STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255267	A. BUILDING _____ B. WING _____	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARKSDALE NURSING CENTER	1120 RITCHIE AVE CLARKSDALE, MS 38614

(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 re-certification survey at the facility from 8/13/24 to 8/15/24. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA identified non-compliance and cited F641, F656, F677, F692, F867 and F880. The census at the time of the survey was 54 and the facility is licensed for 60 beds.	F 000		
F 641 SS=C	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to accurately code the Minimum Data Set Assessment (MDS) for the use of restraints for five (5) of five (5) resident MDS Assessments reviewed for accurate coding of restraints. Resident #5, #18, #25, #33, and #38. Findings include: Record review of the facility policy titled "Resident Assessment" revised 09/19, revealed "...Any healthcare professional that completes a portion of the assessment must sign and certify the accuracy of the portion of the assessment that they have completed..." Resident #5	F 641	F641 Accuracy of Assessment 1) Each resident assessment that was coded with a restraint was opened, modified, transmitted to State and accepted. Resident #5 and #18's modified assessments were transmitted and accepted on 8/18/24. Resident #25's modified assessments were transmitted and accepted on 8/16/24 and 8/20/24. Resident #33's modified assessments were transmitted and accepted on 8/20/24. Resident #38's modified assessments were transmitted and accepted on 8/19/24. 2) Since all residents have the potential to	9/13/24

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

Electronically Signed | 08/28/2024

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F 641	Continued From page 1 Review of the Quarterly MDS dated with an Assessment Reference Date (ARD) of 7/15/24 for Resident #5 revealed "Section P Restraints" was coded that resident uses side rails daily. An observation on 8/13/24 at 11:20 AM, of Resident #5's bed, revealed one-half (½) siderails to the head of the bed only. Interview with Certified Nursing Assistant #1 (CNA) on 8/14/24 at 10:30 AM, she stated that the one-half (1/2) upper side rails on Resident #5's bed do not restrain her or keep her from getting out of the bed. Review of the "Face Sheet" revealed the facility admitted Resident #5 on 6/27/24 with a diagnosis of Pseudobulbar Affect. Resident #18 During an observation and interview on 8/13/24 at 2:02 PM, Resident #18's bed was noted to have upper side rails. The resident revealed that the side rails help her turn. Record review of Resident #18's "Face Sheet" revealed the resident was admitted to the facility on 1/05/24 with medical diagnoses that included Rheumatoid arthritis and a Personal history of stroke. Record review of Resident #18's MDS with an ARD of 7/9/24 revealed under Section: P that Physical restraints was coded to use bed rail daily. Record review of Resident #18's MDS with an	F 641	be affected by this deficient practice all Minimum Data Set's for the year 2024 for current residents and discharged residents were reviewed , modified, transmitted to State and accepted on 8/16/24, 8/18-20/24 and 8/22/24. 3) The Nurse Case Manager and the Assessment Nurse were in-serviced by the Quality Improvement nurse on the Resident Assessment Instrument Manual and supporting documentation on 8/13/24. She in-serviced the Nurse Case Manager and the Assessment Nurse on the importance of proper coding of the MDS by the RAI directions and State Guidelines on 8/15/24. 4) The Director of Nurses and the Administrator will review MDS coding weekly prior to transmission to the State. They will monitor weekly starting 8/21/24 for a month, then monthly for two months. An Emergency Quality Assurance Meeting was called with the Medical Director on 8/16/24 for preliminary approval of the Plan of Correction and on 8/23/24 for approval of the final Plan of Correction. The Plan of Correction monitoring will be reviewed weekly in the Department Head Meeting starting 8/26/24. The Administrator will bring any exceptions to the Quality Assurance Committee monthly starting 9/12/24 for three months or until substantial compliance is achieved.	

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F 641	Continued From page 2	F 641		

ARD of 7/9/24 revealed under Section C that the resident had a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident is moderately cognitive impaired.

Resident #25

Review of the Quarterly MDS with an ARD of 5/14/2024 for Resident #25 revealed Section P-Restraints was coded the resident uses side rails daily.

An observation on 8/13/24 at 10:30 AM, of Resident #25's bed, revealed ½ rails to the head of the bed only.

In an interview with Registered Nurse (RN)/Treatment nurse on 8/14/24 at 10:05 AM, she revealed that Resident #25 was not physically able to get herself out of the bed and the side rails to the top of the bed were not considered restraints.

Review of the "Face Sheet" revealed the facility admitted Resident #25 on 7/05/23 with a diagnosis of Encounter for the orthopedic aftercare.

Resident #33

Review of the Quarterly MDS with an ARD of 7/30/24 revealed "Section P Restraints" was coded that resident uses side rails daily.

An observation on 8/13/24 at 10:58 AM, revealed Resident #33 had two half rails located at the head of the bed only.

