STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A174	A. BUILDING _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YALOBUSHA COUNTY NURSING HOME	630 SOUTH MAIN STREET WATER VALLEY, MS 38965

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey along with a complaint investigation (CI), MS #24428 at the facility from 3/4/24 through 3/7/24. During the survey the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA determined the facility was not in compliance related to CI MS #24428 for failure to report an allegation of abuse and cited F609. The SA also cited F550, F578, F584, F644, F656, F688, and F847 during the survey. The census at the time of the survey was 87 with a bed capacity of 122 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		4/18/24

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

Electronically Signed | 03/21/2024

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review and facility policy review, the facility failed to allow a resident to exercise his right to take a shower as evidenced by the resident not being offered a shower for one (1) of 24 residents reviewed during survey. Resident #61. Findings Include. A review of the facility policy titled "Resident's Rights" with no revision date revealed "Each and every resident has the right to ...9. Receive adequate and appropriate health care and protective support services..." An interview on 03/04/24 at 2:22 PM, with Resident #61 revealed that he gets a bed bath automatically without being asked about a shower	F 550	"Resident #61 was given a shower on March 5, 2024, by a certified nurse aide. A 100% audit of all residents was conducted by the Director of Nursing to ensure bathing preferences were being honored. All preferences voiced were documented. No other resident bathing preferences were found not to be honored. "All residents receiving assistance with bathing in the facility have the potential to be affected. "A 100% audit of all residents was conducted by the Director of Nursing to ensure bathing preferences are being honored on March 13, 2024. Bathing preferences will be obtained on admission by the admitting Registered Nurse. Bathing preferences will be added to the	

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F 550	Continued From page 2 and that he would love to have a shower and have water running on him. The resident revealed that he can't remember the last time he has had a shower. The resident revealed that he has asked for a shower before and was told that they don't have a chair to get him in there. An interview on 03/05/24 at 10:38 AM, with Certified Nursing Assistant (CNA) #1 revealed that the resident has the right to get a shower and should have been offered a shower An interview on 03/05/24 at 10:53 AM, Licensed Practical Nurse (LPN) #1, confirmed Resident #61 had not been given a shower by the staff because they did not get the shower chair to take him to the shower. LPN #1 revealed that the facility does have a shower chair that will accommodate Resident #61 and that it is located on the other wing of the facility. LPN #1 went to the other wing and obtained the shower chair and brought it to the south wing of the facility where Resident #61 is located. LPN #1 confirmed that the resident is requesting to receive a shower and that he should have been offered a shower. LPN #1 revealed that the staff should have gone and found the chair or asked where it was. An interview on 03/05/24 at 11:06 AM, with the Administrator confirmed that the residents should be offered a shower during their bath time. An interview on 03/07/24 at 11:30 AM, with the Director of Nursing (DON) confirmed that Resident #61 should have been offered a shower and that he absolutely had the right to be offered a shower. A record review of Resident #61's documented	F 550	nurse aide care guide and will be reviewed quarterly and as needed. All staff were in serviced beginning on March 13, 2024 by staff education nurse on Resident□s Rights and honoring resident preferences. The Registered Nurse supervisor on day shift shall monitor all baths scheduled are performed per preference for the shift each day for four weeks then twice weekly for four weeks beginning March 13,2024. The licensed practical nurse supervisor on evening shift shall monitor all baths are performed per preference for the shift each day for four weeks beginning March 13,2024. "The Director of Nursing shall monitor bathing preference/bathing audits for accuracy twice weekly for four weeks then once weekly for four weeks beginning on March 13,2024. Any discrepancies with bathing preferences not being honored shall result in disciplinary action. The Director of Nursing shall bring assigned audits to the Quality Assurance Meeting on April, 10, 2024 and monthly for two months then quarterly and as needed.	

