STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255095	A. BUILDING _____ B. WING _____	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF LAUREL	935 WEST DR LAUREL, MS 39440

(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 3/19/24 through 3/21/24. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550, F584, F656, F677, F690, F693, and F700. The census was 92 and the facility had a license for 105 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 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		4/23/24

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

Electronically Signed | 04/02/2024

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review the facility failed to promote the dignity of residents by requiring the residents to use a bedside commode (BSC) in their room instead of a designated restroom when toileting for two (2) of (19) sampled residents. (Resident #29 and Resident #51) Findings Include: Review of the facility's policy, " Dignity and Respect", revised 7/22, revealed, "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 ...The facility shall protect and promote the rights of the resident ...2. Each resident of the facility has the right to a dignified existence ..." Review of the facility's "Resident Rights Policy", revised 12/23, revealed, "Every resident in this	F 550	1) Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 03/22/2024 and based on findings the facility failed to promote the dignity of residents by requiring the residents to use a bedside commode in their room instead of a designated restroom for toileting for Resident #29 and Resident #51, and staff not notifying the Administrator and/or Maintenance Director of a toilet not functioning properly. The toilet for Resident #29 and Resident #51 was replaced on 03/21/2024 by the Maintenance Director to promote dignity of residents in their room by having a toilet to function properly. Resident #29 and Resident #51 was assessed on 03/22/2024 by the Director of Nurses (DON) to ensure no adverse effects to each resident related to failing to promote dignity of resident by requiring the residents to use a bedside commode in	

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F 550	Continued From page 2 facility has the right to ...12. Be treated ...with the fullest measure of dignity...17. Be treated with consideration and respect for their personal privacy including but not limited to toileting ..." During an observation and interview on 3/19/24 at 11:00 AM, with Resident #29 and Resident #51, the residents revealed the toilet in their bathroom did not work. Resident #29 stated the sewage backed up and had overflow issues, so they had been instructed by the facility to use BSCs provided by the facility. The toilet had been in disrepair since January of this year (2024) and both residents expressed they did not feel comfortable using the BSCs because of the odors and the lack of privacy. The staff made sure the curtains were pulled for privacy, but they had to call staff to empty the BSCs after each use. There were two BSCs noted in the residents' room. One BSC was located on each side of the room. During an interview on 3/19/24 at 11:15 AM, with Certified Nursing Aide (CNA) #7, she confirmed the toilet had not worked properly in Resident #29 and Resident #51's bathroom since January 2024. CNA #7 stated the residents used the BSCs that were lined with a clear bag and after use of the BSC, the CNAs removed and disposed of the bags. In an interview on 3/20/24 at 11:00 AM, with the Maintenance Director, he explained that he had installed a new toilet in Resident #29 and Resident #51's room about a week and a half ago and he was unaware the residents were still having problems with the toilet. The Maintenance Director stated that no one had completed a maintenance form indicating the toilet needed to	F 550	their room instead of a designated restroom for toileting. Resident #29□s bedside commode was removed from the room by the Maintenance Director on 03/22/2024. Resident #51 did choose to keep her bedside commode even though the toilet is in working order, and the care plan was revised. 2) Residents□ requiring the use of a toilet that functions properly have the potential to be affected by this deficient practice. 3) On 03/22/2024, an audit was conducted by the Administrator and Maintenance Director to ensure residents□ toilets functions properly. On 03/22/2024, the Maintenance Director was educated by the Administrator on ensuring toilets function properly. Beginning on 03/28/2024, the licensed nurses, CNAs, and housekeeping staff were educated by the DON and/or Staffing Nurse on ensuring residents□ toilets functions properly and to notify the Administrator and/or Maintenance Director if a toilet is not functioning properly, and education will be completed by 04/19/2024. New hires will be educated upon hire on ensuring residents□ toilets function properly and to notify the Administrator and/or Maintenance Director if a toilet is not functioning properly. 4) Beginning on 03/25/2024, the Administrator and/or Maintenance	