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F 641	Continued From page 3	F 641		

In an interview with the RN Treatment nurse on 8/14/24 at 10:00 AM, she revealed that Resident #33 was unable to get herself out of the bed and the side rails to the top of the bed were not considered restraints.

Review of the "Face Sheet" revealed the facility admitted Resident #33 on 7/05/23 with a diagnosis of Type two Diabetes Mellitus.

Resident #38

Review of the Significant Change MDS with an ARD of 6/7/24 for Resident #38 revealed "Section P Restraints" was coded the resident uses side rails daily.

An observation on 8/13/24 at 11:00 AM, of Resident #38's bed, revealed one-half (½) siderails to the head of the bed only.

Interview with Licensed Practical Nurse #2 (LPN) on 8/14/24 at 10:35 AM, she stated that Resident #38 is not physically able to get out of bed without of assistance. She stated that the one-half (1/2) side rails on Resident 38's bed are used to enhance her mobility and do not restrain her. She stated that the facility is restraint free.

Review of the "Face Sheet" revealed the facility admitted Resident #38 on 3/7/24 with a diagnosis of Dementia.

In an interview with the Nurse Case Manager on 8/14/24 at 11:21 AM, she revealed that she found out yesterday 8/13/24 from the Nurse Consultant that the MDS department has been incorrectly coding section P of the MDS for restraints. She then stated that the previous Case Manager

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F 641	Continued From page 4 trained her to code all side rails as restraints on the MDS. She also confirmed that Section P of the MDS for restraints for Resident's #5, #18, #25, #33, and #38 were coded incorrectly, and the residents do not have restraints. Furthermore, she stated that the purpose of coding the MDS correctly is to provide an accurate reflection of the resident's specific care that each resident requires. In an interview with the Administrator on 8/14/24 at 11:30 AM, she revealed the facility has no restraints, and confirmed she was unaware that the resident MDS assessments were being coded incorrectly. In an interview with the RN/ MDS Assessment nurse on 8/14/24 at 11:51 AM, she revealed she was trained to code all side rails as restraints because the residents cannot physically remove side rails from the bed. She stated she knew they were not restraints, but that is the way she was trained.	F 641		
F 656 SS=E	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	F 656		9/13/24

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F 656	Continued From page 5 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to implement care plans related to fluid restriction (Resident #11), nail care (Resident's #24 & #44) and following Enhanced	F 656	F656 Develop/Implement Comprehensive Care Plan 1) Resident #11'S total amount of fluids for the day was divided out on his	

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F 656	Continued From page 6 Barrier Precautions (EBP) for (Resident #157) for four (4) of 19 care plans reviewed. Findings included: Review of the facility policy titled, "Care Plan Process," revised 08/17, revealed "The facility staff shall follow the care plan ..." Resident # 11 Record review of the "Care Plan" for Resident #11 revealed "Resident receives dialysis...Has fluid restrictions 960 cubic centimeters (cc's) in a 24 hour per day (see EMAR)." Record review of August 2024 "Electronic Medical Record" (EMAR) for Resident #11 revealed the resident received more than 960 cc's of fluid per day for none (9) of 13 days from 8/1/24 through 8/13/24. (8/1/24, 8/2/24, 8/5/24, 8/6/24, 8/7/24, 8/8/24, 8/9/24, 8/11/24, and 8/12/24). During an interview with Nurse Case Manager on 8/14/24 at 2:05 PM, she verified that Resident #11's care plan indicated that he was on a 960 cc per day fluid restriction. The Nurse Case Manager stated that staff failed to follow the care plan when they gave the resident more than 960 cc's per day. She stated that this could cause a fluid overload for the resident. Resident #24 A record review of Resident #24's "Care Plan revealed with a problem onset date of 08/29/2023 revealed "Resident needs assistance with ADL'S (Activities of Daily Living) ... Approaches ... Nail Care weekly. Check condition and clean PRN (as	F 656	Electronic Medication Administration Record (EMAR) for each shift for the nurses to sign off when given on 8/22/24. Resident #24 had a resident specific care plan completed for her Activities for Daily Living to include nail care on 8/14/24 by Nurse Case Manager. Resident #24 had her nails cut and cleaned on 8/14/24 by Licensed Practical Nurse #2. Resident #44's care plan was correct. He had his nails cut and cleaned by Licensed Practical Nurse #2 on 8/14/24. Resident #157's care plan included Enhanced Barrier Precautions for a central line. Staff that did not follow the care plan were in-serviced and educated on the policy "Enhanced Barrier Precaution" by the Director of Nurses on 8/15/24. An Enhanced Barrier Precaution sign was placed on resident's door on 8/13/24. 2)All residents have the potential to be affected by the deficient practice of not following their plans of care. All residents on fluid restrictions had their total fluid for each shift placed on their EMAR's to be signed off by nursing. All care plans for residents have been reviewed by the Director of Nurses and completed by 8/28/24. 3) All Nursing staff have been in-serviced on Activities for Daily Living, Care Plans, Nail Care and Enhanced Barrier Precautions policies on 8/15/24, 8/16/24, 8/19/24, 8/20/24, 8/21/24 and 8/22/24 by the Director of Nurses, Staff Development Nurse and Staff Nurse. Housekeeping	