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F 550	Continued From page 3 baths for the past two weeks revealed he received complete bed baths and did not receive a shower or tub bath. A review of the facility "Face Sheet" for Resident #61 revealed that he was admitted to the facility on 8/03/21 with medical diagnoses that included Quadriplegia. A review of Resident #61's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/23/24 revealed in section C a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #61 was cognitively intact.	F 550		
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	F 578		4/18/24

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F 578	Continued From page 4 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 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 resident and staff interview, record review and facility policy review, the facility failed to ensure the residents code status on the advance directive matched the residents code status order on one (1) of 24 residents advanced directives reviewed. Resident #17. Findings include: A review of the facility policy titled "(Proper Name of Facility) Advanced Directive Policy ", with no revision date, revealed, "Purpose: To respect the resident's right to determine the course of treatment; to provide at the time of admission written information on rights under state law to make decisions regarding medical care, including the right to accept or refuse treatment and the right to formulate advance directives; to	F 578	•Resident # 17's advance directive was updated in American HealthTech work center portion of the electronic medical record by the Director of Nursing on March 4, 2024. Resident #17's face sheet and electronic physician orders were reviewed on March 4, 2024, by the Director of Nursing and indicated the correct code status. •All residents in the facility have the potential to be affected. •A 100% audit of all code status forms and electronic records was conducted on March 4, 2024, by the medical records nurse to ensure accuracy of electronic record. Nursing staff were in serviced on advance directives on March 11,2024 by the staff education nurse.	

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F 578	Continued From page 5 implement the requirements of the Patient Self-Determination Act; and to educate the public and staff regarding advance directives ..." A record review of Resident #17's Advance Directive in the electronic record revealed the resident's code status was Do Not Resuscitate (DNR). A record review of Resident #17's Physician's Order List revealed an order dated 07/16/21 for the residents' code status to be a Full Code. An interview on 03/04/24 at 4:50 PM, with Registered Nurse (RN) #1 confirmed that Resident #17 has an electronic Advanced Directive for a DNR and that his physicians' orders indicate the resident is a full code. RN #1 revealed that this could cause a mix up and a delay in performing Cardiopulmonary Resuscitation (CPR) on a resident. RN #1 confirmed that on 07/14/21 that Resident #17 was changed from a DNR to a full code, but the electronic Advance Directive was not updated and that it should have been updated when the order was changed. An interview on 03/05/24 at 9:15 AM, with Resident #17 confirmed that he wants to be a full code. An interview on 03/05/24 at 11:06 AM, with the Administrator confirmed that Resident #17's electronic Advanced Directive did not match the physician's orders and that it should have been updated when the order changed. The Administrator stated, "it could have been bad and caused someone to receive or not receive CPR that should have".	F 578	•All new admissions to the facility and any resident that requests a change in advance directive shall be audited by the Director of Nursing to ensure requested code status' are reflected accurately in the electronic record starting March 13, 2024 and weekly for eight weeks. The Director of Nursing shall bring assigned audits to the Quality Assurance Meeting on April 10, 2024 and monthly for two months then quarterly as needed.	

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F 578	Continued From page 6 A review of the facility "Face Sheet" for Resident #17 revealed that he admitted to the facility on 07/14/21 with medical diagnoses that included Parkinsonism, Muscle Weakness, Dysphagia and Chronic Obstructive Pulmonary Disease. A record review of Resident #17's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/8/24 revealed in section C, a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #17 was cognitively intact.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		4/18/24

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F 584	Continued From page 7 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review the facility failed to provide a safe, clean environment, as evidenced by a dirty wheelchair with torn armrest for Resident #10 and dirty privacy curtains for room numbers 118 and 120 for three (3) of four (4) survey days. Findings include: Record review of facility policy titled "Equipment Needs and Maintenance" undated, revealed, "The equipment shall be kept and maintained in good repair and optimal level of cleanliness. ... Equipment shall be monitored for cleanliness and good repair. Wheelchairs shall be cleaned on the night shift per the wheelchair washing schedule." Record review of facility policy titled, "Resident Room Deep Cleaning" undated, revealed "The deep cleaning shall include ensuring the privacy	F 584	"Resident #10 wheelchair was cleaned by the Registered nurse supervisor on March 5, 2024. Privacy curtains in rooms 120A and 118A were removed and washed on March 5, 2024. "All residents that require the use of appliances and privacy curtains have the potential to be affected. "A 100% audit of all privacy curtains was conducted on March 5, 2024, by the Housekeeping Director. 100% audit of all wheelchairs was conducted on March 5, 2024, by the Restorative Nurse. A 100% audit of all wheelchairs for cleanliness shall be conducted three times a week starting March 13, 2024 by the Registered Nurse supervisor, Licensed Practical Nurse supervisor three times a week for four weeks. A 100% audit of all privacy curtains shall be conducted three times	

