STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25E115	A. BUILDING _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE RETIREMENT HOME	209 OAK CIRCLE DUNCAN, MS 38740

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification at the facility from 7/28/24 through 7/30/24. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F585, F623, F656, F657, F686, F688, F697, and F725. The facility held a license for 60 beds, with a census of 57.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution	F 585		8/26/24

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

Electronically Signed | 08/21/2024

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F 585	Continued From page 1	F 585		

of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately

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F 585	Continued From page 2 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review the facility failed to ensure a grievance was documented and resolved for one (1) of four (4) residents present during the resident council meeting. Resident #33. Findings Included:	F 585	Statement of Compliance: The following represents the Plan of Correction for the alleged deficiencies cited during the Oak Grove Retirement Home annual survey that was conducted on July 30, 2024. Please accept this plan of correction as Oak Grove Retirement Home credible allegation of compliance with the completion date of August 27, 2024. The	

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F 585	Continued From page 3 Record review of the facility policy, "Grievance Policy and Procedure", dated January 23, 2017, revealed "Purpose: ... To ensure each resident grievance will be followed up by prompt efforts to resolve grievance that the resident may have.....Policy: All grievances will be investigated thoroughly and appropriate corrective action taken ... Procedure:...4. Grievances made by a resident's family, a visitor, or the resident are to be documented on the grievance form..." Record review of "Resident Council Minutes" dated 04/29/24 and 06/24/24 revealed Resident #33 attended the meetings and he reported that his toilet was loose and needed repair. On 7/28/24 at 12:45 PM, an interview with Resident #33, Resident Council President, revealed Social Services kept up with any complaints or needs brought up in the monthly resident council meetings. Resident #33 revealed he had reported that the toilet in his bathroom was loose at the base and said it "rocked back and forth" when he sat on it. He revealed the toilet in his bathroom had been loose ever since he had been in that room and it was aggravating to be unable to get anyone to fix it. On 7/29/24 at 09:50 AM, an interview with the Activities Director, revealed that he assisted the residents with scheduling the monthly resident council meetings and assisted with the meetings as needed. He revealed Social Services kept up with the grievances. He revealed if the residents had issues with anything, they would get the associated Department Head to come to the meeting and they would find out about the	F 585	completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing of the part of Oak Grove. This plan of correction is completed in good faith and as the facility's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law. 1. On 7/29/2024 Administrator verified the grievance from resident council meeting was documented and resolved for resident #33. 2. 54 residents had the potential to be affected. 3. On 7/29/2024 administrator reviewed 3 months of resident council notes to ensure grievances were documented and resolved. 4. On 7/29/2024 administrator educated activities director to ensure grievances from resident council meetings are documented and resolved from resident council. Administrator will monitor resident council notes monthly for 3 months starting on 7/30/2024 to ensure any grievances are documented and resolved. Administrator will report negative findings to the Quality Assurance Performance Improvement committee monthly beginning 8/23/2024 for 3 months for review and recommendations.	

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problem and proceed with fixing the issues. The Activities Director revealed that any concerns with the resident rooms, bathrooms, the building, or equipment was handled by Maintenance and they handled the issues promptly.

On 7/29/24 at 10:35 AM, an interview with Social Services revealed she was responsible for keeping a record of the grievances and she followed through until they were resolved. She revealed if a resident reported any issue involving needed repairs, she filled out a grievance form, and reported it to Maintenance. Social Services revealed once the issue was repaired, she documented that it was completed, marked it as resolved and she dated it. Social Services reviewed the "Resident Council Minutes" and confirmed Resident #33 had complained about his toilet needing repair. Social Services also reviewed the "Grievance Log" over the last six months and confirmed she did not fill out a grievance form on the needed repairs to Resident #33's toilet and said she should have.

On 7/29/24 at 1:45 PM, the State Agency (SA) conducted a Resident Council Meeting with four (4) residents who regularly attended the monthly meetings. Resident #33 complained about his toilet in need of repair and revealed he had reported this issue in two (2) or three (3) previous resident council meetings "but it didn't do any good." There were no other unresolved grievances identified during the meeting.

On 7/29/24 at 2:30 PM, an interview with Maintenance, revealed they keep a maintenance log of anything reported that needed fixing and took care of things as soon as they could. He revealed that often things come up in the monthly

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resident council meetings, and the Activities Director or Social Services would report it to the appropriate Department Head. Maintenance revealed no one had reported to him about Resident #33's toilet needing repair and it was not in his log book.