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F 656	Continued From page 7 needed) ... Fingernails: Clean and Trimmed weekly on Tuesdays as indicated..." During an observation on 08/13/24 at 10:40 AM, Resident #24's fingernails were long and jagged, approximately one-half (1/2) inch past the tips of fingers on both hands. An observation on 08/14/24 at 9:13 AM, Resident #24's fingernails were long and jagged, approximately one-half (1/2) inch past the tips of fingers on both hands. During an observation and interview on 08/14/24 at 10:50 AM, Licensed Practical Nurse (LPN) #2 confirmed that resident #24's nails were long and jagged and needed to be trimmed and confirmed that the resident's Care Plan was not being followed and should have been. During an interview on 08/14/24 at 11:10 AM, the Director of Nurses (DON) confirmed that Resident #24's fingernails were to be cleaned daily, and the nurses were to trim them on Tuesdays as indicated. She revealed that her ADL care plan was not being followed if her nails were not trimmed like they should have been. Resident #44 A record review of Resident #44's "Care Plan" with a Problem onset date of 07/19/2023 revealed "Resident needs limited assist with ADL'S (Activities of Daily Living) ... Approaches ...Fingernail: Clean and trimmed weekly as indicated..." During an observation and interview on 08/14/24, at 1:30 PM, Resident #44's fingernails were long	F 656	and laundry were in-serviced on Enhanced Barrier Precautions on 8/22/24 by the Environmental Manager. 4)The Director of Nurses will monitor fluid intake on all residents with fluid restrictions from the EMAR three times a week times two weeks, then two times a week for two weeks, then one time a week for two weeks and then one time a month for two months starting 8/26/24. All resident's nails were monitored on 8/14/24 and 8/21/24 by Staff Development/Infection Preventionist, Registered Nurse Supervisor and Treatment Nurse. All resident's nails will be monitored on 8/28/24. They will be monitored after that for three times a week for two weeks, then two times a week for two weeks, then one time a week for two weeks by the Director of Nurses, RN Supervisor, Staff Development/Infection preventionist and Treatment Nurse starting 8/14/24. The Director of Nurses, Staff Development/Infection Preventionist, RN Supervisors and the Treatment Nurse will monitor residents with Enhanced Barrier Precautions three times a week for two weeks, then two times a week for two weeks, then one time a week for two weeks, then one time a month for two months beginning on 8/26/24. An Emergency Quality Assurance meeting on 8/16/24 was conducted with the Medical Director for approval of the preliminary Plan of Correction and on 8/23/24 for the approval of the final Plan of Correction. The Plan of Correction monitoring will be	

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F 656	Continued From page 8	F 656		

and jagged, approximately one inch past the tips of his fingers, with a brown substance underneath. Resident #44 stated "my nails grow fast, but I think it's been about three weeks since they were cut."

During an interview and observation on 08/14/24 at 2:10 PM, LPN #2 confirmed that Resident #44's fingernails were soiled and needed to be cut and that his plan of care was not being followed.

During an interview and observation on 08/14/24 at 2:20 PM, the DON confirmed that the resident's nails were long and needed to be cut. The DON also confirmed that Resident #44's ADL care regarding his nail care was not being followed.

During an interview on 08/15/24 at 9:50 AM, the Registered Nurse (RN) Supervisor revealed that both Resident #24 and Resident #44's ADL care plans regarding nail care were not being followed, and they should have been.

Resident #157

Record review of the "Care Plan" for Resident #157 revealed "Problem/Need: Resident receives IV (intravenous medications) ...Approaches ...Enhanced barrier precautions followed..."

During an observation on 8/14/24 at 12:35 PM, revealed an enhanced barrier sign observed on the outside doorway to Resident #157's room. Observed the RN Supervisor enter Resident #157's room to administer ceftriaxone intravenous (IV) solution via the PICC line. The RN Supervisor was observed connecting the IV

reviewed weekly in the Department Head Meeting weekly starting 8/26/24. The Administrator will bring any exceptions to the Quality Assurance Committee monthly starting 9/12/24 for three months or until substantial compliance is achieved.