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F 584	Continued From page 8 curtains are maintained clean and in good repair..." Resident #10 An observation on 03/04/24 at 10:42 AM, revealed Resident #10 sitting in a wheelchair that had a brown and gray substance on the frame and the spokes of the wheels. The vinyl on the bilateral armrest was tattered and torn with jagged edges exposed. An observation on 03/05/24 at 8:55 AM, revealed Resident #10's wheelchair remained with a substance on the frame and spokes of the wheels and the bilateral armrest was torn with jagged edges exposed. An interview and observation on 03/05/24 at 10:45 AM, with Licensed Practical Nurse (LPN) #4 revealed the Certified Nursing Assistants (CNA)s on the night shift are responsible for cleaning the wheelchairs and any staff member can let maintenance know about the tattered armrest. She confirmed that the armrests were tattered and needed to be replaced and revealed Resident #10 could get a skin tear from these armrests. She stated, "The wheelchair is dirty, and I will make sure this gets taken care of. " An observation on 03/05/24 at 1:45 PM, Resident #10's wheelchair remained with a brown and gray substance on the frame and spokes of the wheels. An interview and observation on 03/06/24 at 9:25 AM, the Director of Nurses (DON) revealed it was the responsibility of the CNAs to make sure that the wheelchairs were cleaned. She confirmed	F 584	weekly for four weeks by the Registered Nurse Supervisor and Licensed Practical Nurse Supervisor. All Housekeeping staff were in serviced on the deep cleaning schedule and routine for unclean privacy curtains by the Educational Nurse on March 19, 2024. All nursing staff were in serviced on the Equipment cleaning policy and wheelchair cleaning schedule by the Educational Nurse on March 13, 2024. "The Director of Nursing shall monitor the audits of the wheelchairs and privacy curtains twice weekly for 4 weeks, then once weekly for 4 weeks, starting March 13, 2024. Any wheelchair or curtain to be found unclean shall be cleaned immediately. The Director of Nursing shall present the audit findings in the Quality Assurance Meeting on April 10, 2024, monthly for two months then quarterly and as needed.	

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F 584	Continued From page 9	F 584		

that Resident #10's wheelchair was dirty and needed to be cleaned.

A record review of Resident #10's Face Sheet revealed the resident was admitted to the facility on 5/06/19 with diagnoses that included Adult Failure to thrive, Acute Embolism and Thrombosis of peroneal vein, bilateral, Acute upper respiratory infection, and Low back pain.

A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/29/2023 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #10 was cognitively intact.

Rooms S 118 and S 120

An observation on 03/04/24 at 2:32 PM, of resident room S 120 A privacy curtains revealed a brown substance on the bottom half of the curtain that measured approximately one (1) foot in length and approximately two (2) inches wide.

An observation on 03/04/24 at 2:45 PM, of resident room S 118 A privacy curtain revealed there were two brown splattered areas on the bottom half of the curtain measuring approximately four inches in length and 12 inches wide.

An interview/observation on 03/05/24 at 10:38 AM, with Certified Nursing Assistant (CNA) #1 confirmed that there is a brown substance on the bottom half of resident room S 120 A privacy curtain and a brown splattered area on the bottom half of resident room S 118 A privacy curtain. CNA #1 stated "the curtain is dirty and needs to be cleaned. CNA #1 revealed that staff

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F 584	Continued From page 10 is supposed to tell housekeeping when they see a problem. An interview on 03/05/24 at 11:06 AM, with the Administrator confirmed that having a dirty privacy curtain did not provide the residents with a clean, comfortable, homelike environment. The Administrator revealed that they make environmental rounds weekly to identify any issues and get them corrected. The Administrator stated, "Housekeeping has a deep cleaning schedule as well to clean the room completely including the privacy curtains". An interview on 03/05/24 at 12:30 PM, with Housekeeping Supervisor confirmed that they have a deep cleaning schedule for all rooms that housekeeping staff follows and that the dirty curtains should have been found. She confirmed that this keeps the rooms clean and looking nice for the residents and visitors.	F 584		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.	F 644		4/18/24