On 7/29/24 at 2:35 PM, an observation and interview with Maintenance of the toilet in Resident #33's room confirmed the toilet in the bathroom was loose at the base and stated, "I'm going to get something now and see if I can tighten it."

On 7/29/24 at 2:45 PM, an interview with the Administrator (ADM) revealed when a concern or need was brought up in resident council meeting, Social Services filled out a grievance form and took the issues to whatever department head was responsible and they took care of things as soon as possible. She revealed that after the grievances were fixed, Social Services completed the grievance form and marked it as resolved. The ADM revealed that she reviewed the maintenance log book and she confirmed Resident #33's loose toilet was not documented.

Record review of Resident #33's "Admission Record" revealed an admission date of 04/19/2019 and diagnoses including Parkinson's Disease with Dyskinesia and Type 2 Diabetes Mellitus.

Record review of Resident #33's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 06/20/2024 under Section C, revealed a Brief Interview for Mental Status (BIMS) Score of 12 which indicated that he had moderate cognitive deficits.

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F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		8/26/24

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F 623	Continued From page 7 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 8 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to send written notification to the resident and/or Resident Representative (RR) upon transfer to the hospital for one (1) of 16 sampled residents reviewed. Resident #29. Findings Included: Record review of the undated facility policy "Discharge/Transfer of the Resident Policy and Procedure" revealed "Procedure ...5. Complete the Discharge Instructions form ...iv. Give copy of form to the resident and/or representative or person(s) responsible for care." On 7/30/24 at 8:40 AM, an interview with Social Services revealed that she was responsible for notifying the RR when a resident was transferred to the hospital. She revealed the nurses completed the transfer form on the computer and	F 623	1. On 7/30/2024 administrator verified the written notification of transfer to the hospital for resident #29 was given to resident and resident representative. 2. 57 residents had the potential to be affected. 3. On 7/30/2024 administrator reviewed 3 months of transfers to ensure written notifications were given to resident/resident representatives. On 7/30/2024 administrator educated Business Office Manager to ensure written notification is given to the resident and/or resident representative upon transfer to the hospital. 4. Administrator will review transfers of residents weekly x 2 months starting on 7/31/2024 to ensure notice of transfers	

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F 623	Continued From page 9 she (Social Services) called the family by phone and let them know what was going on with the resident and about the transfer. She revealed that sometimes the RR didn't answer the phone, and she would leave a voicemail or try again later. Social Services confirmed she did not mail a notice of the transfer/discharge form to the RR when a resident transferred to the hospital and said that she didn't know she was supposed to. Record review of Resident #29's "Progress Notes" dated 4/03/24 revealed that he was transported to the hospital by ambulance for evaluation of left hip injured from a previous fall. It was determined that his left hip was fractured and he was admitted to the hospital for surgery. This progress note also revealed that Resident #29's RR was contacted by phone and given an update on his condition. There was no documented evidence that a written notice of transfer had been mailed to RR. Record review of Resident #29's Progress Notes dated 5/30/24 revealed that he was discharged to (Proper Name), a behavioral facility and his RR was notified by phone. There was no documentation to indicate a written notice of transfer had been mailed to the RR. Record review of Resident #29's "Admission Record" revealed an admission date of 3/13/2018 and that he had diagnoses including Cerebrovascular Disease and Schizophrenia. Record review of Resident #29's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 6/25/24 under Section C revealed, a Brief Interview for Mental Status (BIMS) Score of 03 which indicated that he had severe cognitive	F 623	are given to resident/resident representative. Administrator will report negative findings to the Quality Assurance Performance Improvement committee monthly beginning 8/23/2024 for 2 months for review and recommendations.	

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F 623	Continued From page 10 deficits.	F 623		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656		8/26/24

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F 656	Continued From page 11 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 observations, staff interview, record review, and facility policy review, the facility failed to develop comprehensive care plans related to pressure ulcer care (Resident #31 and #44) and failed to implement a care plan related to a splinting device (Resident #31) for two (2) of 16 residents reviewed for care plans. Resident #31 and #44 Findings include: Record review of the facility policy titled "Care Plan Policy and Procedure" undated, revealed " ...Policy: Each resident's care plan will remain current and inform staff of resident's needs, strengths, goals and approaches ..." Resident #31 An observation of Resident #31 on 7/28/24 at 11:00 AM revealed a contracture to right hand with no device in place. Record review of the care plan "Focus: The resident has an ADL (activities of daily living) self-care performance deficit hemiplegia and hemiparesis following CVA (Cerebrovascular	F 656	1. On 7/29/2024 administrator reviewed and verified care plans for residents #31 and #41 were updated regarding pressure ulcer care for resident #31 & 41 and splinting device for resident #31. 2.3 residents had the potential to be affected that require pressure ulcer care and/or splinting. 3. On 7/29/2024 the Minimum Data Set nurse reviewed the care plans for residents with the potential to be affected with no further negative findings. On 7/29/2024 Regional Nurse consultant educated clinical department heads (including Minimum Data Set nurse) to ensure care plans are developed related to pressure ulcer care and splinting, including any other care issues. 4.Administrator will observe care plans of 3 residents weekly x 2 months starting on 7/31/2024 to ensure care plans are developed related to pressure ulcer care and splinting, including any other care issues.	