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F 656	Continued From page 9 tubing to the resident's right upper arm PICC line access device. The RN Supervisor did not put on a gown for enhanced barrier precautions before the procedure. Upon exiting the room, the RN Supervisor was asked if Resident #157 was on enhanced barrier precautions. She stated "yes" and pointed to the enhanced barrier precaution sign on the outer doorway of Resident #157's room. She then confirmed that she did not use enhanced barrier precautions while hanging Resident 157's IV antibiotics via his PICC line. During an interview with the Nurse Case Manager on 8/14/24 at 2:03 PM, she verified that Resident #157's care plan indicated that Enhanced Barrier Precautions (EBP) were to be used during administration of medication of IV antibiotics by PICC line. She then stated that staff failed to follow the care plan when they failed to use EBP when administering IV antibiotics and this could increase his risk for infection. She stated that the purpose of the care plan is to identify issues and put interventions in place to help achieve goals related to the resident's needs.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, facility policy review, and record review, the facility failed to ensure fingernails were clean and trimmed, as evidenced by long and jagged nails with a brown substance under	F 677	F677 ADL Care Provided for Dependent Residents 1) Resident #24 had her nails cut and cleaned by Licensed Practical Nurse #2,	9/13/24

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F 677	Continued From page 10	F 677		

nails for two (2) of eight (8) residents observed. Resident #24 and Resident #44

Findings include:

Record review of the facility's, "Nail Care" Policy, revised 07/10, revealed "Purpose: To promote cleanliness, safety, and a neat appearance... Procedure ...1. Perform hand hygiene ... 7. Remove any debris from under the nails. 8. Trim the nails straight across... 14. Document all appropriate information in the clinical record..."

Resident #24

During an observation on 08/13/24 at 10:40 AM, Resident #24's fingernails were long and jagged, approximately one-half (1/2) inch past the tips of fingers on both hands.

An observation on 08/14/24 at 9:13 AM, Resident #24's fingernails were long and jagged, approximately one-half (1/2) inch past the tips of fingers on both hands.

During an observation and interview on 08/14/24 at 10:40 AM, Certified Nurse Aide (CNA) #2 revealed she wasn't sure if the resident was diabetic but thought she was, and the nurses were supposed to trim her fingernails. She confirmed Resident #24's fingernails were long and jagged and revealed she could scratch herself and have a skin tear.

During an observation and interview on 08/14/24 at 10:50 AM, Licensed Practical Nurse (LPN) #2 confirmed that Resident #24's nails were long and jagged and needed to be trimmed. She revealed that the nurses are supposed to trim her

who was assigned to this resident on 8/14/24. Resident #44 had his nails cut and cleaned by Licensed Practical Nurse #2 on 8/14/24.

2) All residents have the potential to be affected by this deficient practice of not keeping a resident's nails clean and cut.

3) All nursing staff were in-serviced on the policy "Activities for Daily Living" and "Nail Care" policy on 8/15/24, 8/16/24, 8/19/24, 8/20/24, 8/21/24 and 8/22/24 by the Director of Nurses, Staff Development/Infection Preventionist and Staff Nurse. All staff will be in-serviced 4x's per year and as needed on Activity of Daily Living and Nail Care policies by Staff Development/Infection Preventionist. The Director of Nursing, Staff Development, Nursing Supervisors, and treatment nurse monitored all residents nails on 8/14/24, 8/21/24 and will do 100% on 8/28/24.

4) Nail care is on the resident's Electronic Medication Administration Record (EMAR)to be documented weekly by Licensed Nurses. The day shift Registered Nurse Supervisor has been added to the EMAR on 8/29/24 to sign off weekly to monitor for continuous compliance beginning on 8/30/24. She will begin on 8/30/24 with documentation on the EMAR. The Director of Nurses, Staff Development/infection Preventionist, Supervisors and Treatment Nurse will make rounds three times a week for two weeks, then two times a week for two weeks, then one time a week for two

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F 677	Continued From page 11 fingernails weekly since she is diabetic. She revealed that she could scratch herself with the jagged nails, get a skin tear, and possibly get an infection. A record review of Resident #24's Electronic Administration Record (EMAR) for August 2024 revealed under Nursing Instruction, "Fingernail: Clean and trimmed weekly on Tuesday as indicated." The weekly dates of August 6 and August 13 were signed off as completed. August 13 was signed off by LPN #2. In an interview on 08/14/24 at 11:10 AM, the Director of Nurses (DON) confirmed that Resident #24's fingernails were to be cleaned daily, and the nurses were to trim the nails on Tuesdays as indicated and sign that it was completed in the EMAR. She confirmed that if the resident's nails were long and not trimmed, it could cause a skin tear injury for the resident. A record review of the "Face Sheet" revealed Resident #24 was admitted to the facility, on 08/29/2023 with diagnoses that included Type 2 diabetes mellitus and Unspecified dementia, severe. Resident #44 During an observation and interview on 08/14/24, at 1:30 PM, Resident #44's fingernails were long and jagged, approximately one inch past the tips of his fingers, with a brown substance underneath. Resident #44 stated "my nails grow fast, but I think it's been about three weeks since they were cut." In an interview on 08/14/24 at 2:00 PM, CNA #2	F 677	weeks, then one time a month for two months beginning 8/14/24. An Emergency Quality Assurance Meeting on August 16 2024 was conducted with the Medical Director for approval of the preliminary Plan of Correction and on 8/23/24 for approval for the final Plan of Correction. The Plan of Correction monitoring will be reviewed weekly in the Department Head Meeting starting 8/26/24. The Administrator will bring any exceptions to the Quality Assurance Committee monthly starting 9/12/24 for three months or until substantial compliance is achieved.	