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F 644	Continued From page 11 §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to incorporate a Preadmission Screening and Resident Review (PASARR) recommendation for specialized mental health services for a resident admitted with a mental illness for one (1) of four (4) residents reviewed for PASARR. Resident #73 Findings Include: Review of the facility's undated policy titled "PASSAR [Preadmission Screening and Resident Review] and Resident Status Changes Policy" revealed, "The facility shall complete the pre-admission screening and resident review upon admission to the facility. The facility shall maintain these records within the resident chart at all times. The facility shall proceed with PASARR [Preadmission Screening and Resident Review] level II [two] screenings as indicated in the initial assessment. The results of the PASARR [Preadmission Screening and Resident Review] level II [two] screenings shall be incorporated in the resident's care planning process to provide optimal care for the resident." Record review of the "Face Sheet" revealed the facility admitted Resident #73 on 4/11/2023 with medical diagnoses that included Bipolar Disorder. Record review of the PASRR evaluation determination for Resident #73 and dated	F 644	"Resident # 73 was seen by the Psychiatric Nurse Practitioner on March 5, 2024, for review and medication management. "All residents that require a PASARR level II resulting in recommendations have the potential to be affected. "A 100% audit of all residents with a PASARR level II with recommendations was conducted by the Social Worker on March 12, 2024. All the residents found to have recommendations were being followed by the Psychiatric Nurse Practitioner. Staff have received an in-service on the PASARR policy on March 12,2024 by the Administrator. "The Social Worker shall report to the Director of Nursing any new admissions that require a PASARR level II with recommendations or any new status changes that result in recommendations starting March 13, 2024. The Social Worker shall keep a log of residents that have PASARR recommendations and report to the Director of Nursing starting March 13, 2024. The Director of Nursing shall audit these residents monthly starting March 14, 2024 to ensure the Psychiatric Nurse practitioner follows the residents with recommendations. The Director of Nursing shall coordinate with the Psychiatric Nurse Practitioner the	

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F 644	Continued From page 12 4/21/2023 revealed under, "Summary of Findings Report ... The individual meets criteria for having a diagnosis of mental illness as defined by PASRR... Resident #73 meets PASRR inclusion criteria with the diagnosis of Bipolar Disorder... Resident #73 will benefit from specialized services of: Medication Evaluation and Monitoring by a psychiatrist to evaluate response to psychotropic (affecting the mind) medications and modify orders, for continues stability of her mental illness..." Record review of Resident #73's Electronic Medical Record (EMR) revealed the resident had not been evaluated by psychiatry services (mental health) since admission to the facility. Record review of Resident #73's "MD (Medical Doctor) Conference" note dated 8/7/2023 revealed under, Pertinent Resident Information: RP (Responsible Party) #1 voicing concern she noticed resident having increased confusion, increase in paranoia, and noted resident rummages thru (through) her stuff and pulls everything out of drawers in her room when up in her w/c (wheelchair). RP #1 wants meds (medications) adjusted she says res (resident) thinks people are talking to her thru (through) the intercom." Also revealed under, "New Orders: Reviewed medication list. I could not recommend stopping any meds @ (at) this time but to add Seroquel 25 mg (milligrams) q (every) hs (hour sleep) to help w/ (with) the paranoia and auditory hallucinations. Record review of Resident #73's "Departmental Notes" revealed the following entries: 1/17/2024, "RP (Responsible Party) #1 called	F 644	need for these residents to be followed by services per recommendations and audit appropriate visits monthly for two months starting March 14, 2024. The Director of Nursing shall present the audits to the Quality Assurance Meeting on April 10, 2024, monthly for two months then quarterly and as needed.	

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F 644	Continued From page 13	F 644		

facility & (and) reported that resident keeps calling her via cell phone multiple times at night anxious, in a panic, having sun downers, confused, & (and) having anxiety. RP #1 says she wants her meds adjusted to help calm her at night. MD (Medical Doctor) conference sheet done."

1/25/2024, "(Proper Name of Physician) visited facility and accessed resident. N.O. (new order) received to increase Seroquel to 50 mg (milligrams) one p.o. (by mouth) Q (every) HS (hour sleep)."

Record review of the "Physician Orders List" for Resident #73 revealed the following orders: 10/17/2023, "Trintellix 10 MG tablet: Give one (1) tablet by mouth daily Dx (diagnosis) Bipolar".

1/25/2024, "Seroquel 50 MG tablet take one (1) by mouth at bedtime Dx: Psychosis".

An interview with the Director of Nursing (DON) on 3/05/2024 at 2:20 PM, confirmed Resident #73 had not been seen by mental health services since admission to the facility. She revealed the facility had a Psychiatric Nurse Practitioner (NP) that came to the facility and explained she was unsure how the resident was overlooked.

