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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and Complaint Investigations (CIs), at the facility from 08/13/24 through 8/15/24. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA investigated a Facility Reported Incident (FRI) CI MS #25862 related to resident abuse and dignity and CI MS #25884 related to employee on resident abuse and dignity and cited F602, F656, and F689 related to these CI's. CI MS #25621, also a FRI was investigated for accidents related to a fall with injury and CI MS#26867 was investigated related physical abuse related to bumping a residents head.There were no deficient practices cited related to these CI's. The SA cited F656, F732, F759, F803 and F812 related to the annual recertification survey. The facility had a census of 53 and was licensed for 60.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to	F 602	1. Upon given the allegation of abuse and review of the video taken the Licensed	9/25/24

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

Electronically Signed | 09/04/2024

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F 602	Continued From page 1 ensure a resident was free from exploitation for one (1) of 16 sampled residents. Resident #12. Findings Include: A review of the facility's policy, "Resident Rights," dated 2018, revealed: "1. Resident Rights. The resident has the right to a dignified existence, self-determination...5. Respect and Dignity. The resident has a right to be treated with respect and dignity..." A review of the facility's policy, "Abuse, Neglect and Exploitation," reviewed/revised 5/25/24, revealed: "Policy: It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property ... Definitions: "Exploitation" means taking advantage of a resident for personal gain ..."Mistreatment" means inappropriate treatment or exploitation of a resident ... IV. Identification of Abuse, Neglect and Exploitation ... B. Possible indicators of abuse include, but are not limited to: 9. Evidence of photographs or videos of a resident that are demeaning or humiliating in nature, regardless of whether the resident provided consent and regardless of the resident's cognitive status ..." A record review of the " Facesheet" revealed that the facility admitted Resident #12 to the facility on 10/20/2020. The resident had diagnoses that included Unspecified Dementia and Cognitive Communication Deficits.. A record review of the quarterly Minimum Data	F 602	Nursing Home Administrator notified the Following Authorities and Persons - a) The Mississippi Department of Health b) The Mississippi Attorney General's Office c) The Rankin County Sherriff's Office d) The Facility Medical Director e) The Resident's Responsible Party d) Local Hospice Administrator. Each of these entities were advised of the allegation of abuse. The employee you committed this deficient practice of abuse was terminated of her employment on July 15, 2024 at 2:00pm. The Licensed Nursing Home Administrator conducted interviews with Nursing Services Staff and Local Hospice Nursing Staff that were currently giving her care, to determine any witness of abuse, neglect, or misappropriation towards Residents #12. Each stated they had not witnessed any type of abuse, neglect, or misappropriation towards Resident #12. 2. The Quality Assurance Committee met on 8/16/2024 to review the deficiency and determine if it will potentially affect all residents or only Resident #12. It was determined by The Quality Assurance Committee by record review, care plans, and documentation that all residents have the potential to be affected by this deficient practice. 3. An Abuse, Neglect, or Misappropriation In-Service was conducted on July 16, 2024 by the Licensed Nursing Home Administrator. All Nursing Home staff will re-sign and give acknowledgement of the Facility's Abuse, Neglect, and	

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F 602	Continued From page 2 Set (MDS) with an Assessment Reference Date (ARD) of 7/12/24 revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 99, indicating that the resident was unable to participate in the interview. A record review of the facility's "Reportable Incident Form", dated 7/19/24, revealed on 7/15/24 at 8:45 AM, two (2) Certified Nurse Aides (CNAs) reported to the Administrator that CNA #1 had made a video in which she forcefully and manually transferred Resident #1 to a Geri (geriatric) chair from her bed. Resident #1's extremities and lower body were exposed during the video, but her private lower body parts could not be seen. Upon receiving the information, the Administrator reported the incident to the state agency, AGO's office, local police, the Resident Representative (RR), the Medical Director, and the resident's Hospice agency. At 1:05 PM on 8/13/24, during an interview, CNA #2 stated she did not know CNA #1 personally because their work schedules differed. She reported that a former coworker called her on the evening of 7/14/24 and told her to watch a live video on social media involving CNA #1 and Resident #12. CNA #2 logged onto the social media account and saw the live video of CNA #1 in the resident's room dancing. She observed CNA #1 put the Geri (Geriatric) chair in front of the resident's bed and then grab the resident under the arms and manually transferred her to the Geri chair. CNA #2 stated that the transfer was unsafe because the resident should have been lifted by two people. She recalled that people watching the video made comments praising CNA #1 and called her "CNA of the year," and CNA #1 showed her thanks by clapping,	F 602	Misappropriation Policy by 9/25/2024. The Director of Nursing Services and the Licensed Facility Administrator will make weekly rounds beginning 9/9/2024 interviewing residents for any signs of abuse, neglect, or misappropriation for 2 months and then bi-monthly. All of these documentations will be brought to the Quality Assurance Committee for review beginning 9/25/2024. 4. Monthly Abuse, Neglect, and Misappropriation In-Services will be conducted by the Licensed Nursing Home Administrator and the Director of Nursing Services and/or the Assistant Director of Nursing Services for 6 months beginning 8/30/24. For these 6 months, these in-services will be brought to the Quality Assurance Committee for review or until such compliance has been determined to have been met beginning 8/30/2024. If compliance has been determined by the Quality Assurance Committee Abuse, Neglect, and Misappropriation In-Services will be brought to the Quality Assurance quarterly for review and continued compliance. A Quality Assurance Performance Improvement Plan will be initiated by 9/25/2024 to maintain implemented actions.	