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stated, "I never cut his fingernails. He doesn't let you do it, so I don't even try."

An observation and interview on 08/14/24 at 2:05 PM revealed Resident #44 sitting in his wheelchair in his room. His fingernails were long, jagged, and had a brown substance underneath. Resident #44 revealed that he doesn't refuse his fingernails to be cut and would like them trimmed.

During an interview and observation on 08/14/24 at 2:10 PM, LPN #2 revealed that the CNAs could do Resident #44's fingernails since he is non-diabetic. When asked about the last time the resident's nails were cleaned and trimmed, LPN #2 stated, "I can't answer that since I don't work down here every day." LPN #2 confirmed she did not look at his nails yesterday but did sign off on the EMAR that they were done. LPN #2 confirmed that Resident #44's fingernails were soiled and needed to be cut. She revealed that the treatment nurse usually does his nails, and the treatment nurse told her yesterday that all the nails were done, so she just signed them off without looking. Resident #44 stated to LPN #2, "I would like my nails cut."

A record review of Resident #44's EMAR for August 2024 revealed under nursing Instruction, "Fingernail: Clean and trimmed weekly on Tuesday as indicated." The weekly dates of August 6 and August 13 were signed off as completed. August 13 was signed off by LPN #2.

During an interview and observation on 08/14/24 at 2:20 PM, the DON confirmed the resident's nails were long and needed to be cut. Resident #44 stated, "Yes, I want them cut." The DON revealed the EMAR shouldn't have been checked

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off without the nurse looking at the nails to make sure they were done.

During an interview on 08/14/24 at 2:35 PM, the Registered Nurse (RN) Treatment Nurse revealed, I asked the resident yesterday if he wanted his nails done, and he was on the phone, and his wife said "not at this time." The RN Treatment Nurse stated "I went back later and asked him again, and he said "no." She confirmed the resident's nails are to be kept clean and trimmed weekly and stated, "I can't really tell you the last time his fingernails were cut."

An interview on 08/15/24 at 9:50 AM with the RN Supervisor revealed the nurses and CNAs can all do nail care, however, the CNAs cannot do residents who are diabetic or on blood thinners, but they can let the nurses know when they do their AM care that the resident's nails need to be tended to. She revealed it doesn't fall under the task for the CNAs to check off, but they know they are to do the nails and then let the nurse know that the nails have been done so she can document them. She revealed it is the responsibility of either the treatment nurse or the charge nurse to physically look at the resident's nails every Tuesday and ensure that the nails are cleaned, trimmed, and appropriately documented on the EMAR.

During an interview on 08/15/24 at 10:59 AM, the Administrator revealed that the CNAs and nurses are both responsible for resident nail care. She revealed that the nurse who is taking care of the residents can easily look at their fingernails when they are passing their medication and make sure they are cleaned and trimmed, and they are to document this weekly.

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F 677	Continued From page 14 A review of the Face Sheet revealed Resident #44 was admitted to the facility on 07/06/2023 with diagnoses that included Peripheral vascular disease and Cerebral infarction. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/26/2024 Section C ,revealed a Brief Interview for Mental Status (BIMS) score of 08, indicating Resident #44 is moderately cognitively impaired.	F 677		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and	F 692	F692 Nutrition/Hydration Status	9/13/24