An interview with the Administrator (ADM) on 3/6/2024 at 9:20 AM, revealed the Psychiatric NP received a copy of the residents admitted to the facility on psychotropic (affecting the mind) medications and a diagnosis list so that he knew which residents he needed to see. She revealed he missed Resident #73, although he was given a list with her name on it. She confirmed that the resident should have received mental health

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F 644	Continued From page 14 services to ensure her mental health remained stable.	F 644		
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	F 656		4/18/24

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F 656	Continued From page 15 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review and facility policy review the facility failed to implement a care plan for a physician ordered brace for one (1) of 24 residents care plans reviewed. Resident #26 Findings Include: A review of the facility policy titled "Care Plan Policy ", with no revision date, revealed. "Purpose: To ensure the facility establishes a guide to resident care to promote the physical and psychological well-being of residents newly admitted and long-term residents residing within the facility...". Record review of the "Care Plan" with a problem on set date of 6/19/19 revealed " ...requires maintenance of ADL (Activities of Daily Living) functions with risk for decline ...Approaches ...Brace to left upper extremity to be donned in AM (morning) upon awakening and removed before going to bed in PM (evening). An observation and interview on 03/04/24 at 02:49 PM, revealed Resident #26 sitting up in his	F 656	•Resident # 26 splint was applied to the resident on March 6, 2024, by the Licensed Practical nurse. •All residents requiring the application of a splint as indicated on the care plan have the potential to be affected. •A 100% audit was conducted on March 6, 2024, by the Director of Nursing that all splints as indicated on the care plan were in use. A staff in-service was conducted by the Nurse Educator on Implementation of Care Plans and splint application on March 12, 2024. •The Registered Nurse supervisor shall monitor splint application on all residents that require a splint daily for four weeks then weekly for four weeks, starting March 13, 2024. Any non-compliance found in the audits is subject to disciplinary action. The Director of Nursing shall bring the audit findings to the Quality Assurance meeting on April 10, 2024, monthly for two months, then quarterly and as needed.	

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wheelchair. Resident #26's left arm was hanging down to the inside of the wheelchair. The resident stated, " I have a brace for my arm over in the chair in the corner and that therapy will put it on me when I ask for it, but nobody else knows how to apply it".

During an observation and interview on 03/06/24 at 8:57 AM, with Licensed Practical Nurse (LPN) #2 confirmed that the resident does not have a brace on his left arm and that he has a care plan for a brace donned in AM upon awakening and removed before going to bed. LPN #2 confirmed that she was the nurse caring for Resident #26 yesterday and today and did not apply the resident's brace. LPN #2 confirmed that the purpose of the care plan is to guide the resident's care. LPN #2 confirmed that she is aware of how to apply the resident's brace.

An interview on 03/07/24 at 11:22 AM, LPN #3 confirmed that if a resident has an order for a brace and has a care plan for a brace but does not have the brace on that the care plan is not being followed. LPN #3 stated, "the purpose of the care plan is to direct the resident's care".

During an interview on 03/07/24 at 11:00 AM, with the Director of Nursing (DON) confirmed that the purpose of the care plan is to guide the residents care. The DON confirmed that if Resident #26 had a care plan for a brace to his left arm and wasn't wearing it that the care plan is not being followed.

A review of the facility "Face Sheet" for Resident #26 revealed that he was admitted to the facility on 06/19/17 with a medical diagnoses that included Stiffness of left shoulder and Stiffness of

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F 656	Continued From page 17 left elbow. A review of Resident #26's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/30/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #26 was cognitively intact.	F 656		
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 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, resident and staff interview, record review and facility policy review, the facility failed to apply a physician ordered brace for one (1) of six (6) residents sampled for range of motion. Resident #26. Findings include:	F 688	•Resident # 26 splint was applied to the resident on March 6, 2024, by the Licensed Practical Nurse. •All residents requiring splint placement to prevent a decrease in range of motion have the potential to be affected. •100% audit of all residents requiring	4/18/24