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which made it appear that she enjoyed the attention. The resident stayed seated in the chair, and while her body was visible in the background, she was not naked. The video ended when CNA #1 looked toward the door, as if she thought someone was coming into the room. CNA #2 stated that she reported the video that she had watched to the Administrator on the morning of 7/15/24.

On 8/13/24 at 1:16 PM during an observation of the social media video footage, which was filmed live and posted online, CNA #1, who posted the video using another name, was observed lifting Resident #12 from her bed into the Geri chair. The resident's thighs, legs, and feet were visible to viewers, but her face was not disclosed. Once Resident #12 was seated in her geriatric chair, CNA #1 turned to the camera, clapped her hands, smiled, and shook her buttocks while the audience praised her. CNA #1 then moved in the video, exposing the resident's face and bottom half of her body. As she continued communicating with the audience, CNA #1 waved her hand in front of her face, indicating that Resident #12 had an odor coming from her body. The audience responded with obscenities, and CNA #1 laughed. In response to viewer comments, CNA #1 said, "Lord forgive me," and the video ended. The live video lasted one minute and seven seconds.

On 8/13/24 at 2:36 PM, during an interview with the Administrator, he reported that a 7/15/24 at approximately 8:45 AM, CNA #2 informed him of a video posting from a current CNA on social media. He stated that he watched the video that morning. He further stated that he personally conducted the investigation, as the current

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Director of Nurses (DON) was not a part of the investigation. He continued by saying that CNA #1 was scheduled to come in that afternoon to work, so he let her come in and that is when he told her that he had seen the video and that he was terminating her employment at the facility and that she needed to leave the building.

At 8:32 AM on 8/15/24, during a telephone interview with CNA #1, she revealed she had been a licensed CNA for about three years and had worked at the facility where Resident #12 lives for about two months. She vehemently denied appearing in the social media video with Resident #12 in the background. She claimed the Administrator called her into the building and told her about a video, but he never allowed her to watch it to ensure it was her. In the interview, she explained that she would not do such a thing because she knew it was wrong to video residents. Since CNA #1 denied it was her in the video, she was asked to explain why it would be wrong for residents to be posted on social media by any staff in general. CNA#1 said it would violate the resident's rights and patient confidentiality. She said it would be wrong since she understood that to video a resident, you must first have the resident's or the responsible party's consent first.

At 8:54 AM on 8/15/24, in a follow-up interview with CNA #1, she was informed that according to the picture of the driver's license in her personnel file, it was her on the live social media. CNA #1 got quiet and responded, "I did not do a video on that particular social media site live. I just want to make sure you do not put that on your paper."

On 8/15/24 at 11:40 AM, during an interview with

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F 602	Continued From page 5 Resident #12's family, the family member stated that the resident was very private and would not have wanted or allowed someone to make such a video of her. He stated that she would have been offended.	F 602		
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.	F 656		9/25/24

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F 656	Continued From page 6 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy reviews, the facility failed to implement/follow the care plan for three (3) of sixteen (16) sampled residents. Resident #12, Resident #13, Resident #48 Findings Include: A review of the facility policy titled "Care Plans," updated 2/3/23 revealed, "Policy: Each resident will have a person-centered plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care...Resident Care Summary-part of the Comprehensive Care Plan is used as the tool to make staff aware of the resident's daily care needs..." Resident #12 A record review of the ADL (Activities of Daily Living) comprehensive Care Plan dated 1/29/24, revealed an intervention related to transfers as	F 656	1. Care Plans for Residents #12, #13, and #48 were reviewed by the Medical Records Licensed Practical Nurse and the Registered Nurse Minimum Data Set Case Manager for accuracy and the care plans were updated as indicated for accuracy on 8/15/2024. 2. The Quality Assurance Committee met on 8/16/2024 and made the determination that all Residents have the potential of being affected by this deficient practice. This determination was made by record review, care plan, and documentation review. The Medical Records Nurse and the Registered Nurse Minimum Data Set Case Manager made this review and presented the potential of affecting all residents to the Quality Assurance Committee on 8/16/2024. 3. A 100% Care Plan Audit was made by the Director of Nursing Services, the	