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F 692	Continued From page 15 facility policy review the facility failed to ensure that a fluid restriction was followed for one (1) of five (5) residents on fluid restrictions. Resident #11. Findings included: Record review of facility policy "Fluid Restriction" with the latest review date of 02/22 revealed "Policy: Fluids will be restricted for residents as directed by physician orders ...Fluid Restriction 1000 cc's (cubic centimeters), Total Nursing 300 cc's, By Shift 120cc's day, 90 cc's evening (eve), 90 cc's night (noc). Total Dietary 700 cc's ..." Record review of August 2024 "Active Orders" for Resident #11 revealed "Fluid Restriction 960 Milliliters (ML) per day" with an onset date of 3/10/23. Record review of August 2024 "Electronic Medical Record" (EMAR) for Resident #11 revealed that Resident #11 received more than 960 cc's of fluid per day for nine (9) of 13 days from 8/1/24 through 8/13/24. (8/1/24, 8/2/24, 8/5/24, 8/6/24, 8/7/24, 8/8/24, 8/9/24, 8/11/24, and 8/12/24). In an interview with the Dietary Manager on 8/14/24 at 1:08 PM, she stated that Resident #11 was on a 1000 milliliter (ml) a day fluid restriction. She stated that the facility follows the fluid restriction policy that breaks down how much fluid nursing and dietary are to provide each shift. The Dietary Manager stated that the facility was following the fluid breakdown for a 1000 ml a day fluid restriction and that dietary provides (1) four (4) ounce (oz.) cup of fluid on each tray. (4) oz. equals 120 ml.	F 692	Maintenance 1) Resident #11 who is on fluid restrictions has had his Electronic Medication Administration Record (EMAR) updated to show how much fluid he is to receive on each of three shifts in a twenty-four-hour period on 8/22/24. The Charge nurse per shift will sign off on how much fluids she gives beginning 8/22/24. 2) all residents on fluid restrictions have the potential to be affected by the deficient practice of not following their fluid restriction orders. all residents on fluid restrictions had their total fluid for each shift placed on their EMAR's to be signed off by the medication nurse. 3) All Nursing Staff were in-serviced on the "Fluid Restriction" policy on 8/15-16/24 and 8/19-22/24 by the Director of Nurses, Staff Development/Infection Preventionist and Staff Nurse. All orders for residents on fluid restrictions were checked and total amount of fluid for the day was divided out to the three different shifts and placed on the residents EMAR on 8/22/24 by the Director of Nurses. The nursing staff will know how much fluid is to be given on each shift and will sign off on the EMAR when given. 4) The Director of Nurses will monitor the resident's EMARS three times a week for two weeks, then two times a week for two weeks, then one time a week for two weeks, then one time a month for two months Beginning 8/26/24. An Emergency	

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F 692	Continued From page 16 During an interview with Licensed Practical Nurse (LPN) #1 on 8/14/24 at 1:34 PM, she stated that Resident #11 was on a 1000 ml/day fluid restriction. When asked how she knew how much fluid the resident was to receive on her shift she stated that dietary provided a (4) oz. cup of fluid on each tray, and she provided a (4) oz. cup of fluid during each med pass. LPN #1 verified that she gives Resident #11 (2) four ounce cups of fluid on her shift. An interview with the Director of Nursing (DON) on 8/14/24 at 1:45 PM, she verified Resident #11 should be on a 960 ml per day fluid restriction not a 1000 ml per day fluid restriction. The DON verified that documentation on the EMAR did reflect that the resident received more than 960 ml per day on nine (9) out of 13 days in August 2024. She stated that failure to follow the fluid restriction for Resident #11 could lead to fluid overload. Record review of the "Face Sheet" for Resident #11 revealed that the facility admitted him on 3/10/23 with a diagnoses that included End Stage Renal Disease.	F 692	Quality Assurance meeting was held with the Medical Director on 8/16/24 for review of the preliminary Plan of Correction and 8/23/24 for approval of the final Plan of Correction. The plan of correction monitoring will be reviewed weekly in the Department Head Meeting starting 8/26/24. The Administrator will bring any exceptions t the Quality Assurance Committee monthly starting 9/12/24 for three months or until substantial compliance is achieved.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F 867		9/13/24

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F 867	Continued From page 17 §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.	F 867		

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§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

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

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

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement

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F 867	Continued From page 19 projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor the interventions the committee put in placing following the recertification survey on 4/6/2023 and the complaint survey on 6/26/2024. This was for deficiency recited during a recertification on 8/15/2024 in the area of F677 Activities of Daily Living (ADL). The continued failure of the facility during three State Surveys of record shows a pattern of the facility to sustain an effective QAA program. This was for one (1) of seven (7) deficient practice citations.	F 867	F867 QAPI/QAA Improvement Activities 1) The Administrator was in-serviced on the facility Quality Assurance Performance Improvement Program (QAPI) policy and QAPI Performance Improvement Project (PIP) policy by her Regional Supervisor on 8/27/24. The Administrator reviewed a training video on QAPI on 8/27/24. A new Performance Improvement Plan was written on Activities for Daily Living Care on 8/27/24. 2) All residents have the potential to be affected by the deficient practice of not	