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F 550	Continued From page 3 be repaired. During an interview on 3/21/24 at 10:00 AM, with the Director of Nursing (DON), she stated that she did not know the residents were having issues with the toilet. The DON said she understood why using BSCs rather than the toilet would be upsetting to the residents. During an interview on 3/21/24 at 10:15 AM, with the Administrator, she stated that she was aware the toilet was not working properly for Resident #29 and Resident #51, but thought it was repaired when the Maintenance Director installed a new toilet in the residents' room. The Administrator was unaware the residents were currently using BSCs and confirmed this could be a dignity issue for the residents. She reported that she would work to have the toilet flushing issue repaired immediately. Resident #29 A record review of the "Face Sheet" revealed the facility admitted Resident #29 on 10/11/18 and she had current diagnoses including Hemiplegia, Hypertension, and Anxiety. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/13/23 revealed Resident #29 had a Brief Interview of Mental Status (BIMS) score of 12, which indicated her cognition was moderately impaired. Resident #51 A record review of the "Face Sheet" revealed the facility admitted Resident #51 on 12/7/23 and she	F 550	Director will conduct an audit on a resident bathroom to ensure the toilet functions properly on 5 resident bathrooms 5 times a week for 4 weeks and then 5 resident bathrooms monthly for 3 months. Areas of concern will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review. The QAPI Committee will convene on 04/22/2024 to discuss further recommendations as needed and once a month for 3 months. Additional training and/or disciplinary action will be considered as warranted.	

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F 550	Continued From page 4 had current diagnoses including Heart Failure, Renal Disease, and Diabetes Mellitus. A record review of the Admission MDS with an ARD of 12/15/23 revealed a BIMS score of 15, which indicated she was cognitively intact.	F 550		
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; §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);	F 584		4/23/24

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F 584	Continued From page 5 §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, interviews, and facility policy review, the facility failed to ensure residents' rights for a comfortable, homelike environment as evidenced by not providing hot water in the shower room and for four (4) of 27 residents residing on the Primary Care Unit (PCU). Resident #17, Resident #42, Resident #66 and Resident #72. Findings include: A review of the facility's policy, "Resident Environment", dated 09/15, revealed, "It is the policy of this facility to provide a ...comfortable and homelike environment ..." Resident #17 On 03/19/24 at 10:21 AM, during an interview with Resident #17, reported the water in her room and the shower room was not hot. At 9:45 AM on 03/20/24, during an observation of Resident #17's bathroom, the hot water in the sink measured 60 F after three (3) minutes with a thermometer and 64 F after four (4) minutes.	F 584	1) Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 03/22/2024 and based on findings the facility failed to provide hot water in the Primary Care Unit (PCU) shower room and for Resident #17, Resident #42, Resident #66, and Resident #72 residing in the PCU Hall. Resident #17, Resident #42, Resident #66, and Resident #72 were assessed on 03/22/2024 by the DON to ensure no adverse effects to each resident related to not providing hot water. An outside vendor came to make repairs on 03/21/2024 to ensure hot water is provided in the PCU hall. 2) Residents residing in the PCU Hall have the potential to be affected by this deficient practice. 3) On 03/22/2024, an audit was conducted by the Maintenance Director and Administrator to ensure hot water is provided in the PCU hall. On 03/22/2024, the Maintenance Director was educated	

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F 584	Continued From page 6 Resident #42 On 03/19/24 at 11:50 AM, during an observation and interview with Resident #42, he complained the hot water in his bathroom did not work. The hot water in the bathroom sink was turned on and was not warm after approximately one (1) minute. On 03/20/24 at 09:50 AM, during an observation of Resident #42's bathroom, the hot water in the skin reached 74 F after two (2) minutes and was cool. Resident #66 At 09:55 AM on 03/20/24, during an interview with CNA #4, she explained the water in Resident #66's (PCU) bathroom would not get hot, so she usually got hot water from the other side of the building and brought it back to Resident #66's room to give her a bath. Resident #72 At 11:15 AM on 03/19/24, during an interview with Resident #72, he complained the water in the bathroom sink did not get warm. On 03/20/24 at 9:35 AM, during an interview with Certified Nursing Assistant (CNA) #5, she explained the water in Resident #72's bathroom (PCU) did not get hot. The hot water temperature was checked with a thermometer and after two (2) minutes, the thermometer reading was 60 degrees Fahrenheit (F) and after four (4) minutes it was 64 F. On 03/19/24 at 11:00 AM, during an interview with CNA #6, she confirmed the water on the PCU did	F 584	by the Administrator on ensuring hot water is provided to residents in the facility ranging between 100-110 degrees Fahrenheit (F) through weekly water temperature checks. Beginning on 03/28/2024, the licensed nurses, CNAs, housekeeping staff, and therapy staff were educated by the DON and/or Staffing Nurse on ensuring hot water is provided to residents in the facility and to notify the Administrator or Maintenance Director if the water is not hot. Education will be completed by 04/19/2024. New hires will be educated upon hire on ensuring hot water is provided to residents in the facility and to notify the Administrator or Maintenance Director if the water is not hot. 4) Beginning on 03/25/2024, the Administrator and/or Maintenance Director will conduct an audit of ensuring water temperatures are between 100-110 F on 5 resident rooms or shower rooms 5 times a week for 4 weeks and then 5 resident rooms or shower rooms monthly for 3 months. Areas of concern will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review. The QAPI Committee will convene on 04/22/2024 to discuss further recommendations as needed and once a month for 3 months. Additional training and/or disciplinary action will be considered as warranted.	

