, F684, F688, F759, F761, and F880. The census at the time of the survey was 57 and the facility was licensed for 66 beds.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and facility policy review, the facility failed to ensure a resident's call light was in reach for one (1) of 57 residents residing in the facility. Resident #4 Findings include: Review of the facility policy titled "Call Lights: Accessibility and Timely Response" with a revision date of 3/19/2024 revealed, "Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to	F 558	1.The call light for resident # 4 was placed within easy reach immediately on 3/19/24. 2.The facility has determined that all residents have the potential to be affected. 3.The Director of Nursing (DON) and Staff Development Nurse educated all staff on 3/19/24 addressing policies and procedures, regulations and facility expectations of staff to always assure the accessibility of call lights in resident	4/30/24

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

Electronically Signed | 04/01/2024

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F 558	Continued From page 1 allow residents to call for assistance." Also revealed under, "Policy Explanation and Compliance Guidelines: ... 5. Staff will ensure the call light is within reach of resident and secured, as needed." Resident #4 An observation of Resident #4 on 3/18/2024 at 11:16 AM, revealed her lying in bed with a pillow under her left arm with the call light hanging down from the left side of the bed on the floor. An observation and interview on 03/19/2024 at 2:02 PM, revealed Resident #4 hollering for help down the south hallway. The resident was observed sitting in a wheelchair facing a window in her room and stated she needed help and asked, "Can you open my chocolate?" The call light was hanging down from the left bed rail, which was positioned up against the wall and the resident could not access it. The resident stated she could use the call light to request help if she had it. An observation and interview with Certified Nurse Aide (CNA) #1 on 3/19/2024 at 2:05 PM, revealed she was assigned to Resident # 4 and explained that she brought the resident to her room and got called away to do something else and confirmed that the call light was unreachable and should not be. CNA #1 explained that the purpose of having the call light close by was for the resident to call when she needed help. An interview with the Director of Nursing (DON) on 3/19/2024 at 2:24 PM, confirmed Resident #4's call light should be accessible when the resident was in her room so she could call for	F 558	rooms. 4.Ward Clerk, night shift and weekend RN Supervisor's will make rounds twice daily starting 3/25/24 through 5/31/24 to ensure compliance. Daily checks will be made ongoing to ensure compliance. Round results will be reviewed by the administrator and DON with corrective actions taken immediately when required. The administrator will report results to the Quality Assurance (QA) Committee at monthly QA meeting for three months for recommendations or need for further interventions to ensure consistent substantial compliance. Immediate QA was held on 3/22/24 and first monthly QA meeting will be held on 4/29/2024.	

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F 558	Continued From page 2 assistance when needed. Record review of Resident #4's "Face Sheet" revealed the facility admitted the resident on 5/10/2016 with medical diagnoses that included Cerebral Infarct, Type 2 Diabetes Mellitus, Epilepsy, and Paranoid Schizophrenia.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive	F 578		4/30/24

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F 578	Continued From page 3 information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 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 honor a resident's preference for end of life Advance Directives for one (1) of 24 residents sampled. Resident #57. Findings include: Record review of facility policy titled, "Advance Directive Policy", undated, revealed, "This facility recognizes the resident's right under the State Law to accept or refuse medical treatment and to formulate advance directives such as a Living Will, Durable Power of Attorney for Healthcare and decisions regarding resuscitation ....The facility supports the need for resident's participation in health care decisions and will make every effort to provide the resident and their family with information to enhance decision making capacity and to reasonably assure the ability to make voluntary and informed decisions." Record review of Resident #57's Advance directives/Medical treatment decisions ..."I do not choose to formulate or issue any Advance Directives at this time. I want efforts made to	F 578	1.The code status of resident #57 was verified with the resident and entered consistently into all relevant locations within the medical record and correction communicated to the hospice agency on 3/19/24. 2.Determining the code status or presence/absence of Advance Directives is required for all residents. Therefore, all residents have the potential to be affected. 3.The Administrator educated social services, admission nurse Director of Nursing and Medical Records on resident's rights, residents' choice and communication of code status on 3/25/24. Staff Development educated licensed nurses regarding the documentation procedures for Advance Directives/code status and residents rights of choice starting 3/25/24. A chart audit of all residents code status was completed by medical records on 3/25/24. Discrepant findings were addressed immediately, and	

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F 578	Continued From page 4 prolong my life and I want life-sustaining treatment to be provided." Signed by Resident and dated 9/7/23. Record review revealed a hospice form for Do-Not-Resuscitate (DNR) signed by daughter and dated 10/6/23. Record review of Resident #57's Physician orders for the month of: September 2023 revealed "Code Status: Full code." Record review of Resident #57's Physician orders for the month of: March 2024 revealed an order dated 10/8/23 "Code Status: Do Not Resuscitate." An interview on 03/19/24 at 3:30 PM, with Resident #57 stated, "I know I'm on hospice services but if I stop breathing, I want cardiopulmonary resuscitation (CPR). I want to come back. That's what I want." He revealed his daughter signed his hospice paperwork, but he wasn't aware that his code status had changed, and it hadn't been discussed with him. An interview on 03/19/24 at 4:25 PM, the Admission Liaison Nurse revealed when Resident #57 was admitted to the facility he signed his own Advance Directive paperwork, and his wish was to be a full code meaning he wished to have CPR performed. She confirmed that the resident had a form signed by Resident #57's daughter when he went on hospice services on 10/6/23, and a physician order for 10/8/23 for DNR by the hospice physician. She revealed, "I don't think his code status was discussed with him when they admitted him to hospice services." She revealed they have no paperwork confirming the daughter is his Power of Attorney (POA) She confirmed it is	F 578	all needed actions were completed on 3/26/24. 4.The Admissions Nurse will perform weekly audits of new admissions for three months beginning 3/27/24. All residents on the MDS assessment schedule will have advanced directives reviewed for consistent documentation of the resident's code status throughout the medical record per the MDS nurses for three months beginning 4/1/2024. The Director of Social Services will discuss code status with residents and responsible party at each care plan meeting on going. Results of the audits will be review and discussed monthly with the Quality Assurance (QA) committee for three months, to ensure consistent substantial compliance. Immediate QA meeting held on 3/22/24 with first monthly QA Meeting to be held on 4/29/2024.	

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F 578	Continued From page 5 his right to choose his end-of-life status and it is supposed to be according to his wishes. She revealed she wasn't aware that his end-of-life choice had changed from CPR to DNR. An observation on 3/19/24 at 4:45 PM, revealed an interview between Resident #57 and the Admission Liaison Nurse in which the nurse explained to the resident his end-of-life choices. The nurse explained the difference between the DNR code status and the Full code status. Resident #57 verbalized understanding of the difference and stated, "If you can get my heart to beating, I want you to try, it may not get back to beating but I want you to try." An interview on 3/20/24 at 2:02 PM, the Administrator confirmed that the resident had completed his own Advance Directive and had chosen a full code status when he was admitted to the facility. She revealed she wasn't aware of the change in his code status when he went on hospice services, and it wasn't communicated through the proper channels, and it should have been. Record review of Resident #57's "Face Sheet" revealed he was admitted to the facility on 9/07/23 with diagnoses that included Chronic Obstructive Pulmonary Disease and Chronic Respiratory Failure. Record review of Resident #57's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/15/2024 revealed a Brief Interview for Mental Status (BIMS) score of 11 which indicated the resident has moderate cognitive impairment.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.)	F 580		4/30/24

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F 580	Continued From page 6 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580		