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F 656	Continued From page 7 "Transfers: Extensive Two Person Assist ...." At 1:05 PM on August 13, 2024, as Certified Nursing Assistant (CNA) #2 recapped what she saw in the social media video, she specifically pointed out that she saw CNA #1 grab the resident under the arm and move her to the geriatric chair without assistance. She stated the transfer was unsafe because the resident should have been lifted by two people. On 8/14/24 at 9:28 AM, in an interview with Minimum Data Set (MDS) Nurse, she reviews and confirms with that the care plan for Resident #12 states that for transfers, the resident is an extensive two person assist. She said this intervention was put into place to ensure the safety of the resident. The MDS Nurse further added that care written and available on the kiosk (interactive computer terminal) of the wall in the hall of resident care areas, so that CNAs (Certified Nurse Aides) will know how to care for residents. Resident #13 A record review of Resident #13's comprehensive "Care Plan" dated 2/23/23 revealed "At risk for Dyspnea/Shortness of Breath/Difficulty Breathing related to COPD and Respiratory Failure with Hypoxia ...Interventions ...Fluticasone Prop (Propionate) 50 mcg (micrograms) Spray, spray two (2) sprays in each nostril daily ...Nasal Spray (sodium chloride), spray one (1) spray intranasally twice daily every day in each nostril..." At 8:35 AM on 08/14/23, during an observation of medication administration with an observation and interview of medication administration with	F 656	Medical Records Licensed Practical Nurse, and the Registered Nurse Minimum Data Set Case Manager for accuracy and will be updated as indicated for accuracy. An In-Service designed for following the Care Plan of each Resident and the location of each Resident's Care Plan will be given by 9/25/2024. This In-Service will be conducted by the Director of Nursing Services and the Assistant Director of Nursing Services on 9/25/2024. 4. The Director of Nursing Services and the Assistant Director of Nursing Services will will complete weekly audits of the Nursing Staff(Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants) for 2 months to ensure the Nursing Services Staff is following the Resident's Plan of Care. These audit records will be brought to the Quality Assurance Committee, beginning 9/25/2024, for review for 2 months until such time that consistent substantial compliance has been achieved as determined by the Quality Assurance Committee. After such time and compliance has been met, the Director of Nursing Services and the Assistant Director of Nursing Services will make quarterly audits to ensure the Nursing Services Staff is following of Resident Plan's of Care. At such time, these audit records will be brought to the Quality Assurance Committee for review and to maintain compliance.	

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Licensed Practical Nurse (LPN) #2 reported and confirmed Fluticasone Propionate nasal spray and Saline nasal spray was out of stock. Therefore, Resident #13 was unable to receive the ordered medications.

A record review of Resident #13's "Admission Record" revealed that the facility admitted the resident on 2/15/23, with diagnoses that included Chronic Obstructive Pulmonary Disease and Acute and Chronic Respiratory Failure with Hypoxia.

A record review of Resident #13's "Order Summary Report, with active orders as of 8/15/24, revealed a physician's order, with an order date of 4/2/24, for Nasal Spray (sodium chloride) 0.65% aerosol: one (1) spray in each nostril twice a day, every day, related to Chronic Respiratory Failure with Hypoxia and an order, with an order date of 2/15/23, for Fluticasone Propionate 50 MCG (microgram) Spray for two (2) sprays in each nostril daily, related to Chronic Obstructive Pulmonary Disease.

Record review of the August 2024 Electronic Medication Administration Record (eMAR) documentation revealed Resident #13 had not received the Saline Nasal Spray at 9 PM on 8/13/24 and the 9 AM dose on 8/14/24. Fluticasone Propionate nasal spray was not documented as received at 8 AM on 8/14/24.

Resident #48

A record review of Resident #48's comprehensive "Care Plan" dated 4/18/24 revealed "Hypertension, controlled ...Care Plan Goal ... Reduce complications from Hypertensive

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symptoms ...Bethanechol Chloride 25 mg tablet: Give 1 tablet via peg (Percutaneous Endoscopic Gastrostomy) tube before meals every day ..."

On 8/14/24 at 2:46 PM, during an observation and interview with LPN #2 administering medications via PEG tube to Resident #48, his medications included Bethanechol Chloride. LPN #2 stated the Bethanechol Chloride was not available on her medication cart. The nurse checked her medication cart twice and checked the Omnicell (an automated medication dispensing cabinet) in the medication room, however, the medication was not available.

Review of Resident #48's "Admission Record" revealed an admission date of 4/2/24 with diagnosis of Essential (Primary) Hypertension and Chronic Systolic (Congestive) Heart Failure.

Record review of Resident #48's "Order Summary Report" with active orders as of 8/15/24 revealed an order dated 4/19/24 for Bethanechol Chloride Tab 25 mg Give 1 tablet via PEG-tube three times a day related to Essential (primary) hypertension."

A record review of Resident #48's August 2024 Electronic Medication Administration Record (eMAR) documentation revealed Bethanechol Chloride was documented as unavailable for two doses on 8/13/24 and the morning dose on 8/14/24.