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F 584	Continued From page 7 not get hot and residents have complained. She stated management was aware of the problem. On 03/20/24 at 2:45 PM, during an interview with the Administrator, she explained a new hot water heater had been installed for the PCU and she was not aware that residents still had complaints regarding hot water since the installation of the new hot water heater. At 3:10 PM on 03/20/24, during an interview and observation with the Maintenance Director, he explained that after the new hot water tank was installed on the PCU, he had some complaints about the hot water. The facility decided to get a different type of recycling pump and was currently waiting on the plumbing company to replace it. During observation of Resident #72's bathroom sink, the hot water reached 64 F after running for three (3) minutes. In Resident #17's bathroom sink, the hot water temperature reached 64 F after running for three (3) minutes. Resident #42's bathroom sink reached 74 F after running for two (2) minutes. The shower room on the PCU reached 64 F after running for two (2) minutes. He confirmed the hot water temperatures were cold and that all residents have the right to hot water. On 03/21/24 at 12:28 PM, during an interview with the Administrator, she stated that she expected all residents to have hot water in their bathrooms and showers.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		4/23/24

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F 656	Continued From page 8	F 656		

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

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F 656	Continued From page 9 §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 observations, interviews, record review, and the facility policy review, the facility failed to implement comprehensive care plan interventions for a resident with a feeding tube (Resident #26) and failed to develop a comprehensive care plan for a resident with full length bedrails (Resident #66) for two (2) of 19 sampled residents. Findings include: A review of the facility's policy, "Care Plan Process", revised 08/17, revealed, " ...The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs ...The facility staff shall follow the care plan ..." Resident #26 Cross Reference: F693 A record review of the "Face Sheet" revealed the facility re-admitted Resident #26 on 5/23/23 and he had current diagnoses including Cerebral Infraction, Aphasia, and Dysphagia. A record review of the "Care Plan" revealed Resident #26 had a "Problem/Need" of "Resident has a feeding tube", with an onset date of 5/3/23, and an approach of "Keep HOB (Head of Bed)	F 656	1) Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 03/22/2024 and based on findings the facility did not implement a comprehensive care plan intervention related to a feeding tube for Resident #26. Certified Nursing Assistant (CNA)#9 was educated on 03/22/2024 to ensure to implement the care plan intervention related to keeping the head of the bed elevated 30 degrees for a feeding tube resident by the Director of Nurses (DON). Resident #26 was assessed by the DON on 03/22/2024 with no adverse findings and reviewed the comprehensive care plan with no changes needed. Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 03/22/2024 and based on findings the facility did not develop a comprehensive care plan for a resident with full length bedrails for Resident #66. Resident #66 was assessed by the DON and 03/22/2024 with no adverse findings and developed the comprehensive care plan for a resident with bedrails. The Maintenance Director removed the full-length bedrails and replaced with half-length bedrails on 03/22/2024. 2) Residents who receive tube feeding	