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F 580	Continued From page 7 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). 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 notify a resident's physician of a skin concern for one (1) of 19 sampled residents. Resident #216. Cross Reference F684 Findings Include: Record review of the facility policy titled "Notification of Changes" with a revision date of 12/20/2022 revealed, "Policy: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification...Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification .... 3. Circumstances that require a need to alter treatment. This may include: a. New treatment..." An observation and interview with Resident #216 on 3/19/2024 at 2:40 PM, revealed the resident	F 580	1.The physician and the resident's representative were notified immediately on 3/19/24. Resident # 216 received a shower with medicated shampoo to treat the skin issue on 3/20/24. A 100% body audit of all residents was completed on 3/25/24 by the treatment nurse. Discrepant findings were addressed immediately, and all needed actions were completed by 3/26/24. 2.The facility has determined that all residents have the potential to be affected. 3.The Staff Development Nurse educated all licensed staff addressing circumstances that require notification of the resident's physician and resident's representative on 3/22/24. 4.The Registered Nurse (RN) Supervisor will conduct an audit of five (5) residents weekly for four (4) consecutive weeks, three residents weekly for two consecutive weeks and one resident weekly for two	

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F 580	Continued From page 8 sitting in a wheelchair with his head laid over a bedside table. The resident was observed with an excessive thick layer of white buildup with patchy areas of flaking to the entire scalp (all hair) that extended to the ear lobes. The white buildup was also observed in the resident's facial beard that extended to the front of his neck. The resident stated that it did itch at times and revealed that the facility was not performing treatment to the areas. An observation and interview with Licensed Practical Nurse (LPN) #1, on 3/19/2024 at 2:43 PM, confirmed Resident #216's skin concern. She revealed she was not aware of the skin issue and stated the resident was not getting any type of treatment and she was unsure if the physician had been notified, and confirmed he should have been. Record review of Resident #216's "Physician Orders" revealed there was not a treatment order for his skin concern. Record review of Resident #216's "Departmental Notes" dated 2/21/2024 through 3/11/2024, revealed the resident had dry skin to the BLE (bilateral lower extremities) with no documentation of his skin concern to the scalp and beard. An interview with Registered Nurse (RN) #1 on 3/20/2024 at 1:40 PM, revealed the staff had not reported any skin issues to her for Resident #216. She stated the physician should have been contacted when the issue was first observed. Record review of the "Skin Inspection Report" dated 2/28/2024, 3/11/2024, and 3/18/2024	F 580	consecutive weeks starting 4/1/24, for notification to physician and representative of changes with the residents. Findings of this audit will be reviewed by the Administrator and Director of Nurses with any needed corrective actions taken immediately. Audit results will be reviewed and discussed at the monthly Quality Assurance (QA) meeting for three months, for recommendations or changes needed to ensure consistent substantial compliance. Immediate QA was held on 3/22/24 with first monthly QA meeting to be held on 4/29/2024	

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F 580	Continued From page 9 revealed "Skin Intact" which indicated Resident #216 had no identified skin concern. An interview with LPN #2 on 3/20/2024 at 3:55 PM, revealed she was the person responsible for completing the last two weeks of skin audits on Resident #216. She revealed she did not find any skin concerns on either of the skin audits and stated the resident was lying in bed when she conducted the audits, and she must have overlooked it. An interview with the Director of Nursing (DON) on 3/20/24 at 4:00 PM, confirmed Resident #216's skin concern should have been caught on the weekly skin audits and stated the physician should have been notified for a treatment. Record review of Resident #216's "Face Sheet" revealed the facility admitted the resident on 2/21/24 with medical diagnoses that included Chronic Systolic (congestive) Heart Failure and Type 2 Diabetes mellitus.	F 580		
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 582		4/30/24

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F 582	Continued From page 10 (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.	F 582		

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F 582	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility record review, the facility failed to provide the Notice of Medicare Non-Coverage to two (2) of three (3) residents discharged from Medicare Part A services with service times remaining. Resident #3 and Resident #7 Findings include: Record review of facility letterhead note signed by the Administrator and dated on 3/20/24 revealed: "(Proper name of facility) does not have a beneficiary notification policy." An interview with the Administrator on 3/19/24 at 11:08 AM, revealed she was aware of the requirement for the Notice of Medicare Non-Coverage to be provided to the resident or the resident representative and was aware that it was not being done due to staff turnover and it just fell through the cracks. She confirmed the facility failed to complete the Notice of Medicare Non-Coverage for residents who were discharged with time remaining on their Part A coverage. Record review of Resident #3's Face Sheet revealed he was admitted to the facility on 3/11/22 with diagnosis of displaced fracture of base of neck of right femur. Record review of Resident #3's Beneficiary Protection Notification Review revealed the resident's Medicare Part A skilled services episode start date of 10/3/23 and last covered day of Part A service was 11/15/23. This form revealed the facility/provider initiated the discharge from Medicare Part A Services when	F 582	1.Resident #3 was informed of payment status, by MDS coordinator, as of the resident's last covered day of 11/15/23 on 4/1/2024 and signature of notification was obtained. For Resident #7, the resident's representative was notified via telephone of the resident's last covered day of 10/21/23 on 4/1/2024 per the Minimum Data Set (MDS) Assessment nurse and witness verification was documented. 2.The facility has determined that residents with a qualifying hospital stay and Medicare Part A benefit days available have the potential to be affected. The administrator conducted an audit on current residents who were admitted in the past six months, and corrective actions were completed on 4/1/24. 3.The Administrator educated the following personnel on the facility's Advance Beneficiary Notices policy Business Office Manager, Social Services Director, MDS Coordinator and Director of Nursing. Copies of the relevant forms were placed in a binder in the PPS Meeting Room and the offices of the Business Office Manager and Social Services Director. These actions were completed on 3/21/2024. 4.The Administrator will conduct an audit of skilled residents weekly for three months to verify that notices were issued	

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F 582	Continued From page 12 benefit days were not exhausted. Review of this form revealed the Notice of Medicare Non-Coverage form was not provided to the resident. Record review of Resident #7's Face Sheet revealed she was admitted to the facility on 4/17/08 with diagnoses that include Unspecified Combined Systolic and Diastolic Congestive Heart Failure and Acute Kidney Failure. Record review of Resident #7's Beneficiary Protection Notification Review revealed the resident's Medicare Part A skilled services episode start date of 8/23/23 and last covered day of Part A service was 10/21/23. This form revealed the facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted. Review of this form revealed the Notice of Medicare Non-Coverage form was not provided to the resident.	F 582	timely and appropriately starting 3/25/24 . Any needed corrective actions will be taken immediately. Results of the audit will be presented to the Quality Assurance (QA) Committee for three months, for review and recommendations of further audits to ensure consistent substantial compliance has been met. Immediate QA meeting was held on 3/22/24 with first monthly QA meeting to be held on 4/29/24.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the	F 583		4/30/24

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F 583	Continued From page 13 residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, facility policy review, the facility failed to ensure privacy for a resident as evidenced by a staff member changing a residents brief next to a window with no curtain or blind for one (1) of 57 residents observed for privacy. Resident #35 Findings include: Review of facility policy titled, "Resident Rights," with a revision date of 9/22/22 revealed, "The resident has the right to a dignified existence ...7. Privacy and confidentiality: The resident has a right to personal privacy ..." An observation on 3/18/24 at 10:35 AM revealed no curtains or blinds on the window in Resident	F 583	Resident #35□s room had a blind placed on the window on 3/18/24 per the maintenance supervisor. Audit of all rooms was completed by Maintenance Supervisor and Administrator, to ensure there were no other rooms without window coverings on 3/18/24. The facility has determined that all residents have the potential to be affected. An in-service education was conducted by the Director of Nursing Services with all staff on privacy, and to report improper/insufficient window coverings to Maintenance Supervisor or Administrator,	