On 8/14/24 at 1:52 PM, in an interview with Assistant Director of Nursing (ADON) stated they should reorder medications when it gets down to five (5) days left. She confirmed the residents' medications are listed on the care plans and the

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F 656	Continued From page 10 care plan is not followed if the medications are not given. On 08/14/24 at 4:03 PM, during an interview with the Director of Nurses (DON), she explained her expectations of nurses are to give medications per physician orders and follow care plans. She stated residents should receive medications as prescribed for their health conditions.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the facility failed to ensure a two-person transfer, as evidenced by video evidence of a Certified Nursing Assistant (CNA) transferring a resident from the bed to the geriatric chair by herself. The resident required a 2-person transfer. This was for one (1) of 16 sampled residents. Resident # 12. Findings Include: A review of the facility policy titled "Modified Lifting Policy", no date, reveals, "...Facility will provide a safe work environment for patient care areas by providing and requiring the use of safety materials, equipment and training designed to	F 689	1. The RN Supervisor/Infection Preventionist assessed Resident #12 for injury,brusing,skin tears. No signs of pain, injury, or bruising was found. No actual harm occurred. 2. The Quality Assurance Committee met on 8/16/2024 to review the deficiency and determine if it will potentially affect all residents or certain residents. It is the determination of the Quality Assurance Committee through the review of Medical Record, Care Plans, and Documentation that all Residents have the potential to be affected by this deficient practice.	9/25/24

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F 689	Continued From page 11 prevent personnel and patient injury...It is crucial that health care professionals practice safe lifting, transporting..." At 1:05 PM on 8/13/24, as Certified Nursing Aide (CNA) #2 recapped what she saw in the social media video, she specifically pointed out that she saw CNA #1 put the geriatric chair in front of the resident's bed. She remembers seeing CNA #1 grab the resident under the arms and move her to the geriatric chair by hand. She stated the transfer was unsafe because the resident should have been transferred by two people, as the resident was an extensive two person assist for transfer. On 8/13/24 at 1:16 PM during an observation of the social media video footage, which was filmed live and posted online, CNA #1, lifted the resident without assistance and transferred her to a geriatric chair. On 8/13/24 at 2:36 PM, during an interview with the Administrator, he confirmed that on 7/15/24 at approximately 8:45 AM, CNA #2 informed him of a video posting from a current CNA on social media. He stated that he watched the video that morning. He continued by saying that CNA #1 was scheduled to come in that afternoon to work, so he let her come in he explained to her that he had seen the video that she had posted that involved the care of Resident #12. At time, her reported that he told CNA #1 that he was terminating her employment and that she needed to leave the building. On 8/14/24 at 9:28 AM, in an interview with Minimum Data Set (MDS) Nurse, she confirmed that for transfers, Resident #12 is care planned	F 689	3. An all Nursing Service Staff Meeting(Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants)will be held on 9/17/2024 for Lift Training to be conducted by the distributor of the facility lifts and it components. Also, the Medical Records Licensed Practical Nurse and the Registered Nurse Minimum Data Set Case Manager will perform a 100% Care Plan Audit to ensure proper lift assessments are included in each Resident's Plan of Care and will be completed by 9/25/2024. Any additions or adjustments found to be needed will be made by the Medical Records Nurse and/or the Registered Nurse Minimum Data Set Case Manager and will be completed by 9/25/2024. The Director of Nursing Services, the Assistant Director of Nursing Services, or the Registered Nurse Supervisor will monitor Resident #12 when being transfered from the bed to the geriatric chair weekly for 3 months and then quarterly to ensure the safety of Resident #12 during transfer. These audit documentations will be brought to the Quality Assurance Committee beginning 9/25/2024 for review and further recommendation if the Quality Assurance Committee deems necessary. 4. The Director of Nursing Services and the Assistant Director of Nursing Services will make weekly audits for 2 months beginning 8/19/2024 and will continue until 10/15/2024 for the proper use of mechanical lifts and for 2 person assist beginning on 8/19/2024. These audit	

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F 689	Continued From page 12 as an extensive two person assist. She stated this was put into place to ensure the safety of the resident to prevent the resident from falling and having any injuries. She added that the CNAs can use the kiosk (interactive computer terminal) on the wall to identify the plan of care for residents. Therefore, with this resident they should never attempt to lift or transfer the resident by themselves. On 8/14/24 at 2:01 PM in an interview with CNA #3, she confirmed that Resident #12 is one her residents that she is assigned to from time-to-time. She explained that this resident is a total body lift and requires an extensive two person transfer when moving her out of the bed. A record review of the "Facesheet" revealed Resident #12 was admitted on 10/20/20 by the facility. Her diagnosis includes Cognitive Communication Deficit and Unspecified Dementia. A record review of the quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 7/12/24 revealed a Brief Interview Mental Status (BIMS) score of 99, which indicated that the resident was unable to participate in the interview.	F 689	records will be brought to the Quality Assurance Committee for 2 months until such time consistent substantial compliance has been met beginning on 9/25/2024. After 2 months and compliance is met, the Director of Nursing Services and the Assistant Director of Nursing Services will make quarterly audits for the use of proper mechanical lift procedure and 2 person assist. These audit records will be brought to the Quality Assurance Committee for review and compliance.	
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.	F 732		9/25/24