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F 656	Continued From page 10 elevated 30 degrees." On 03/20/24 at 11:00 AM, during an observation, Certified Nursing Assistant (CNA) #9 lowered the head of bed (HOB) until Resident #26 was lying flat. CNA #9 completed incontinent care and the HOB was not elevated during the care. On 03/20/24 at 11:30 AM, during an interview, CNA #9 confirmed she had lowered the HOB and Resident #26 was lying flat while she provided care. CNA #9 said that she was aware Resident #26 had a high risk for aspiration and explained that it was difficult to turn the resident without assistance if the HOB was elevated. CNA #9 confirmed that she had not asked any other staff to assist with providing care to Resident #26. On 3/21/24 at 10:30 AM, in an interview with Licensed Practical Nurse (LPN) #4, she stated she expected the staff to implement care plan approaches and keep Resident #26's HOB elevated at all times due to his high risk for aspiration. Resident #66 Cross Reference: F700 During an observation on 3/20/24 at 8:30 AM, Resident #66 was lying in bed and there were two (2) full length bedrails noted on the bed. The right bedrail was raised, and the left bedrail was lowered at the head of the bed and was slanted. Resident #66 was leaning toward the left side of the bed, and she had her right foot propped up on the middle of the right raised bed rail. Record review of the "Face Sheet" revealed the	F 656	and have bedrails have the potential to be affected by the deficient practice. 3) On 03/22/2024, an audit was conducted by the DON to ensure the implementation of a comprehensive care plan has an intervention related to head of the bed elevated 30 degrees for a feeding tube resident and the development of a comprehensive care plan for a resident with bedrails. Beginning on 03/28/2024, licensed nurses were educated by the DON and/or Staffing Nurse on ensuring the implementation of a comprehensive care plan has an intervention related to head of the bed elevated 30 degrees for a feeding tube resident and the development of a comprehensive care plan for a resident with bedrails. Education will be completed by 04/19/2024. New hires will be educated upon hire on ensuring the implementation of a comprehensive care plan has an intervention related to head of the bed elevated 30 degrees for a feeding tube resident and the development of a comprehensive care plan for a resident with bedrails. 4) Beginning on 03/25/2024, the DON and/or Case Management Nurse will review care plans to ensure the implementation of a comprehensive care plan has an intervention related to head of the bed elevated 30 degrees for a feeding tube resident and the development of a	

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CARE CENTER OF LAUREL	935 WEST DR LAUREL, MS 39440

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F 656	Continued From page 11 facility admitted Resident #66 on 9/29/20 and she had current diagnoses including Dementia. A review of the comprehensive care plans revealed Resident #66 did not have a care plan regarding full length bedrails. On 03/21/24 at 11:29 AM, during an interview with LPN #4, she explained she was not aware until this week that Resident #66 had full length bedrails. She reported that she had not completed a care plan with approaches for bedrails for Resident #66.	F 656	comprehensive care plan for a resident with bedrails on 5 residents 5 times a week for 4 weeks and then 5 residents monthly for 3 months. Areas of concern will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review. The QAPI Committee will convene on 04/22/2024 to discuss further recommendations as needed and once a month for 3 months. Additional training and/or disciplinary action will be considered as warranted.	
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 interviews, record review, and facility policy review, the facility failed to clean, cut, and file fingernails for a resident who required assistance with Activities of Daily Livings (ADLs) for personal hygiene for one (1) of 19 sampled residents. Resident #55 Findings include: A review of the facility's policy "Nail Care", revised 01/24, revealed "Purpose ...To promote cleanliness, safety and a neat appearance ..." On 03/19/24 at 10:22 AM, Resident #55 was lying in bed and had long fingernails on both hands. The resident was able to respond to questions	F 677	1) Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 03/22/2024 and based on findings the facility failed to clean, cut, and file fingernails for a resident who required assistance with Activities of Daily Livings (ADLs) for personal hygiene for Resident #55. Resident #55□s fingernails were cut, trimmed, and filed on 03/22/2024 by the Director of Nurses (DON). 2) Residents who require assistance with ADL for nail care have the potential to be affected by this deficient practice.	4/23/24