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F 583	Continued From page 14 #35's room with the resident's bed situated in front of the window with a view outside of a driveway with a trash dumpster and several parked cars. An interview on 3/18/24 at 1:54 PM, Resident #35 revealed in a slurred speech that she would like curtains on her window and wasn't sure why she didn't have a curtain. An interview on 03/18/24 at 2:30 PM, Certified Nurse Aide (CNA) #3 revealed the resident's window hadn't had a curtain or blind for a while but she was unsure how long it had been off. She revealed we change her briefs and do her peri care while she is standing up, we can't change her while she is in bed because her legs flail around so much. An observation on 03/18/24 at 2:55 PM, CNA #3 entered Resident # 35's room with an incontinence disposable brief in her hand, she pulled the privacy curtain between Resident A and Resident B's bed and was changing Resident #35's brief and administering peri-care in front of the open window that lacked any covering from the outside view. An interview on 03/18/24 at 3:05 PM, the Administrator confirmed there was no blind or curtain on the resident's window and revealed that it should be. She stated she wasn't sure how long it had been like this and confirmed this is a privacy and dignity issue. Record review of Resident #35's Face Sheet revealed she was admitted to the facility on 5/25/19 with diagnoses that included Huntington's disease, Slurred Speech, and Anxiety Disorder.	F 583	on 3/22/24. The Administrator or Maintenance Supervisor will conduct a room audit of five (5) rooms weekly for four (4) weeks, three (3) rooms weekly for two weeks, and (1) one room weekly for two weeks to ensure window coverings are in place, starting 3/25/24. Any needed corrections will be made immediately. Findings of this audit will be discussed at the monthly Quality Assurance (QA) meeting for three months. QA Committee may make recommendations or changes to ensure consistent substantial compliance. Immediate QA meeting was held on 3/22/24 first monthly QA meeting will be held on 4/29/2024.	

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F 583	Continued From page 15 Record review of the quarterly Minimum Data Set with an Assessment Reference Date of 1/20/24 revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderately impaired cognitive skills.	F 583		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures.	F 636		4/30/24

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F 636	Continued From page 16 (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to complete a Comprehensive Admission Minimum Data Set (MDS) assessment within fourteen days for one (1) of 19 sampled residents Resident #216 Findings Include: Record review of Resident #216's "Face Sheet"	F 636	1. The Admission Minimum Data Set (MDS) Assessment for Resident #216 was completed on 3/20/24 submitted and accepted on 3/21/2024. 2. All residents who meet the requirements for an MDS Assessment have the potential to be at risk of this deficient practice.	

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F 636	Continued From page 17 revealed the facility admitted the resident on 2/21/2024. Record review of Resident #216's Admission "Minimum Data Set" (MDS) with an Assessment Reference Date (ARD) of 2/28/2024, revealed under section Z, the date a Registered Nurse (RN) signed the assessment as complete was left blank. It also revealed a status of "Open", which indicated the admission assessment had not been completed and closed for transmittal. An interview with the Minimum Data Set (MDS) Nurse #2 on 3/20/2024 at 9:49 AM, confirmed Resident #216's Admission MDS assessment was not completed and should have been completed within 14 days of admission. She revealed she overlooked the assessment and thought it had been completed. She explained the comprehensive assessment must be completed to develop the resident's care plans, which gave the staff a guide of how to care for the resident. An interview with the Director of Nursing (DON) on 3/20/2024 at 3:20 PM, revealed she was not aware that Resident #216's Admission MDS assessment had not been completed. She confirmed the MDS assessments should be completed and submitted per the Resident Assessment Instrument (RAI) guidelines.	F 636	3. The Administrator, Director of Nursing (DON), MDS Coordinator and Case Management Nurse revised policy Assessment Frequency/Timelines on 3/28/24. The administrator and MDS Coordinator will audit the validation reports weekly beginning 3/29/2024. The MDS Coordinator completed an audit of all MDS assessments on current calendar and validation reports submitted through 3/25/24 with no additional missed assessments or submissions found, on 3/25/24. The Administrator held an in-service/education with the MDS Coordinator and Case Management Nurse on 3/27/2024 to ensure the understanding that assessments must be completed and transmitted 14 days after the completion date and to also correct and resubmit any rejected assessments immediately. 4. Administrator will review validation reports once weekly for 3 months to ensure submission of all assessments on the MDS calendar have been accepted starting 4/1/24. Negative findings will be addressed, and corrective actions taken immediately. All findings of the reviews will be brought to the Quality Assurance Committee (QA) monthly for 3 months. The Quality Assurance (QA) Committee will make recommendations or modifications as needed, to ensure consistent substantial compliance. Immediate QA meeting held on 3/22/24 with first monthly QA meeting to be held	

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F 636	Continued From page 18	F 636	on 4/29/2024.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for resident(s) with upper body contractures for two (2) of 19 resident assessments reviewed. Resident #34 and #46 Findings include: Record review of facility policy titled "Resident Assessment - RAI," dated 6/18/23, revealed, "This facility makes a comprehensive assessment of each resident's needs, strengths, goals, life history, and preferences using the resident assessment instrument (RAI) specified by CMS (Centers for Medicare and Medicaid Services)..." Resident #34 An observation and interview with Resident #34 on 3/19/24 at 8:20 AM, revealed resident's left hand and fingers were contracted and a gauze dressing was in her palm. She stated it had been like that for a long time and she had a wound in her hand. Record review of Resident #34's MDS with Assessment Reference Date (ARD) of 1/30/24, Section GG revealed the resident had "no	F 641	1.The corrected Minimum Data Set (MDS) Assessment for Resident #36 and resident #45 was resubmitted on 3/27/24 and accepted. The Administrator held an in-service/education with the MDS Coordinator and Case Management Nurse on 3/27/2024 to ensure the understanding that assessments must be completed accurately per the RAI Manual. 2.All residents who meet the requirements for an MDS Assessment have the potential to be at risk of this deficient practice. 3.The Administrator, Director of Nursing (DON), MDS Coordinator and Case Management Nurses revised policy Assessment Frequency/Timeliness on 3/28/24. The MDS Coordinator will audit the assessments prior to submission weekly beginning 3/29/2024. Negative findings will be addressed immediately. 4.The MDS Coordinator will audit the assessments prior to submission weekly beginning 3/29/2024 for 3 months to ensure assessments are accurate.	4/30/24

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F 641	Continued From page 19 impairment" with range of motion of upper extremities. An interview with MDS Registered Nurse (RN) #1 on 3/20/24 at 3:40 PM, revealed she was the person that completed Resident #34's MDS assessment and made an error by not marking limited range of motion to upper extremity. She stated she was aware of the contracture to the resident's left hand and fingers, but she did not realize that contractures of the hand/fingers would be considered an upper extremity range of motion limitation, so therefore, she failed to code it correctly. She stated she reviewed the RAI and realized she should have marked the limited range of motion for this resident's upper extremities and confirmed she did not enter accurate information in the MDS assessment. During an interview on 3/20/24 at 3:45 PM, the Director of Nursing (DON) revealed the MDS assessment should represent an accurate assessment of the resident's condition at that time. She confirmed the facility failed to code and submit an accurate MDS assessment concerning contractures for Resident #34. Record review of the Physician Orders List for Resident #34 revealed an order dated 12/28/22 for a hand roll to left hand during waking hours as tolerated. Record review of Resident #34's MDS with ARD of 1/30/24, revealed a Brief Interview for Mental Status (BIMS) of 8 which indicated the resident had a moderate cognitive impairment. Record review of Resident #34's "Face Sheet" revealed she was admitted to the facility on	F 641	Inaccuracies will be corrected prior to submission. The Administrator will review the findings of the audits. Audit results will be brought to the Quality Assurance (QA) Committee monthly for 3 months. The Quality Assurance (QA) Committee will make recommendations or modifications as needed, to ensure consistent substantial compliance. Immediate QA meeting was held on 3/22/24 with first monthly QA meeting to be held on 4/29/2024.	

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9/2/22 with medical diagnoses that include Parkinson's Disease and Abnormalities of gait and mobility.

Resident #46

An observation of Resident #46 on 03/18/2024 at 11:14 AM, revealed him lying in bed awake. The resident was observed with paralysis to the left arm and contractures to the left fingers.

Record review of Resident #46's "Physician Orders" revealed an order dated 7/04/2023, "Hand roll to Lt (left) hand during waking hours to prevent further contractures ..."

Record review of the MDS with an ARD of 3/11/2024 revealed, under section GG, functional limitation in Range of Motion - Upper extremity was marked as 0 (zero), which indicated Resident #46's had no impairment.