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F 732	Continued From page 13 (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to post the direct care daily staffing numbers in a location accessible to residents and visitors for two (2) of three (3) days of survey. Findings Include:	F 732	1. The Director of Nursing Services was instructed to amend the document titled "Direct Care - Daily Staffing Patterns" to include the total number of staff as well as the actual hours worked on 8/30/2024. The actual correct posting was made on 8/14/2024 by the Director of Nursing	

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F 732	Continued From page 14 Review of the facility ' s policy, "Nurse Staffing Posting Information", revised 2/3/2023, revealed, " ...It is the policy of this facility to make staffing information readily available in a readable format to residents and visitors at any given time. Policy Explanation and Compliance Guidelines: 1. The nurse staffing information will be posted on a daily basis ...2. The facility will post the nursing staffing data at the beginning of each shift ..." On 8/13/24 at 9:30 AM, there were no direct care daily staffing numbers posted in the facility. On 8/14/24 at 8:30 AM, there were no direct care daily staffing numbers posted in the facility. On 8/15/24 at 10:15 AM, in an interview with the Director of Nursing, she stated she was aware the nursing staffing had to posted in a prominent place that was readily accessible to residents and visitors at the beginning of the shift. On 8/13/24 at 2:45 PM, in an interview with Licensed Practical Nurse (LPN) #1, she revealed she was aware that staffing should be posted and stated that it was usually posted at the front desk. She stated that on Tuesday and Wednesday of this week there must have been a breakdown in communication since the staffing numbers did not get posted. On 08/15/24 at 10:34 AM, an interview with the Administrator revealed it was the policy of the facility to post the facility staffing information to ensure it was readily available in a manner that was readable by residents and visitors at any given time. The Administrator was unsure why the staffing information was not posted on the first	F 732	Services and the posting was placed at the Nurse's Desk. 2. The Quality Assurance Committee met on 8/16/2024 to review the deficiency and determine if it will potentially affect all residents or only certain resident. It is the determination of the Quality Assurance Committee that all residents have the potential to be affected by this deficient practice. 3. On 8/16/2024, the Licensed Nursing Home Administrator conducted an In-Service for the Director of Nursing Services and the Assistant Director of Nursing Services related to how to correctly post nurse staffing information in order to ensure that the properly posted staffing information continually includes the total number of staff as well as the actual hours worked. The Licensed Facility Administrator will make a weekly audit of the "Direct Care - Daily Staffing Patterns Form" for accuracy beginning 9-02-2024 until compliance has been met and determined by the Quality Assurance Committee. These audit documentations will be brought by the Licensed Facility Adminstrator beginning 9/25/2024. 4. The Director of Nursing Services and the Assistant Director of Nursing Services will perform weekly audits beginning 8/19/2024 of the document titled "Direct Care-Daily Staffing Patterns" to ensure its proper posting as well as its proper inclusion of the total number of staff and the actual hours worked. These audits will	

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F 732	Continued From page 15 and second day of the survey and he commented that it was normally posted at the nursing station for visitors and residents and that it was an important aspect of resident care and customer service.	F 732	be performed for 2 months and brought to the Quality Assurance Committee beginning 9/25/2024 for review and to sustain compliance.The Quality Assurance Committee will receive and review audit records performed by the Director of Nursing Services and the Assistant Director of Nursing Services pertaining to the document titled "Direct Care-Daily Staffing Patterns" beginnng 9/25/2024 for 2 months and will immediately initiate corrective actions when necessary, and determine the continued frequency of all pertinent audits and in-services based upon the results received. This will be performed for 2 months until such compliance is met and then these audit records will be reviewed quarterly by the Quality Assurance Committee.	
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; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure their medication error rate was less than five percent as evidenced by three (3) errors were observed out of twenty-six (26) medication administration opportunities. This affected two (2) of seven (7) residents observed during medication pass, resulting in a medication error	F 759	1. The Facility Pharmacy was called to obtain Resident #48's missing blood pressure medication on 8/14/2024 and was received later that afternoon and administered to Resident #48. On 8/14/2024, Saline Nasal Spray was purchased from the local pharmacy for Resident #13 and an order for Fluticasone	9/25/24