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F 867	Continued From page 20 Findings Included: This citation is cross-referenced to: F677 Review of the facility policy titled "QAPI Performance Improvement Project (PIP)" with a revision date of 11/22 revealed, "The QA Committee annually prioritizes activities, endorses or re-endorses policies and procedures, and continually monitors for improvement through the use of a QAPI self-assessment. In addition, the QA Committee will implement any PIP topics as indicated through data analysis. ... PIPs are implemented in accordance with CMS' protocol for conducting PIPs, including: 1. Measurement of performance using objective quality indicators. 2. Implementation of system interventions to achieve improvement in quality based on Root Cause Analysis. 3. Evaluation of the effectiveness of the interventions. 4. Plan and initiation of activities for increasing or sustaining improvement." An interview with the Administrator (ADM) on 08/15/24 at 10:05 AM revealed she was not aware that the resident's Activities of Daily Living (ADL) were not being done and was a concern for the facility again. She revealed after we were cited for ADLs during our annual survey last year and again cited on a complaint survey this year, the Interdisciplinary Team (IDT) discussed those in Quality Assurance Performance Improvement (QAPI), which involved our Medical Director, and we put measures in place, with monitoring to ensure this would be resolved but obviously something is wrong if this is a continued issue, and our plan is not working. Record review of the Facility's Plan of Correction	F 867	following a QAPI program in the facility. 3) The Quality Assurance Committee were in-serviced on QAPI and the importance of the Quality Assurance Program in the facility. This included the importance of continuing follow up and re-evaluation of our policies, reports, and results on 8/28/24 by the Administrator. An Emergency Quality Assurance Meeting was held with the Medical Director on 8/28/24 to hear the in-service and approve the Performance Improvement Plan for the ADL Care. 4)The Administrator will review the QAPI program and PIP's with the Regional Supervisor quarterly beginning 9/12/24 for two quarters. The Regional Supervisor will review QAPI performance process to ensure compliance quarterly until substantial compliance has been achieved staring 9/12/24.	

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(POC) dated 5/5/23 revealed under, "3. All Licensed Practical Nurses, Registered Nurses and Certified Nursing Assistants were in-serviced on the policy "Nail Care" on 04/13/23, 04/18/23 & 04/19/23 by the Director of Nursing. Orders were written for nail care and placed on the Electronic Medical Administration Record (EMAR) for nurses to check and initial weekly to assure that proper nail care is being done on all residents. 4. Nail care has been added to all resident's EMAR. Licensed Practical Nurses or Registered Nurses will assess all fingernails weekly and clean and trim as indicated. The Registered Nurse Supervisor will monitor nail care five times a week while making daily rounds. The Director of Nursing will monitor the EMAR weekly for four weeks and then monthly for two months. Monitoring began on April 7, 2023. The director of Nurses will report any concerns to the Quality Assurance Committee. The Director of Nurses or the Administrator will report any concerns to the Quality Assurance Committee weekly for four weeks and then quarterly. The Quality Assurance Committee met with the Medical Director on April 10, 2023, post annual State Survey to review potential tags. The Medical Director will meet with the Quality Assurance Committee on May 2, 2023 to review/approve the Plan of Correction for the actual tags. The Quality Assurance Committee will monitor quarterly for one year until the deficient practice is resolved and will make revisions and/or corrections when needed to current plan of corrections."

Record review of the Facility's Plan of Correction (POC) dated 7/2/24 revealed under, "3. All nursing staff were in-serviced on the policy "Activities for Daily Living" and the importance of following the residents care plans on June 26, 27,

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F 867	Continued From page 22 28, 29 and July 1, 2024 by the Director of Nursing, Staff Development/Infection Preventionist and Staff Nurse. All Staff will be in-serviced four times per year and as needed on Activity of Daily Living including incontinent care, good nutrition, grooming, personal and oral hygiene by Staff Development. The Director of Nursing, Staff Development/Infection Preventionist and Nursing Supervisors will make random rounds on eight residents daily for two weeks, then two times a week for two weeks. An emergency Quality Assurance meeting on June 28, 2024 was held with the Medical Director for approval of Plan of Correction. Any problems will be placed on a Quality Improvement form and weekly in the Department Head Meeting until resolved. 4. The Administrator will report to the Quality Assurance Committee quarterly. The Quality Assurance Committee will monitor quarterly until the deficient practice is no longer an issue and will make revisions and/or corrections when needed.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		9/13/24

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	255267	A. BUILDING _____ B. WING _____	08/15/2024