An interview with the MDS #1 on 3/20/2024 at 2:29 PM, revealed she was the person that completed Resident #46's MDS assessment and stated that she made an error by not marking limited range of motion (ROM) for the upper extremity. She revealed that she did not reference the RAI when she completed the assessment, and revealed that she should have. She revealed the MDS did not represent an accurate assessment of the resident.

Record review of the "Face Sheet" revealed the facility admitted Resident #46 on 4/08/2022 with medical diagnosis that included hemiplegia following Cerebral Infarction affecting the left nondominant side, Type 2 Diabetes Mellitus,

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F 641	Continued From page 21 Seizures, and Depression.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (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	F 656		4/30/24

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F 656	Continued From page 22 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 develop comprehensive care plans timely, failed to implement care plans for residents' Activities of Daily Living (ADL) care and position and mobility needs for five (5) of 19 resident careplans reviewed. Residents #1, #13, #26, #46, and #216. Findings include: Record review of facility policy titled "Comprehensive Care Plans" dated 12/15/22, revealed, "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 time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." Resident #1 Record review of Resident #1's "Care Plan" with problem onset 09/12/2023, revealed the resident was unable to assist with her care and required total assistance with Activities of Daily Living	F 656	1.Resident #1 was given mouth care per the care plan on 3/18/2024. Resident #13 received mouth care on 3/19/24 and all remaining scheduled medications were given per the care plan and physicians order on 3/20/24. Resident #26 had her nails clipped by the nurse supervisor on 3/19/2024. Assessment Coordinator completed care plan for resident #216 on 3/20/24. Resident #46 had hand roll placed in his hand on 3/19/2024. 2. Facility has determined that all residents have the potential to be affected by this practice. 3. Assessment nurses were educated on 3/27/24 on person centered care plan creation and updating by the Administrator. Nurses and Certified Nursing Assistants (CNA) were educated on placement of devices, nail, oral and mouth care per the care plan on by the Director of Nursing (DON) beginning 3/19/2024. All interdisciplinary care team members responsible for writing care plans were educated on facilities updated	

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F 656	Continued From page 23 (ADLs) due to cognitive impairment related to diagnosis of infantile cerebral palsy, and spastic quadriplegia. An intervention listed was oral care every shift with swabs. On 3/18/24 at 11:20 AM, Resident #1 was observed in her wheelchair at the nurses station. Her lips were noted to be covered with a white crusty covering with a white thick secretion noted. An interview on 3/19/24 at 2:40 PM, with the Director of Nursing (DON) confirmed the facility failed to ensure the resident's oral care was done as needed and therefore, the care plan was not followed. An interview with the Minimum Data Set (MDS) Registered Nurse (RN) #1 on 3/20/24 at 4:10 PM, revealed the care plan was to inform the staff of how to take care of the residents. She stated it was a guide for the staff to follow for the needed care of each resident and confirmed this care plan for oral care was not followed. Record review of Resident #1's "Face Sheet" revealed resident was admitted to the facility on 8/5/20. Diagnoses included cerebral palsy, spastic quadriplegic cerebral palsy, convulsions, intellectual disabilities. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/26/24, revealed in Section GG for oral hygiene, this resident was dependent. Review of the Brief Interview for Mental Status (BIMS) score of 0 indicated the resident was severely cognitively impaired.	F 656	care plan policy beginning 3/25/2024 by the Administrator. 4. Interdisciplinary team will discuss resident changes and care plan needs daily in morning meeting beginning 3/25/24. The DON will complete weekly audits on three resident care plans per week for three weeks, two resident care plans per week for three weeks and one resident care plan for two weeks to ensure that comprehensive care plans are developed and updated on resident beginning 4/1/2024. The DON will complete audits of ADL documentation completion for three residents per week for three weeks, two residents per week for three weeks and one resident per week for two weeks, to ensure ADL care plans are being followed starting 04/01/24. Audit records will be reviewed by the Administrator and DON and corrections made as needed. Audit findings will be brought to the Quality Assurance (QA)/Risk Management Committee for three months for determination of further interventions to ensure consistent substantial compliance. Immediate QA meeting held on 3/22/24 with first monthly QA meeting to be held on 4/29/24.	

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F 656	Continued From page 24 Resident #13 Record review of the care plan with a problem onset date of 10/23/23, revealed Resident #13 requires total care with ADL needs due to immobility, chronic flexion contractures of all four extremities. An intervention was to provide with oral care every 2 hours and as needed with swabs, wipe his mouth after oral care and apply Vaseline to his lips. An observation on 03/18/24 at 10:45 AM and again at 12:15 PM, of Resident #13 revealed a large amount of thick, white dried substance on his upper and lower lips. An interview on 3/19/24 at 3:15 PM, the DON confirmed Resident #13 not having the proper oral care is not acceptable. She confirmed it is the responsibility of the CNA's on each shift to make sure the resident's lips and oral care are taken care of and the responsibility of the nurses to ensure the scopolamine patch is on to help reduce his oral secretions. An interview on 3/20 at 2:45 PM, MDS Nurse #1 revealed the care plan is developed to ensure staff knows how to take care of the individual needs of each resident. She revealed Resident #13's care plan was developed due to his excessive secretion buildup and for the staff to know he is to receive oral care every two (2) hours and as needed as it is written. She confirmed Resident #13's oral care plan was not being followed and it should have been. Record review of Resident #13's "Care Plan" with a problem onset date of 10/41/22 revealed "I	F 656		

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have dysphagia, I am NPO (nothing to eat or drink by mouth), I require PEG (Percutaneous Endoscopic Gastrostomy) tube for all nutrition and hydration, I am at risk for aspiration and other complications due to tube feeding". An intervention listed was "PEG tube meds must be given individual".

An observation of medication administration via PEG tube on 3/20/24 at 8:45 AM, revealed Licensed Practical Nurse (LPN) #1 crushed six tablet medications together and mixed those with one liquid medication and administered through PEG tube.

Interview with the DON on 3/20/24 at 9:50 AM, confirmed that LPN #1 did not follow the physician order or the care plan and give each medication individually.

An interview with the MDS RN #1 on 3/20/24 at 4:10 PM, revealed the care plan was to inform the staff of how to take care of the residents. She stated it was a guide for the staff to follow for the needed care of each resident and confirmed this care plan for PEG medication administration was not followed.

Record review of Resident #13's "Face Sheet" revealed the resident was admitted to the facility on 1/24/13 with medical diagnoses that included Convulsions, Gastrostomy status, Dysphagia, and Hemiplegia.

Record review of MDS with ARD of 1/23/24 revealed a BIMS of 0 score which indicated the resident had severe cognitive impairment.

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Resident #26

Record review of Resident #26's "Care Plans" revealed, "Problem Onset: 1/08/2024, I require extensive to total assistance with ADLs....Approaches ... Nail care to be done weekly on shower days ..."

An observation of Resident #26 on 3/18/2024 at 11:16 AM, revealed her lying in bed with long nails on both hands measuring three-eights (3/8) inch in length.

An observation and interview with the DON on 3/19/2024 at 2:25 PM confirmed Resident #26's long nails.

An interview with MDS Nurse #1 on 3/20/2024 at 2:26 PM confirmed Resident #26's care plan was not followed for nail care weekly. She revealed the purpose of the care plan was to be able to provide the needed care for the residents.

Record review of Resident #26's "Face Sheet" revealed the facility admitted the resident on 3/30/2022 with medical diagnoses that included Depression, Essential (primary) Hypertension, and Osteoarthritis.

Resident #46

Record review of Resident #46's "Care Plan" with a problem onset date of 3/228/22 revealed, "Problem/Need: ...contracture to left hand...Approaches ... Hand roll to Lt (left) hand during waking hours to prevent further contracture as resident will allow..."

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An observation of Resident #46 on 03/18/2024 at 11:14 AM revealed him lying in bed awake. The resident was observed with paralysis to the left arm and contractures to the left fingers, with no device in use.