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F 677	Continued From page 12 and answered "yes" when asked if she would like to have her nails trimmed. On 03/20/24 at 10:05 AM, during an observation of Resident #55 and an interview with Certified Nurse Aide (CNA) #3, she confirmed Resident #55 had long nails that were dirty. CNA #3 explained Resident #55 had a diagnosis of Diabetes and CNAs were not allowed to trim her nails. At 10: 15 AM on 03/20/24, during an observation of Resident #55 and an interview with Licensed Practical Nurse (LPN) #2, she explained LPNs were not allowed to clip Resident #55's nails because she had a diagnosis of Diabetes, and a Registered Nurse (RN) clipped the resident's nails on weekends and as needed. LPN #2 observed Resident #55's fingernails and confirmed the resident's fingernails were long, jagged, and dirty and asked Resident #55 if a nurse could trim her nails, and the resident replied "yes". LPN #2 reported that the resident's nails had not been clipped recently. On 03/20/24 at 03:35 PM, during an interview with the Director of Nursing (DON), she explained the weekend RNs are to assess resident nails weekly and they only checked the condition of the nail and cleaned and clipped as needed. She explained she was not sure if Resident #55 refused nail care but if so, it would be documented in the medical chart. She stated she expected staff to adequately complete ADL care for all residents, which included clipping and cleaning their fingernails. At 4:00 PM on 03/20/24, during a phone interview with RN#2, she explained she worked at the	F 677	3) On 03/22/2024, an audit was conducted by the DON to ensure ADL nail care was provided to residents and nail care performed if needed. Beginning on 03/28/2024, the licensed nurses and CNAs were educated by the DON and/or Staffing Nurse on ensuring ADL nail care is provided to residents and nail care performed if needed. Education will be completed by 04/19/2024. New hires will be educated upon hire on ensuring ADL nail care is provided to residents and nail care performed if needed. 4) Beginning on 03/25/2024, the DON and/or Nurse Supervisor will audit to ensure ADL nail is provided on 5 residents 5 times a week for 4 weeks and then 5 residents monthly for 3 months. Areas of concern will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review. The QAPI Committee will convene on 04/22/2024 to discuss further recommendations as needed and once a month for 3 months. Additional training and/or disciplinary action will be considered as warranted.	

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F 677	Continued From page 13 facility on the weekend on a part-time basis. She explained that she looked at the at the nails for residents with Diabetes, but she did not clip all the resident's nails in the facility every week and rotated nail care from week to week. She confirmed that she did not clip Resident #55's nails this month, but she did observe them to ensure they were clean. She was unable to recall if Resident #55 ever refused to have her nails clipped. Record review of the "Face Sheet" revealed the facility admitted Resident #55 on 12/15/21, and she had current diagnoses including Type 2 Diabetes Mellitus. Record review of the Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 01/08/24 revealed Resident #55 had a Brief Interview for Mental Status (BIMS) score of six (6), which indicated her cognition was severely impaired. Further review revealed she required moderate assistance with personal hygiene.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		4/23/24

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F 690	Continued From page 14 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to provide incontinent care in a manner to prevent complications for one (1) of two (2) residents reviewed for care. (Resident #26) Findings Include: Review of the facility's policy, "Perineal Care", revised 1/24, revealed, " ...Purpose ...To prevent irritation or infection ...Male-Without Catheter ...4. Hold the shaft of the penis with on hand. 5. Using the other hand gently cleanse from the tip to the base of the penis ..."	F 690	1) Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 03/22/2024 and based on findings the facility failed to provide incontinent care in a manner to prevent complications for Resident #26. Certified Nursing Assistant (CNA)#9 was educated on 03/22/2024 by the Director of Nurses (DON) to ensure perineal care is provided correctly to male residents to prevent complications. Resident #26 was assessed on 03/22/2024 by the DON with no adverse findings.	

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F 690	Continued From page 15 On 03/20/24 at 11:00 AM, Certified Nurse Aide (CNA) #9 provided incontinent care for Resident #26 after he had an incontinent episode and had a soiled brief. During the care, the CNA did not clean the resident's penis. In an interview on 03/20/24 at 11:30 AM with CNA #9, she confirmed she failed to cleanse the resident's penis during care. She explained that she had forgotten and confirmed that not cleansing the penis after an incontinent episode could have caused the resident to acquire an infection. During an interview on 3/21/24 at 10:00 AM, with the Director of Nursing (DON), she stated she expected the staff to follow the standards of practice while providing incontinent care and she reported the staff received training regarding how to appropriately provide care, including cleaning the penis. A record review of the "Face Sheet" revealed the facility admitted Resident #26 on 5/23/23 and he had current diagnoses including Cerebral Infraction, Aphasia, and Dysphagia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/10/24 revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident was severely cognitively impaired.	F 690	2) Male residents who require incontinent care have the potential to be affected by this deficient practice. 3) On 03/22/2024, an audit was conducted by the DON to ensure incontinent care is provided in a manner to prevent complications. Beginning on 03/28/2024, the licensed nurses and CNAs were educated by the DON and/or Staffing Nurse on ensuring incontinent care is provided in a manner to prevent complications. Education will be completed by 04/19/2024. New hires will be educated upon hire on ensuring incontinent care is provided in a manner to prevent complications. 4) Beginning on 03/25/2024, the DON and/or Staffing Nurse will audit to ensure incontinent care is provided in a manner to prevent complications on 5 residents 5 times a week for 4 weeks and then 5 residents monthly for 3 months. Areas of concern will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review. The QAPI Committee will convene on 04/22/2024 to discuss further recommendations as needed and once a month for 3 months. Additional training and/or disciplinary action will be considered as warranted.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)	F 693		4/23/24