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F 759	Continued From page 16 rate of 11.54%. (Residents #48 and #13) Findings include: A review of the facility's policy titled, "Medication Administration General Guidelines," (undated) revealed, "Medications are to be administered as prescribed in accordance with good nursing principles and practices ...Procedure...2. Medications are to be administered in accordance with the written orders of attending physicians, taking into consideration manufacturer's specifications, and professional standards of practice ..." A review of the facility's policy titled, "Ordering and Receiving Medications from Pharmacy," (undated) revealed, "Medications are ordered and received from the pharmacy in a timely manner ...Procedure... 2. A. Re-order medication in advance of need to ensure an adequate supply is on hand ..." Resident #48 On 8/13/24 at 2:46 PM, during an observation with Licensed Practical Nurse (LPN) #2 as she administered medications to Resident #48 via PEG(Percutaneous Endoscopic Gastrostomy) tube, it was noted the medications due at that time were Gabapentin 400 milligrams (mg) capsule (three times a day) and Bethanechol Chloride 25 mg tablet (three times a day) via PEG tube. LPN #2 stated that the Bethanechol Chloride was not in the medication cart. The nurse checked her cart twice and checked the Omnicell (an automated medication dispensing cabinet) in the medication room, but the medication was unavailable.	F 759	Propionate was given to the Facility Pharmacy for Resident #13. Resident #13 was administered his Nasal Spray and Fluticasone Propionate that same afternoon, 8/14/2024. The Nurse Practitioner was making rounds on 8/14/2024 within the facility and observed Resident #48 and Resident #13 for any adverse side affects from not receiving medications as ordered. No adverse affects were found. 2. The Quality Assurance Committee met on 8/16/2024 to review the deficiency and determine if it will potentially affect all residents or only certain residents. The Quality Assurance Committee through Medical Record, Care Plan, and Documentation review has determined all residents have the potential to be affected by this deficient practice. 3. The Facility Pharmacy Representative will give 2 Onsight In-Services on 9/12/2024 and 9/13/2024 pertaining to Medication Administration. 4. Monthly Medication Administration Observance will be done by the Facility Pharmacy Representative Registered Nurse for 6 months beginning 8/16/2024. Each of the audit documentations will be brought to the Quality Assurance Committee beginning 9/25/2024. Monthly Medication Administration Observance will be done by the Facility Pharmacy Representative, Registered Nurse for 6 months beginning 8/16/2024 and will be taken to the Quality Committee for review	

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F 759	Continued From page 17 Record review of Resident #48's "Order Summary Report" with active orders as of 8/15/24 revealed an order dated 4/19/24 for Bethanechol Chloride Tab 25 mg Give 1 tablet via PEG-tube three times a day related to Essential (primary) hypertension." A record review of Resident #48's "Admission Record" revealed that the facility admitted the resident on 4/2/24, with diagnoses that included Essential Hypertension and Chronic Systolic Heart Failure. A record review of Resident #48's August 2024 Electronic Medication Administration Record (eMAR) documentation revealed Bethanechol Chloride was documented as unavailable for two doses on 8/13/24 and the morning dose on 8/14/24. On 8/14/24 at 9:07 AM, during an interview, LPN #2 stated it was the responsibility of the Director of Nursing (DON), Assistant Director of Nursing (ADON), and the cart nurses to ensure that medications were available for residents. She stated that if a resident was out of medications, the nurses must report it. She usually ordered medications when she noticed the supply was down to five (5) days. She emphasized the importance of residents receiving medications as ordered by the physician. She also stated that she usually ordered medications stat (meaning that the pharmacy was to deliver them the same day), but admitted she forgot to order Resident #48's blood pressure medication stat, which should have been done. Resident #13	F 759	and to maintain compliance for 6 months on 9/25/2024. If substantial compliance is met, these audit documents will be brought the Quality Assurance Committee on a quarterly basis to maintain compliance. The Director of Nursing Services will perform weekly medication administration audits beginning 8/19/2024 to determine proper medication administration. Medication Match Backs are performed by the Licensed Practical Nurse and/or the Registered Nurses daily on the 11/7 shift, with a frequency of 4 residents per night, to ensure the correct medications are on each perspective cart beginning 8/28/2024.	

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F 759	Continued From page 18	F 759		

At 8:35 AM on 08/14/23, during medication administration an observation and interview with Licensed Practical Nurse (LPN) #2 revealed that (LPN) #2 reported and confirmed Fluticasone Propionate nasal spray and Saline nasal spray was out of stock. Therefore, Resident #13 was unable to receive the ordered medications.

On 8/14/24 at 9:05 AM, during an observation of Resident #13 receiving his inhaler medication, the resident asked LPN #2 if they had found his nasal spray. The nurse stated, "No," and the resident commented that the last time he had received it was yesterday.

A record review of Resident #13's "Admission Record" revealed that the facility admitted the resident on 2/15/23, with diagnoses that included Chronic Obstructive Pulmonary Disease and Acute and Chronic Respiratory Failure with Hypoxia.