An observation of Resident #46 on 3/19/2024 at 1:59 PM revealed him sitting in a wheelchair at the nurse's station. No device in place to the left hand.

An interview and observation on 3/19/2024 at 2:10 PM with LPN #1 confirmed Resident #46 did not have a left hand roll in use.

An interview with MDS Nurse #1 on 3/20/2024 at 2:29 PM confirmed Resident #46's care plan was not followed for applying the left hand roll.

Record review of the "Face Sheet" revealed the facility admitted Resident #46 on 4/08/2022 with medical diagnosis that included Hemiplegia following cerebral infarction affecting the left nondominant side, Type 2 Diabetes Mellitus, Seizures, and Depression.

Resident #216

Record review of Resident #216's "Face Sheet" revealed the facility admitted the resident on 2/21/2024 with medical diagnoses that included Hyperlipidemia, Chronic Systolic (congestive) Heart Failure, Type 2 Diabetes Mellitus, Vitamin D deficiency, and Paroxysmal Atrial Fibrillation.

Record review of Resident #216's Electronic Medical Record (EMR) revealed there were not any care plans developed since admission.

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F 656	Continued From page 28 An interview with MDS Nurse #2 on 3/20/2024 at 9:49 AM, confirmed she had not developed comprehensive care plans for Resident #216. She explained they overlooked completing the admission MDS assessment; therefore, the care plans had not been developed. She revealed the staff would not know how to care for the resident since he did not have care plans. An interview with the DON on 3/20/2024 at 3:20 PM, revealed she was not aware Resident #216 did not have care plans. She revealed without the care plans, the staff would not know how to care for the resident. She confirmed the care plans should be completed within the time frame according to the Resident Assessment Instrument (RAI) guidelines.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, facility statement, and facility policy review, the facility failed to follow professional standards of practice for a feeding tube as evidenced by crushing and administering multiple medications at once without the use of flushes and gravity for one (1) of four (4) residents observed during medication administration. Resident #13.	F 658	Licensed Practical Nurse (LPN) # 1 was immediately in-serviced on following care plan and physicians order of giving resident medication by the Director of Nursing. Residents' physician was notified of medications being given together on 3/20/24. LPN #1 was given one on one education and check off on 3/26/24 with check offs on all licensed nurses beginning 3/25/24. DON assessed	4/30/24

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F 658	Continued From page 29 Cross Reference F759 Findings include: Record review of statement signed by the Administrator on facility letterhead and dated 3/20/24, revealed "(Proper name of facility) does not have a current policy on giving medications through the PEG (Percutaneous Endoscopic Gastrostomy) tube". Record review of facility policy titled, "Medication Set-up, Administration and Documentation Policy", undated, revealed, "You must have an order to crush medications". An observation of Licensed Practical Nurse (LPN) #1 during medication pass for Resident #13's PEG tube medication administration on 3/20/24 at 8:45 AM, revealed LPN #1 crushed Vitamin C 250 milligrams (MG), Metoprolol Tartrate 25 MG, Vitamin D3 1000 units, Zestril 5 MG, Hydrochlorothiazide 12.5 MG, and Aspirin 81 MG together and placed these into the container with the liquid Keppra medication. She stated she was hesitant to give the medications together since in nursing school she learned to give each one separately, but at the facility she was instructed to administer them together, so that was what she was going to do. She entered the resident's room and once again questioned this technique and went back to the medication cart to verify the order and stated there was an order to administer these together. She then returned to the room, checked the residual, pushed 15 milliliters of water, next pushed the seven combined medications, then flushed with 15 milliliters of water. This was all given by syringe and pushed in with plunger and not by gravity.	F 658	resident #13 with no adverse outcomes identified. The facility has determined that all residents with feeding tubes have the potential to be affected. All licensed nursing staff will be educated on medication administration via the PEG (percutaneous endoscopic gastrostomy) tube which includes observation of each nurse performing the procedure. A Validation Checklist will be completed for each nurse to determine if the nurse was performing the procedure correctly. Findings will be reviewed with each nurse beginning 3/25/2024. Corrective action will be provided as needed. A new PEG Tube policy was put in place 3/29/24. The Director of Nursing (DON) or Staff Development Coordinator will complete Validation Checklists of nurses performing feeding tube procedures for three residents per week for six (6) consecutive weeks starting 4/1/24, to ensure nurses are performing the procedure in accordance with our facility's policy, the resident's physician order and care plan. Validation Checklists will be reviewed by the Administrator and DON to ensure corrective actions are taken if needed. Results of validation checklist will be brought to the Risk Management/Quality Assurance (QA) Committee for three months, committee will approve or make recommendations for further interventions to ensure consistent substantial	

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F 658	Continued From page 30 An interview with the Director of Nursing (DON) on 3/20/24 at 9:50 AM, confirmed that Resident #13 did not have a physician order to crush and administer the PEG medications together. She confirmed that LPN #1 did not follow the physician order for the PEG medications to be given individually. She also confirmed that PEG medications should be given by gravity for the resident's comfort and to prevent damage to the PEG tube and given individually with flush between each to ensure compatibility. She stated the facility used Potter and Perry as a nursing reference and did not have a policy for PEG medication administration. She also confirmed the facility did not meet the professional standards for nursing practice related to PEG medication administration. During an interview on 3/21/24 at 10:50 AM, LPN #1 revealed she had misread the order that actually read that medications could be crushed and given together if taken by mouth, but had to be given individually by PEG tube. She confirmed the purpose of administering medications separately was to ensure the medications were compatible and the medications and flushes needed to be administered by gravity and she failed to do this. Record review of Resident #13's "Physician Orders List" revealed an order dated 1/21/22, "May administer crushed medications that are being given PO (by mouth) together. PEG tube meds must be given individual". Record review also revealed orders for Hydrochlorothiazide 12.5 mg per g-tube (gastrostomy tube), Aspirin 81 mg per PEG, Zestril 5 mg tablet per g-tube, Vitamin D3 1000 unit per g-tube, Vitamin C 250 mg per PEG, Metoprolol Tartrate 25 mg per g-tube, and	F 658	compliance. Immediate QA meeting held on 3/22/24 with first QA meeting to be held on 4/29/2024.	

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F 658	Continued From page 31 Keppra 100 milligram/milliliter 7.5 ml per PEG. Record review of Resident #13's "Face Sheet" revealed the resident was admitted to the facility on 1/24/13 with medical diagnoses that included Convulsions, Gastrostomy status, Dysphagia, and Hypertension. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/23/24 revealed a Brief Interview for Mental Status (BIMS) of 0 which indicated the resident had severe cognitive impairment.	F 658		
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 observations, staff, resident and resident representative interviews, record review, and facility policy review the facility failed to ensure dependent residents received appropriate oral care, nail care and shaving for four (4) of 57 residents observed. Resident #1, #13, #26 and #216. Findings include: Record review of facility policy titled, "Activities of Daily Living (ADLs), dated 12/15/22 revealed, "A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene".	F 677	1.Resident #216 was given a shower and shave per residents request on 3/19/24. Resident #1 received oral care per Certified Nursing Assistant (CNA) #4 on 3/18/24. Resident # 13 received oral care per CNA #2 on 3/19/24. Resident #26 received nail care, getting her nails clipped per the Registered Nurse (Rn) Supervisor on 3/18/2024. All Percutaneous Endoscopic Gastrostomy (PEG) residents oral care was added to the treatment administration record (TAR). . Nursing staff did 100% audit of all residents nails on 3/28/24. 2.The facility has determined that all	4/30/24