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F 693	Continued From page 16 §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review, the facility failed to ensure the head of the bed (HOB) was properly elevated for a resident who required enteral feedings and was at high risk for aspiration for one (1) of nine (9) residents observed who received nutrition by a feeding tube. Resident #26 Findings include: Record review of the facility's policy, "Tube Feedings" revised 12/15, revealed, " ...4. A resident who is fed by nasogastric, jejunostomy or gastrostomy tubes will receive appropriate	F 693	1) Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 03/22/2024 and based on findings the facility failed to ensure the head of the bed (HOB) was properly elevated for a resident who required enteral feedings for Resident #26. Certified Nursing Assistant (CNA)#9 was educated on 03/22/2024 to ensure the HOB is properly elevated for a resident who requires enteral feedings by the DON. Resident #26 was assessed on 03/22/2024 by the Director of Nurses (DON) with no adverse findings.	

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F 693	Continued From page 17 treatment and services to prevent aspiration pneumonia ..." During an interview on 03/19/24 at 01:07 PM, a family member for Resident #26 stated the staff provided care to the resident by laying him flat, even though he had a high risk for aspiration. She stated the feeding tube was not infusing while staff provided care, but the resident could not tolerate lying flat at any time and the HOB must be kept elevated. During an observation on 03/20/24 at 11:00 AM, Certified Nursing Assistant (CNA) #9 lowered the HOB until Resident #26 was lying flat. CNA #9 completed incontinent care and the HOB was not elevated during the care. During an interview on 03/20/24 at 11:30 AM, with CNA #9, she confirmed she had lowered the HOB and Resident #26 was lying flat while she provided care. CNA #9 said that she was aware Resident #26 had a high risk for aspiration and explained that it was difficult to turn the resident without assistance if the HOB was elevated. CNA #9 confirmed that she had not asked any other staff to assist with providing care to Resident #26. During an interview on 3/21/24 at 10:00 AM, with the Director of Nursing (DON), she said she expected the staff to follow the standards of practice while providing care to residents. The DON confirmed the CNA should have kept the Resident #26's HOB elevated at least 30 degrees and stated "she should have asked for assistance rather than lying the resident flat." A record review of the "Face Sheet" revealed the facility re-admitted Resident #26 on 5/23/23 and	F 693	2) Residents who receive tube feeding have the potential to be affected by this deficient practice. 3) On 03/22/2024, an audit was conducted by the DON to ensure the HOB is properly elevated for a resident who requires enteral feedings. Beginning on 03/28/2024, licensed nurses and CNAs were educated by the DON and/or Staffing Nurse on ensuring the HOB is properly elevated for a resident who requires enteral feedings. Education will be completed by 04/19/2024. New hires will be educated upon hire on ensuring the HOB is properly elevated for a resident who requires enteral feedings. 4) Beginning on 03/25/2024, the DON and/or Nurse Supervisor will audit to ensure the HOB is properly elevated for a resident who requires enteral feedings on 5 residents 5 times a week for 4 weeks and then 5 residents monthly for 3 months. Areas of concern will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review. The QAPI Committee will convene on 04/22/2024 to discuss further recommendations as needed and once a month for 3 months. Additional training and/or disciplinary action will be considered as warranted.	