A record review of Resident #13's "Order Summary Report, with active orders as of 8/15/24, revealed a physician's order, with an order date of 4/2/24, for Nasal Spray (sodium chloride) 0.65% aerosol: one (1) spray in each nostril twice a day, every day, related to Chronic Respiratory Failure with Hypoxia and an order, with an order date of 2/15/23, for Fluticasone Propionate 50 MCG (microgram) Spray for two (2) sprays in each nostril daily, related to Chronic Obstructive Pulmonary Disease.

Record review of the August 2024 eMAR documentation revealed Resident #13 had not received the Saline Nasal Spray at 9 PM on 8/13/24 and the 9 AM dose on 8/14/24.

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F 759	Continued From page 19	F 759		

Fluticasone Propionate nasal spray was not documented as received at 8 AM on 8/14/24.

A record review of Resident #13's eMAR revealed that this was the second (2nd) dose of saline nasal spray and first (1st) dose of Fluticasone Propionate nasal spray that the resident had missed.

On 8/14/24 at 1:52 PM, during an interview with the ADON, it was confirmed that medications should be reordered when the supply reached five (5) days.

On 8/14/24 at 2:56 PM, in a phone interview, LPN #2 confirmed that she did not administer Resident #48's Bethanechol Chloride medication the previous day. However, she also added that she had spoken to the NP (Nurse Practitioner) and the NP clarified the order was for urine retention and not blood pressure. She stated she informed the Administrator, DON, and ADON about Resident #48's medication and Resident #13's medications being out of stock. She mentioned that she was unaware of the backup pharmacy and had charted it as a "9" on the eMAR because the medication was not in stock.

On 08/14/24 at 4:03 PM, during an interview with the DON, it was confirmed that cart nurses were responsible for informing her and the ADON when medications were out of stock. The DON stated that cart nurses should ensure that medications are in stock for residents to receive their medications as scheduled. She expressed uncertainty about why the nurses ran out of medications but confirmed that nurses were supposed to order medications when the supply was down to a five-day supply to avoid running

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F 759	Continued From page 20 out. She also stated that nurses were expected to follow physician orders. The DON mentioned she was unaware of a backup pharmacy but stated that medications should arrive the day they are ordered unless they are special-order medications. She emphasized that the out-of-stock medications were not special-order medications and reiterated her expectation that nurses administer medications per physician orders, as not receiving medications as prescribed could harm residents due to their health conditions.	F 759		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and	F 803		9/25/24

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F 803	Continued From page 21 §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to serve therapeutic portion sizes of foods as planned per the facility's menu for one (1) of seven (7) food items requiring specific portions on the lunch meal tray line. Resident #40 Findings Include: A review of the facility's policy, "Tray Assembly", revised 6/17, revealed, " ...Prepared foods are portioned and assembled for individual meals in the food and nutrition services department. Procedure ...6. Menu items and equipment are positioned in reach of the food service employees. These items include ...c. Serving utensils as specified on the menu and equipment needed for correct portions ...10. Portions are ...weighed on portion scales ..." A record review of the facility's "Menu Guide Report" for Spring/Summer 2024 revealed the following portion sizes to be served at lunch: 3 ounces of country meatloaf, 1/3 cup of mashed potatoes,1-ounce brown gravy, 1/3 cup of buttered green peas, one (1) fresh baked roll, one (1) piece of confetti cake with icing, and one (1) cup of iced tea. On 08/13/24 at 10:51 AM, during an interview, Resident #40 complained her meals had inconsistent portion sizes and stated she had mentioned this concern to the facility staff.	F 803	1. An In-Service was given by the Certified Dietary Manager to the Morning Cook on 8/14/2024 explaining how the Menu's are to be followed, explaining how portion sizes are to be weighed on the portion scale, explaining if the Menu states a specific weight it must be weighed on the portion scale, and explaining that she and all cooks must use portion control. 2. On 8/16/2024, the Quality Assurance Committee met to review the deficiency and determine if it will potentially affect all residents or only certain residents. Through Medical Record, Care Plan, and Documentation review, the Quality Assurance Committee determined that all residents have the potential to be affected by this deficient practice. 3. On 8/19/2024 the Registered Dietician held an In-service with all Kitchen Staff, including the Certified Dietary Manager concerning the Knowledge and Understanding of proper utensils for serving sizes of the Dietary Menus. 4. A Bi-Weekly Audit for verifying proper portion sizes and the use of proper utensils and following the dietary menus will be performed by the Certified Dietary Manager for 3 months beginning 8/19/2024. Audit records will be brought to	