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F 677	Continued From page 32 Record review of the facility policy titled, "Oral Care" with a revision date of 12/20/2022 revealed, "It is the practice of this facility to provide oral care to residents in order to prevent and control plaque-associated oral diseases....Assist in wiping resident's mouth with towel". Resident #1 On 3/18/24 at 11:20 AM, Resident #1 was observed in her wheelchair at the nurses's station. Her lips were noted to be covered with a white, crusty substance and a thick, white secretion. An interview with Resident #1's Resident Representative (RR) on 3/18/24 at 2:15 PM, revealed she visited the resident frequently and assisted with her care. She stated when she arrived today, the resident's lips were covered with a thick crusty build up and so she cleaned resident's lips and put moisturizer on them for protection. She stated this had also occurred on other occasions. During an observation on 3/19/24 at 8:20 AM, Resident #1's lips were noted to have some dry cracked skin/crusty dry secretions present. During an observation and interview on 3/19/24 at 2:00 PM, Certified Nurses Assistant (CNA) #4 revealed Resident #1 needed frequent mouth and lip care due to her moving her lips inside her mouth and not eating or drinking by mouth. She revealed Resident #1 developed a dry crust covered with secretions on her lips that required them to be cleaned with a cloth and moisturizer	F 677	dependent residents have the potential to be affected by this practice. 3. Licensed nurses and Certified Nursing Assistant□s (CNA□s) were educated immediately on 3/19/24 per the Director of Nursing (DON) on Activities of Daily Living (ADL) care with emphasis on oral and nail care, grooming and bathing and Residents Rights. Nurses and CNA's were educated on ADL care, bathing per schedule or upon resident request, grooming, oral and nail care, documentation of or refusal of ADL care on 3/19/2024 per the DON. 4.DON implemented monitoring of ADL care by RN Supervisors 3/21/24. DON or Nurse Supervisor will monitor bathing, grooming, oral and nail care. Nail care, showers and grooming monitoring of five residents a week for three weeks, three residents a week for three weeks, two residents a week for two weeks and one resident a week for two weeks. Oral care monitoring on all PEG residents three times per week for four weeks, two times per week for four weeks, and one time per week for two weeks. Audit records will be reviewed by the administrator and DON with immediate corrective actions with staff as needed. Findings will be brought to the Quality Assurance (QA)/ Risk management committee for three months for	

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F 677	Continued From page 33 applied frequently. She revealed she was responsible for oral care and did care earlier this shift, but Resident #1 needed her lips to be cleaned again to protect them from cracking. During an observation and interview on 3/19/24 at 2:20 PM, Licensed Practical Nurse (LPN) #3 revealed she was the nurse for Resident #1. She revealed the resident was a mouth breather and she did not eat or drink by mouth, therefore, she required frequent oral/lip care. She stated the resident had a thick layer of dried and moist secretions on her lips which appeared to have been there a while, and oral care was needed. An observation and interview with the Director of Nursing (DON) on 3/19/24 at 2:40 PM, revealed Resident #1's lips were covered with a layer of secretions and also dry/flaky skin in some areas and oral care was needed. She stated mouth care was to be done every shift and as needed and the facility failed to ensure the resident's oral care was done as needed and this could lead to tender, dry, cracked, bleeding lips. Record review of Resident #1's "Face Sheet" revealed resident was admitted to the facility on 8/5/20. Diagnoses included Spastic Quadriplegic Cerebral Palsy, Convulsions, and Intellectual Disabilities. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/26/24, revealed for oral hygiene, this resident was dependent. Review of the Brief Interview for Mental Status (BIMS) score of 0 indicated the resident was severely cognitively impaired.	F 677	determination for further interventions to assure consistent substantial compliance. Immediate QA meeting held on 3/22/24 with first QA meeting to be held on 4/29/2024.	

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Resident #13

An observation on 3/18/24 at 10:45 AM, of Resident #13 revealed a large amount of thick, white dried substance on his upper and lower lips.

An observation on 3/18/24 at 12:15 PM, of Resident #13 revealed a large amount of thick, white dried substance on his upper and lower lips.

An interview on 3/19/24 at 2:45 PM, CNA #2 revealed he was assigned to the resident today, and when he came in this morning the resident had a large amount of the white substance on his lips and confirmed it was the CNA's responsibility on each shift to make sure Resident #13's oral care is being done.

An interview on 3/19/24 at 2:55 PM, CNA #3 revealed the resident wears a patch behind his ear and she noticed when he doesn't have his patch on the buildup is a lot worse. She confirmed his mouth care is supposed to be done often and if it is built up then it hasn't been done in a while.

An interview on 3/19/24 at 3:05 PM, LPN #1 revealed Resident #13 is Nothing by Mouth (NPO) and wears a scopolamine patch to reduce his oral secretions. She revealed a lot of times his scopolamine patch will come off and doesn't get reported to her. She revealed his mouth gets foamy and has a white substance that dries on his lips, but his oral care is supposed to be done more often because of this.

An interview on 3/19/24 at 3:15 PM, the DON confirmed Resident #13 not having the proper

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oral care is not acceptable. She confirmed it is the responsibility of the aides on each shift to make sure the resident's lips are taken care of and the responsibility of the nurses to ensure the scopolamine patch is on to help reduce his oral secretions.

Record review of the "Face Sheet" revealed Resident #13 was admitted to the facility on 1/24/13 with medical diagnoses that included Unspecified Convulsions, and Hemiplegia.

Review of the facility policy titled "Nail Care" with a revision date of 12/15/2023 revealed under, "Policy Explanation and Compliance Guidelines: ... 4. Routine nail care, to include trimming and filing, will be provided on a regular schedule or as needed. Nail care will be provided between scheduled occasions as the need arises..."

Resident #26

An observation and interview with Resident #26 on 03/18/2024 at 11:16 AM, revealed long fingernails on both hands measuring three-eights (3/8) inch in length. The resident's left fingers were contracted and bent inward toward the palm. She stated she would like to have her nails trimmed, but no one had offered.

An observation and interview with the DON on 3/19/2024 at 2:25 PM, revealed the aides were responsible for cutting the resident's nails during bathing or at any time they noticed the nails required trimming. She confirmed Resident #26's long nails could result in skin injury.

An interview with Registered Nurse (RN) #1 on 3/19/2024 3:45 PM, confirmed she was

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F 677	Continued From page 36	F 677		

responsible for following up and ensuring the resident's ADL care was provided daily.

Record review of Resident #26's "Face Sheet" revealed the facility admitted the resident on 3/30/2022 with medical diagnoses that included Depression and Osteoarthritis.

Resident #216

Review of the facility policy titled "Grooming a Resident's Facial Hair" with a revision date of 12/20/2022 revealed under, "Policy: It is the practice of this facility to assist residents with grooming facial hair to help maintain proper hygiene as per current standards of practice..."

An observation and interview with Resident #216 on 3/18/2024 at 2:25 PM, revealed long, black facial hair (mustache and beard) measuring approximately one-half (1/2) inch in length. The resident stated he would like it shaved, but has been unable to do so due to weakness in his arm.

An interview with LPN #1 on 3/19/2024 at 2:43 PM, confirmed Resident #216 needed shaving. She stated that the aides were responsible for shaving the residents with bathing and as requested.

An interview with the DON on 3/19/2024 at 2:55 PM, revealed she expected the aides shaved the male residents on bath days and as they requested.