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F 688	Continued From page 18 A review of the facility policy titled "Range of Motion" with no revision date, revealed: ... "The facility shall assist the resident to maintain the highest level of functional ability and range of motion. ... Devices shall be donned and doffed as ordered by the physician. The use of the devices shall be documented in the residents' medical records and shall be reflected on the resident's care plan". During an observation and interview on 03/04/24 at 02:49 PM, of Resident #26 revealed the resident sitting up in his wheelchair. The residents' left arm was hanging down to the inside of the wheelchair. The resident stated, " I have a brace for my arm over in the chair in the corner. Therapy will put it on me when I ask for it, but nobody else knows how to apply it". Record review revealed that the Physician Orders List revealed an order dated 01/24/19 "Brace to the left upper extremity to be donned in AM (morning) upon awakening and removed before going to bed in PM (evening)." An observation on 03/05/24 at 9:20 AM, revealed Resident #26 up in his wheelchair with no brace noted to his left arm. An interview and observation on 03/06/24 at 8:57 AM, with Resident #26 and Licensed Practical Nurse (LPN) #2 revealed Resident #26 was sitting up in his wheelchair with no brace noted to his left arm. Resident #26 confirmed that he has not had his brace applied in several days. LPN #2 confirmed that Resident #26 does not have a brace on his left arm and that his order is to have the brace donned in AM upon awakening and	F 688	devices to aid in the prevention of a decrease in range of motion for splint placement was conducted on March 6, 2024, by the Director of Nursing. All nursing staff shall be in-serviced on range of motion and splint application on March 12,2024 by the Educational Nurse. •A 100% audit of all residents requiring splint placement shall be conducted by the Registered Nurse Supervisor or Licensed Practical Nurse supervisor daily for two weeks, then twice weekly for two weeks, then once weekly for 4 weeks, starting March 13, 2024. The Director of Nursing shall present the findings of the audit at the Quality Assurance Meeting April 10, 2024, monthly for two months, then quarterly and as needed.	

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removed before going to bed. LPN #2 confirmed that she was the nurse caring for Resident # 26 today and yesterday and did not apply the resident's brace. LPN #2 confirmed that the purpose of the brace is to prevent the residents' hand from becoming more contracted and that without wearing it his contractures would get worse. LPN #2 confirmed that she is aware of how to apply the resident's brace and she should have applied it.

An interview on 03/06/24 at 9:37 AM, with the Occupational Therapist (OT) confirmed that Resident #26 should have a brace on his left arm/wrist to prevent further contracture on the left hand. OT confirmed that therapy has shown the nursing staff how to put the brace on the resident and they all know he is supposed to have it every day.

An interview and observation on 03/06/24 at 9:55 AM, with the Director of Nursing (DON) confirmed that the purpose of Resident #26's brace was to prevent further contractures to his left hand. The DON confirmed that the resident did not have his brace on and that he was supposed to have it on daily.

A review of the facility "Face Sheet" for Resident #26 revealed that he was admitted to the facility on 06/19/17 with a diagnoses of Stiffness of left shoulder and Stiffness of left elbow.

A review of Resident #26's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/30/24 revealed in section C a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #26 was cognitively intact. Section O indicated "Splint or brace

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F 688	Continued From page 20 assistance number of days coded as zero (0)."	F 688		
F 847 SS=D	Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement	F 847		4/18/24

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F 847	Continued From page 21 for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to include the required components in the arbitration agreement for three (3) of 3 arbitration agreements reviewed. Findings include: Record review of facility letterhead notice dated 3/7/24, and signed by the Administrator revealed, "[Proper name of facility] does not have a policy on Arbitration Agreements". During an interview on 3/7/24 at 9:20 AM, the Administrator revealed during the entrance conference, the facility did not offer arbitration agreements and she was unaware that the facility's admission packet contained an arbitration agreement. The Administrator confirmed the facility failed to include required components into the arbitration agreement which included that signing the arbitration agreement was not a requirement for admission to the facility, that the resident or representative had the right to rescind the agreement within 30 calendar	F 847	"The facility Arbitration Agreement was reviewed and updated with required components by the Administrator on March 13, 2024. "All residents entering into an Arbitration Agreement have the potential to be affected. "Staff presenting Arbitration Agreements were in-serviced by the Administrator on the updated Arbitration Agreement with required components on March 13,2024. "The Administrator shall audit Arbitration Agreements once every four weeks for eight weeks starting March 13, 2024. The Administrator shall present the changes made to the Arbitration Agreement to the Quality Assurance meeting on April 10, 2024, monthly for two months then quarterly and as needed.	

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F 847	Continued From page 22 days of signing, and the right for the resident or representative to communicate with federal and state officials including the Ombudsman. Record review of the admission packet with the arbitration agreement revealed, "The provisions contained in this admission agreement are completely goverened by the Federal Arbitration Act (FAA). I enter into the Arbitration Agreement freely and voluntarily and therefore knowingly and intelligently agree to arbitrate any and all claims that may arise as a result of my residing at the [proper name of facility]."	F 847		