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F 693	Continued From page 18 he had current diagnoses including Cerebral Infraction, Aphasia, and Dysphagia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/10/24 revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident was severely cognitively impaired.	F 693		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and the facility policy review, the facility failed to	F 700	1) Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on	4/23/24

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F 700	Continued From page 19 adequately assess a resident for bedrail use, failed to attempt alternative measures prior to the placement of full bedrails, and failed to ensure bedrails were properly installed and assessed for the risk of entrapment for one (1) of 19 sampled residents. Resident #66 Findings include: Record review of a statement provided by the Administrator on facility letterhead, dated March 21, 2024 revealed, " The facility does not have a specific policy and procedure that only states "Bed/Side Rails ..." On 3/20/24 at 8:30 AM, during an observation, Resident #66 was lying in bed and there were two (2) full length bedrails noted on the bed. The right bedrail was raised, and the left bedrail was lowered at the head of the bed and was slanted. Resident #66 was leaning toward the left side of the bed, and she had her right foot propped up on the middle of the right raised bed rail. On 03/20/24 at 9:55 AM, in an interview and observation, Resident #66 was lying in bed and Certified Nursing Assistant (CNA) #4 confirmed the resident had full length bedrails. CNA #4 reported the resident had full bedrails for the past couple of months because the resident was crawling out of the bed. At 2:35 PM on 03/20/24, during an interview with Licensed Practical Nurse (LPN) #2, she explained Resident #66 had gotten a new bed approximately two (2) months ago because the resident had falls. On 03/20/24 at 2:45 PM, during an interview with	F 700	03/22/2024 and based on findings the facility failed to adequately assess a resident for bedrail use, failed to attempt alternative measures prior to the placement of full bedrails, and failed to ensure bedrails were properly installed and assessed for the risk of entrapment on Resident #66. Resident #66 was assessed on 03/22/2024 by the Director of Nurses (DON) to ensure adequate bedrail use and assessed for the risk of entrapment. The Maintenance Director removed the full bedrails on 03/22/2024 and installed half bedrails that were inspected prior to installation on 03/22/2024. 2) Residents who have bedrails have the potential to be affected by this deficient practice. 3) On 03/22/2024, an audit was conducted by the DON to ensure the adequate assessment of a resident for bedrail use and assessed for the risk of entrapment. On 03/22/2024, an audit was conducted by the Administrator and Maintenance Director to ensure bedrails were properly installed. The Maintenance Director was educated on 03/22/2024 by the Administrator to ensure bedrails were properly installed according to manufacturer's guideline. Beginning on 03/28/2024, the licensed nurses, CNAs, and therapy staff were educated by the DON and/or Staffing Nurse on ensuring	

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F 700	Continued From page 20 the Director of Nursing (DON), she explained she was unaware that Resident #66 had full length bedrails. Resident #66 received hospice services and the hospice provider brought the resident a new bed. At 11:04 AM on 3/21/24, during an interview with the DON, she explained Resident #66 had not been assessed for bedrail use or entrapment. The DON further explained that when the resident's bed was delivered and set up, a new bedrail assessment was not completed. The DON reported that Resident #66's family member had signed a bedrail consent on admission, but it was not updated to indicate the resident had full length bedrails. Record review of the "Face Sheet" revealed the facility admitted Resident #66 on 9/29/20 and she had current diagnoses including Dementia. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/05/24 revealed Resident #66 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated her cognition was severely impaired. Record review of Resident #66's "Device/Physical Restraint Consent" signed 09/18/20 revealed " I (Proper Name of Resident #66) have been informed ... that a side rails device will be used ..." The consent does not indicate the type of siderails to be used or the benefits of using siderails. The consent was signed by the Resident Representative. Record review of the "Nurse Data Collection and Screening", dated 12/11/23 revealed the bed rail	F 700	the adequate assessment of a resident for bedrail use and assessed for the risk of entrapment. Education will be completed by 04/19/2024. New hires will be educated upon hire on ensuring the adequate assessment of a resident for bedrail use and assessed for the risk of entrapment. 4) Beginning on 03/25/2024, the DON and/or Case Management Nurse will audit to ensure the adequate assessment of a resident for bedrail use and assessed for the risk of entrapment on 5 residents 5 times a week for 4 weeks and then 5 residents monthly for 3 months. Areas of concern will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee for review. The QAPI Committee will convene on 04/22/2024 to discuss further recommendations as needed and once a month for 3 months. Additional training and/or disciplinary action will be considered as warranted.	

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F 700	Continued From page 21 was "Not used"	F 700		