Record review of Resident #216's "Face Sheet" revealed the facility admitted the resident on 2/21/2024 with medical diagnoses that included Type 2 Diabetes Mellitus, and Paroxysmal Atrial

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F 677	Continued From page 37 Fibrillation.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. 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 identify and treat a resident with a skin concern for one (1) of 19 residents sampled. Resident #216. Cross Reference F580 Findings Include: Review of facility policy titled, "Resident Rights," with a revision date of 9/22/22 revealed, "The resident has the right to a dignified existence..." Record review of facility policy titled, "Activities of Daily Living (ADLs), dated 12/15/22 revealed, "A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene". On 3/19/2024 at 2:40 PM, an observation and interview with Resident #216, revealed the	F 684	Resident # 216 received a shower with medicated shampoo to treat the skin issue on 3/19/2024. The physician and the resident's representative were notified immediately on 3/19/24. A 100% body audit of all residents was completed on 3/25/24 by the treatment nurse. Discrepant findings were addressed immediately, and all needed actions were completed on 3/26/24. The facility has determined that all residents have the potential to be affected. The Director of Nursing Services educated all licensed staff addressing residents' treatment needs and notification of the resident's physician to receive treatment orders 3/20/2024. The Registered Nurse (RN) Supervisor will conduct an audit of five (5) residents	4/30/24

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F 684	Continued From page 38 resident sitting in a wheelchair with his head laid over a bedside table. An excessive thick layer of white buildup with patchy areas of flaking to the entire scalp (all hair) extended to the ear lobes. The white buildup was also observed in the resident's beard that extended to the front of his neck. The resident stated that it did itch at times. He revealed that the facility was not performing treatment to the areas. On 3/19/2024 at 2:43 PM, observation and interview, with Licensed Practical Nurse (LPN) #1 confirmed Resident #216's skin concern. She revealed she was not aware of the skin issue and stated the resident was not getting any type of treatment that she knew of. Record review of Resident #216's "Physician Orders" revealed there was not a treatment order for his skin concern. Record review of Resident #216's "Departmental Notes" dated 2/21/2024 through 3/11/2024, revealed the resident had dry skin to the BLE (bilateral lower extremities) with no documentation of his skin concern to the scalp and beard. An interview with Registered Nurse (RN) #1 on 3/20/2024 at 1:40 PM, revealed the staff had not reported any skin issues to her for Resident #216. She stated the physician should have been contacted when the issue was first observed. Record review of the "Skin Inspection Report" dated 2/28/2024, 3/11/2024, and 3/18/2024 revealed "Skin Intact" which indicated Resident #216 had no identified skin concern.	F 684	weekly for four (4) consecutive weeks, three residents weekly for two consecutive weeks and one resident weekly for two consecutive weeks starting 4/1/24, for treatment needs and notification to physician and representative of changes with the residents. Findings of this audit will be reviewed by the Administrator and Director of Nurses with any needed corrective actions taken immediately. Audit results will be reviewed and discussed at the monthly Quality Assurance (QA) meeting for three months, for recommendations of further interventions if needed to ensure consistent substantial compliance. Immediate QA meeting held on 3/22/24 with first monthly QA meeting to be held on 4/29/24.	

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F 684	Continued From page 39 On 3/20/2024 at 3:55 PM, an interview with LPN #2 revealed she was the person responsible for completing the last two weeks of skin audits on Resident #216. She revealed she did not find any skin concerns on either of the skin audits that were completed. She stated the resident was lying in bed when she conducted the audits, and she must have overlooked it. On 3/20/2024 at 4:00 PM, an interview with the Director of Nursing (DON) confirmed Resident #216's skin concern should have been caught on the weekly skin audits and stated the physician should have been notified for a treatment. Record review of Resident #216's "Face Sheet" revealed the facility admitted the resident on 2/21/2024 with medical diagnoses that included Chronic systolic (congestive) heart failure, Type 2 diabetes mellitus, Vitamin D deficiency, and Paroxysmal atrial fibrillation.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688		4/30/24

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F 688	Continued From page 40 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to apply a hand roll to a resident with a contracture for one (1) of 17 residents with contractures. Resident #46 Findings Include: Review of the facility policy titled "Splint and Brace Application and Use" undated, revealed under, "Purpose: 1. To assure that residents who have splints or braces prescribed will use them when ordered. 2. To use splints to prevent and/or correct contractures." Record review of Resident #46's "Physician Orders" revealed an order dated 7/04/2023, "Hand roll to Lt (left) hand during waking hours to prevent further contractures ..." Record review of Resident #46's "Treatment Administration Record" (TAR) for the month of March 2024 revealed an order dated 7/04/2023, "Hand roll to Lt (left) hand during waking hours to prevent further contracture as resident will allow" with documented signatures that the hand roll was applied on 3/18 and 3/19. An observation of Resident #46 on 03/18/2024 at 11:14 AM revealed him lying in bed awake. The resident was observed with paralysis to the left arm and contractures to the left fingers, with no device in use.	F 688	Resident # 46 had hand roll splint applied to resident left hand per the Licensed practical nurse (LPN) #1 on 3/20/24. Director of Nursing (DON) observed resident for further contracture on 3/21/24 with no adverse outcomes noted. Occupation therapy screened resident for changes on 3/28/24 with no changes ordered. Facility audit determined that there were four residents with device orders that have the potential to be affected by this practice. Nursing staff were educated on administering treatments/device placement as per the physicians orders and documentation of placement or refusal per resident by the DON beginning 3/20/24. Nurse Supervisor will check devices daily to ensure proper placement of ordered devices beginning 3/20/24. Registered Nurse (RN) will audit treatment administration record (TAR) for completeness daily starting 03/27/24 with device checks daily through 5/31/24. Audit records will be reviewed by the Administrator and DON with corrective actions as needed with staff. Findings will be brought to the monthly QA/Risk	

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F 688	Continued From page 41 An observation of Resident #46 on 3/19/2024 at 1:59 PM revealed him sitting in a wheelchair at the nurse's station with no device in place to the left hand. An interview and observation on 3/19/2024 at 2:10 PM with Licensed Practical Nurse (LPN) #1 confirmed Resident #46 did not have a left hand roll. She revealed the aides were responsible for applying it, and she was responsible for ensuring it was in place. She revealed that the purpose of the hand roll was to prevent further worsening of the contracture and to prevent skin impairment from the contracted fingers. An interview with the Director of Nursing (DON) on 3/19/2024 at 2:30 PM revealed the aides were responsible for applying the hand roll and the order was also on the TAR for the nurses to ensure it was on. She confirmed that not applying the hand roll could result in worsening contractures. Record review of the "Face Sheet" revealed the facility admitted Resident #46 on 4/08/2022 with medical diagnosis that included hemiplegia following cerebral infarction affecting the left nondominant side, type 2 diabetes mellitus, seizures, and depression.	F 688	Management Committee for three months for determination of further interventions to assure consistent substantial compliance. Immediate QA meeting held on 3/22/24 with first monthly QA to be held on 4/29/2024.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;	F 759		4/30/24

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F 759	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the medication error rate was less than five percent for seven (7) of thirty-two medication opportunities. Medication error rate of 21.88% Cross Reference F658 Findings include: Record review of facility letterhead statement signed by the Administrator and dated 3/20/24, revealed "(Proper name of facility) does not have a current policy on giving medications through the PEG (Percutaneous Endoscopic Gastrostomy) tube". Record review of facility policy titled, "Medication Set-up, Administration and Documentation Policy", undated, revealed, "You must have an order to crush medications". On 3/20/24 at 8:45 AM, an observation of Licensed Practical Nurse (LPN) #1 during medication pass for Resident #13's PEG tube medication administration revealed LPN #1 crushed Vitamin C 250 milligrams (MG), Metoprolol Tartrate 25 MG, Vitamin D3 1000 units, Zestril 5 MG, Hydrochlorothiazide 12.5 MG, and Aspirin 81 MG together and placed these into the container with the liquid Keppra medication. She stated she was hesitant to give the medications together since in nursing school she learned to give each one separately, but at the facility she was instructed to administer them together, so that was what she was going to do. She entered the resident's room and once again	F 759	Licensed Practical Nurse (LPN) # 1 was immediately in-serviced on following care plan and physicians order of giving resident medication by the Director of Nursing. Residents' physician was notified of medications being given together on 3/20/24. LPN #1 was given one on one education and check off on 3/26/24 with check offs on all licensed nurses beginning 3/25/24. DON assessed resident #13 with no adverse outcomes identified. The facility has determined that all residents with feeding tubes have the potential to be affected. All licensed nursing staff will be educated on medication administration via the PEG (percutaneous endoscopic gastrostomy) tube which includes observation of each nurse performing the procedure. A Validation Checklist will be completed for each nurse to determine if the nurse was performing the procedure correctly. Findings will be reviewed with each nurse beginning 3/25/2024. Corrective action will be provided as needed. A new PEG Tube policy was put in place 3/29/24. The Director of Nursing (DON) or Staff Development Coordinator will complete Validation Checklists of nurses performing feeding tube procedures for three residents per week for six (6) consecutive weeks starting 4/1/24, to ensure nurses are performing the procedure in	