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F 803	Continued From page 22 On 08/13/24 at 12:35 PM, an observation of two (2) sampled meal trays with the Certified Dietary Manager (CDM) revealed the meal consisted of meatloaf, mashed potatoes, green peas, roll, cake and tea. The portion sizes for the meatloaf were notably different. On 08/13/24 at 12:50 PM, during an interview, Dietary Staff #1 acknowledged that she sliced the meatloaf freehand, resulting in each slice being visibly different in size. The cook confirmed that a serving of meatloaf should be 3 ounces and reported that the facility had not provided any means for her to measure a serving of meatloaf. On 08/13/24 at 1:00 PM, during an interview with the Certified Dietary Manager (CDM), he stated that he was unaware the meatloaf was not evenly sliced. The CDM confirmed that a serving of meatloaf should be 3 ounces and reported that the facility had a scale available to measure portions of meatloaf. However, he confirmed that no scale was present during the serving of that day's meatloaf. On 08/15/24 at 10:34 AM, during an interview with the Administrator, it was confirmed that he had already been made aware of the inconsistent portions of food served during lunch on 08/13/24. The Administrator stated that he expected the dietary staff to follow the portion sizes identified on the menu. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/01/2024 revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.	F 803	the Quality Assurance Committee monthly beginning 9/25/2024 for 3 months to determine substantial compliance has been attained. After such substantial compliance has been met, the Bi-Weekly audits perfomed by the Certified Dietary manager will be brought to the Quality Assurance Committee quartrly to maintain such substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255303	A. BUILDING _____ B. WING _____	C 08/15/2024

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F 803	Continued From page 23 Record review of the "Care Profile" revealed a physician order that Resident #40 was to receive a "Regular diet, Regular texture, and Large portions.	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and facility policy review, the facility failed to store food and maintain sanitary practices in accordance with professional standards for food safety related to unlabeled foods, foods without identified dates, exposed foods, and overly ripe produce for one (1) of two (2) kitchen observations. Findings Include:	F 812	1.The overly ripe produce, outdated milk, and unlabeled food items in the kitchen, along with the exposed shrimp and the unopened bag of salad was disguarded into the garbage on 8/13/2024. 2. The Quality Assurance Committee met on 8/16/2024 to review the deficiency and determine if it will potentially affect all	9/25/24

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F 812	Continued From page 24 A review of the facility's policy, "Storage of Refrigerated Food", revised 10/17, revealed, "The facility ensures the quality and safety and sanitation of refrigerated foods through accepted storage practices. Procedure ...4. No food is left uncovered. 5. All opened foods are labeled with common name of food, date stored, and use-by date ..." On 08/13/24 at 9:19 AM, during an observation of the kitchen and interview with the Certified Dietary Manager (CDM), Refrigerator #1 had nine (9) overly ripe tomatoes containing white biological growth on each tomato. There was (1) unopened bag of salad mix with a facility received sticker of 8/7/24, with no manufacturer's date, and a brown discolored liquid inside the bag. There was (1) opened block of cream cheese inside a plastic food storage bag with a written-on date of 6/30/24. The CDM explained that this was the date it came in and most likely the date it was opened. Additionally, there was (1) plastic storage bag of sliced ham with a handwritten date of 7/28, (1) plastic storage bag of bologna dated 8/12/24, (1) plastic storage bag of bologna with a date of 8/7/24, and (1) plastic storage bag of bologna dated 7/8/24. The CDM stated these were the dates the sliced ham and bologna were opened and placed in the bags. An observation of Refrigerator #3 revealed four (4) eight (8) ounce containers of chocolate milk wrapped in plastic wrap with a manufacturer's date of "Aug 11" and a "received-on" date of 7/31." An observation of the freezer revealed (1) bag of shrimp that was opened, and the shrimp was exposed. On 08/13/24 at 01:00 PM, during an interview, the	F 812	residents or only certain residents. The Quality Assurance Committee agreed with this being an unsanitary practice and that all residents have the potential of being affected by this deficient practice. 3. An In-Service was held by the Licensed Nursing Home Administrator and the Certified Dietary Manager will all kitchen staff on 8/20/2024 pertaining to Preventing Foodborne Illnesses. On 8/19/2024 the Registered Dietician conducted an In-Service with the Certified Dietary Manager and all kitchen staff pertaining to Food Storage, Sanitary Conditions, and Dietary Policies. 4. A Bi-Weekly Audit for verifying proper food storage, sanitary conditions and following dietary policies will be performed by the Certified Dietary Manager beginning 8/19/2024 for 3 months. Audit records will be brought to the Quality Assurance Committee monthly beginning 9/25/2024 for those 3 months to determine substantial compliance has been attained. After such substantial compliance has been met, the Bi-Weekly audits perfomed by the Certified Dietary Manager will be brought to the Quality Assurance Committee quartrly to maintain such substantial compliance.	

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F 812	Continued From page 25 CDM acknowledged the overly ripe produce, outdated milk, and unlabeled food items in the kitchen. The CDM stated it was his responsibility to check for outdated foods and to insure proper labeling. He expressed that food should be checked daily and confirmed that he in-serviced the staff monthly on food safety. On 08/15/24 at 12:20 PM, an interview with the Administrator revealed he was aware of the findings during the kitchen observations regarding unlabeled and out of date food items, as well as expired and exposed foods. The Administrator stated he expected the kitchen staff to monitor the foods daily for expired items and to inspect the produce daily.	F 812		