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F 880	Continued From page 23 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 24 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to implement Enhanced Barrier Precautions (EBP) for a resident with a peripherally inserted central catheter (PICC) for intravenous antibiotic therapy on two (2) of five (5) care area observations requiring enhanced barrier precautions. (Resident # 157). Findings include: A review of the facility policy titled, "Enhanced Barrier Precautions," revised 03/24, revealed " ...Indwelling medical device examples include central lines ... A peripheral intravenous line "(not a peripherally inserted central catheter)" is not considered an indwelling medical device for the purpose of EBP ..." During entrance rounds on 8/13/24 at 12:00 PM, an observation revealed Registered Nurse (RN)/ Treatment nurse hanging a bag of intravenous (IV) fluids to Resident #157 right upper arm access device. The RN/Treatment nurse was not observed to be wearing a gown for enhanced	F 880	F880 Infection Prevention & Control 1) Resident #157 did not have an Enhanced Barrier Precaution sign on his door on 8/13/24 when nurse administered his intra venous medication. A sign was placed later that day. The Treatment Nurse did not use Enhanced Barrier Precautions when she administered the resident's Intra venous medication. The Registered Nurse Supervisor did not use a gown on 8/14/24 when administering the resident's IV medication and the sign was on the door. Both nurses were in-serviced and educated on the policy and procedures of "Enhanced Barrier Precautions" on 8/15/24 by the Director of Nurses. 2) All residents with enhanced barrier precautions have the potential to be affected by the deficient practice of not following the policy of enhanced barrier precautions.	

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F 880	Continued From page 25 barrier precautions, and there were no signs observed in the resident's room or on the doorway to alert staff of enhanced barrier precautions. Record review of the "Physician Orders List" revealed an order dated 7/23/24 for "ceftriaxone 2-gram solution for injection: Administer 2 mg (milligrams)/100 milliliter(s) intravenous once daily until 8/18/2024. d/c (discontinue) PICC midline catheter care after last dose of IV antibiotic ..." In an observation on 8/14/24 at 12:35 PM, revealed an enhanced barrier sign observed on the outside doorway to Resident #157's room. Observed the RN Supervisor enter Resident #157's room to administer ceftriaxone intravenous (IV) solution via the PICC line. The RN Supervisor was observed connecting the IV tubing to the resident's right upper arm PICC line access device. The RN Supervisor did not put on a gown for enhanced barrier precautions before the procedure. Upon exiting the room, the RN Supervisor was asked if Resident #157 was on enhanced barrier precautions. She stated "yes" and pointed to the enhanced barrier precaution sign on the outer doorway of Resident #157's room. She then confirmed that she did not use enhanced barrier precautions while hanging Resident 157's IV antibiotics via his PICC line. In an interview with the Infection Control Nurse on 8/14/24 at 1:04 PM, she revealed she was unaware Resident #157 had a PICC line. She confirmed the resident should be on enhanced barrier to reduce the risk of transmission of bacteria while providing care to the PICC line device.	F 880	3) All nursing staff were in-serviced on the policy of Enhanced Barrier Precautions on 8/15-8/16/24 and 8/19/24-22/24 by the Director of Nurses, Staff Development/Infection Preventionist Nurse and Staff nurses. Housekeeping and laundry were in-serviced by the Environmental Manager on 8/22/24. The Infection Preventionist Nurse will attend daily Stand-Up meeting to hear when orders are read beginning 8/26/24. She will be able to identify who is placed on enhanced barrier precautions at that time. Residents on Enhanced barrier precautions will have an isolation rack hung on their doors which contain supplies of gowns and gloves. They will have signage on the door, also. 4) The Director of Nurses, Staff Development/Infection Preventionist, Registered Nurse Supervisors and the Treatment Nurse will monitor residents with Enhanced Barrier Precautions three times a week for two weeks, then two times a week for two weeks, then one time a week for two weeks, then one time a month for two months beginning 8/22/24. An Emergency Quality Assurance meeting on 8/16/24 was conducted with the Medical Director for approval of the preliminary Plan of Correction and on 8/23/24 for the final plan of correction. The Plan of Correction monitoring will be reviewed weekly in the Department Head Meeting starting 8/26/24. The Administrator will bring any exceptions to the Quality Assurance Committee monthly starting 9/12/24 for three months or until	

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F 880	Continued From page 26 An interview with RN/Treatment nurse on 8/14/24 at 1:18 PM, she confirmed she hung the IV antibiotics on 8/13/24 around noon, she confirmed there was no enhanced barrier sign on the doorway on 8/13/24 and that she did not use enhanced barrier precautions because she was unable to find a gown. She revealed she was aware that she should have followed the enhanced barrier precautions because Resident #157 had a PICC line device. During an interview with the Resident #157 on 8/14/24 at 1:50 PM, he revealed that he has only seen staff wear a gown a couple of times to hang his IV medications. On 8/14/24 at 2:00 PM, in an interview with the Director of Nursing she confirmed staff should have been using enhanced barrier precautions while administering the IV antibiotics for Resident #157's through his PICC line device. Review of the "Face Sheet" revealed the facility admitted Resident #157 key on 7/23/24 with diagnoses that included Osteomyelitis of vertebra, lumbar region.	F 880	substantial compliance is achieved.	