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F 759	Continued From page 43 questioned this technique and went back to the medication cart to verify the order and stated there was an order to administer these together. She then returned to room, checked residual, pushed 15 milliliters of water, next pushed the seven combined medications, then flushed with 15 milliliters of water. On 3/20/24 at 9:50 AM, during an interview with the Director of Nursing (DON) , confirmed that Resident #13 did not have a physician order to crush and administer the PEG medications together. She confirmed that LPN #1 did not follow the physician order for the PEG medications to give individually with a flush between each to ensure compatibility. The DON confirmed that this would be considered a medication error when the medications are all combined together in a PEG tube. On 3/21/24 at 10:50 AM, during an interview LPN #1 revealed she had misread the order that actually read that medications could be crushed and given together if taken by mouth, but had to be given individually by PEG tube. She confirmed the purpose of administering medications separately was to ensure the medications were compatible. Record review of Resident #13's "Physician Orders List" revealed an order dated 1/21/22, "May administer crushed medications that are being given PO (by mouth) together. PEG tube meds must be given individual". Record review also revealed orders for Hydrochlorothiazide 12.5 mg per g-tube (gastrostomy tube), Aspirin 81 mg per PEG, Zestril 5 mg tablet per g-tube, Vitamin D3 1000 unit per g-tube, Vitamin C 250 mg per PEG, Metoprolol Tartrate 25 mg per g-tube, and	F 759	accordance with our facility's policy, the resident's physician order and care plan. Validation Checklists will be reviewed by the Administrator and DON to ensure corrective actions are taken if needed. Results of validation checklist will be brought to the Risk Management/Quality Assurance (QA) Committee for three months, committee will approve or make recommendations for further interventions to ensure consistent substantial compliance. Immediate QA meeting held on 3/22/24 with first QA meeting to be held on 4/29/2024.	

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F 759	Continued From page 44 Keppra 100 milligram/milliliter(ml) 7.5 ml per PEG. Record review of Resident #13's "Face Sheet" revealed the resident was admitted to the facility on 1/24/13 with medical diagnoses that included Convulsions, Gastrostomy status, Dysphagia, and Hypertension. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/23/24 revealed a Brief Interview for Mental Status (BIMS) score of 0 which indicated the resident had severe cognitive impairment.	F 759		
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	F 761		4/30/24

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	255306	A. BUILDING _____ B. WING _____	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRACE EXTENDED CARE & REHABILITATION	1000 EAST MADISON STREET HOUSTON, MS 38851

(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 761	Continued From page 45 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure proper medication storage as evidenced by leaving keys for the medication cart, medication room, and controlled medication locked box unattended on the medication cart in the resident hallway for one (1) of four (4) survey days. Findings include: Record review of facility's letterhead statement signed by the Administrator and dated 3/21/24, revealed, "(Proper name of facility) does not have a policy on medication storage". An observation on 03/21/24 at 10:20 AM, revealed an unattended medication cart on the south hall with a set of keys laying on top of the cart. Licensed Practical Nurse (LPN) #1 was observed in a resident's room and was not visible from the cart. After approximately four minutes, LPN #1 returned to the cart. When asked about the keys on top of the cart LPN #1 stated those were the keys to the medication cart, locked narcotic box, and medication room. She stated leaving the keys unattended was not acceptable and was a risk since "anybody that wanted to get them could have, and medications need to be out of reach". She stated any resident, visitor, or staff could have obtained these since they were left unattended on top of the cart in a resident hallway.	F 761	Licensed Practical Nurse (LPN)# 1 retrieved her cart keys immediately on 3/21/24 and was immediately educated by Director of Nursing (DON) on 3/21/24. There were no missing items from the cart. The facility has determined that all residents receiving medications have the potential to be affected. An in-service education program was conducted by the Staff Development Nurse with all staff nurses beginning on 3/25/2024 addressing the facility policy regarding the proper storage of medications. Medication Storage policy put into place on 3/29/24. DON will monitor all medication carts daily for three weeks, three times per week for three weeks, two times per week for two weeks and one time a week for one week starting 3/25/24, to ensure carts are locked and nurses have keys. Findings of this audit will be discussed with the Administrator and corrective actions taken immediately. Results of audit will be presented at the monthly quality assurance (QA) meeting for three months. QA Committee will review for determination of further interventions to ensure consistent substantial compliance.	

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F 761	Continued From page 46 During an interview on 3/21/24 at 10:25 AM, the Director of Nursing (DON) confirmed that by leaving the keys on a cart in an open hallway, the facility failed to ensure proper storage of medication. She stated this could have allowed an unauthorized person to have access to the medications and controlled medications. She stated the facility had no policy for medication storage.	F 761	Immediate QA meeting held on 3/22/24 with first monthly QA meeting to be held on 4/29/2024	
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 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:	F 880		4/30/24

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F 880	Continued From page 47 (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 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:	F 880		

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F 880	Continued From page 48 Based on observation, staff interview, and facility policy review, the facility failed to decrease the likelihood of the spread of infection as evidenced by a nurse dropping a glove on the floor in a resident's room, retrieving it off the floor, putting it on, and continuing with medication pass and insulin administration for one (1) of four (4) resident medication administrations observed. Findings include: Record review of facility policy titled, "Infection Prevention and Control Program", dated 5/15/23, revealed, "This facility has established and maintains 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 as per accepted national standards and guidelines." The policy also revealed, "4. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures. c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. d. Licensed staff shall adhere to safe injection and medication administration practices." During an observation of medication pass on 3/20/24 at 8:20 AM, Licensed Practical Nurse (LPN) #1 prepared Resident #3's medications for administration. The medications consisted of 12 by mouth medications, one topical ointment, and one subcutaneous insulin injection. While in resident's room, LPN #1 washed her hands and preceded to put on her gloves, but one glove dropped one on the floor. She picked this glove up and placed it on her hand and began to	F 880	1.Licensed Practical Nurse (LPN) #1 was educated on proper infection control procedures during medication administration on 3/20/24 per the Infection Preventionist and Director of Nursing (DON). DON observed resident #3, for adverse outcomes beginning 3/20/24 with none noted. 2.The facility has determined that all residents have the potential to be affected by this practice. 3.All staff were educated on the facility's policy on hand hygiene and infection control procedures when donning/doffing and wearing of gloves and incidence of dropping items on the floor contaminating them by the Infection Preventionist and Director of Nursing beginning 3/25/2024. 4.Infection Preventionist will do infection control rounds three times per week for four weeks, two times a week for four weeks and one time a week for two weeks starting 03/27/24. Audit records with be reviewed by the Administrator and DON with corrective actions with staff as needed, findings will be presented to the Quality Assurance (QA)/Risk Management Committee for three months for any recommendations for further interventions to assure consistent substantial compliance. Immediate QA meeting was held on 3/22/24 with first monthly QA meeting	

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F 880	Continued From page 49 prepare for the medication administration by opening the alcohol prep for the insulin injection. After administration was completed the nurse stated "I shouldn't have put it on. I should have washed my hands and started with new gloves for the meds." She stated this could spread infections especially since one medication was an injection. An interview with the Director of Nursing (DON) on 3/20/24 at 9:50 AM, revealed proper infection control techniques were not used when a glove that had been on the floor was picked up and put on by a nurse for resident care. She confirmed the facility failed to prevent the likelihood of the spread of infection and the nurse should have washed her hands and applied new gloves for the resident's medication administration. Record review of Resident #3's "Face Sheet" revealed the resident was admitted to the facility on 3/11/22. Diagnoses included Type 2 diabetes mellitus, Chronic Obstructive Pulmonary Disease, Epilepsy, Hypertension, and Schizophrenia.	F 880	scheduled for 4/29/2024.	