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F 656	Continued From page 12 Accident) affecting right dominant side, contracture to muscle of right lower leg and left lower leg ...Interventions/Tasks: Palm guards to hands. Remove Palm guards at bedtime..." An observation on 7/28/24 at 2:52 PM revealed Resident #31 lying in bed with no palm guard observed on right hand. Record review of the care plans for Resident #31 revealed no care plan for the reopened stage IV pressure ulcer to the right hip that was identified on 7/6/24. Record review of the "Order Summary Report" with active orders as of 7/29/24 revealed an order dated 7/17/24 "TX (treatment) Cleanse stage 4 pressure ulcer area to (R) right hip with wound cleanser. Apply light dusting of collagen particles, pack with calcium alginate and cover with bordered foam drsg (dressing) daily/PRN (as needed). An interview with the Administrator on 7/29/24 at 2:50 PM, she confirmed after review of the care plans for Resident #31 there was no care plan developed when the Stage IV to the right hip that had reopened. An interview with the Administrator on 7/29/24 at 3:50 PM, she revealed after review of the care plan related to contractures for Resident #31 that the intervention for the palm guards was not implemented. Record review of the "Admission Record" revealed Resident #31 was admitted by the facility on 8/01/2018 with diagnoses that included Hemiplegia and Hemiparesis following a Cerebral	F 656	Administrator will report negative findings to the Quality Assurance Performance Improvement committee monthly beginning 8/23/2024 for 2 months for review and recommendations.	

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F 656	Continued From page 13 Infarction affecting the right dominant side. Record review of Resident #31's Annual Minimum Data Set (MDS) with an Assessment Reference date of 6/27/24, revealed Section GG0115: coded 2.) Impairment on both sides to upper extremities. Resident #44 Record review of Resident #44's Care Plans revealed a care plan was not developed for the pressure ulcer on the left lateral ankle. Review of Resident #44's physician orders revealed an order dated 7/19/2024, "Clean left lateral ankle Stage 3 pressure ulcer with wound cleanser. Pat dry. Apply Mepilex AG to affected areas and cover with 4x4 gauze. Cover with ABD (abdominal) PAD and apply Kerlix (gauze wrap). Wrap wounds above ankles but not tight. Perform wound care every Monday, Wednesday and Friday daily..." An interview with the Regional Clinical Director on 7/29/2024 at 2:10 PM, confirmed Resident #44's pressure ulcer care plan had been mistakenly resolved in May.	F 656		
F 657 SS=G	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		8/26/24

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F 657	Continued From page 14 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to revise a care plan related to pain risk for (1) one of 16 care plans reviewed. (Resident #31) Findings include: Record review of the facility policy titled, "Care plan Policy and Procedure," undated, revealed, " ...Policy: Each resident's care plan will remain current ...Procedure: ... 3. The Resident's care plan will be updated quarterly and as needed ..." Record review of a care plan for Resident #31 with a revision date on 6/3/24 revealed "The resident has risk for pain r/t (related to) dx (diagnoses) polyosteoarthritis, polyneuropathy, and arthritis of the right knee." The care plan had	F 657	1.On 7/29/2024 administrator verified the revision of Resident #31 care plan to include pain risk was completed. 2. All residents had the potential to be affected. 3. On 7/29/2024 Minimum Data Set nurse reviewed resident care plans for pain risk to ensure care plans reflect pain risk, with no further negative findings. On 7/29/2024 administrator educated clinical department heads (including Minimum Data Set nurse) to ensure care plans reflect pain risk. 4. Administrator will review care plans of 3 residents weekly x 2 months starting on	

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F 657	Continued From page 15 not been revised to include a Stage IV wound to the right hip that was identified on 7/6/24. During an observation of wound care on 7/29/24 at 9:50 AM, for Resident #31, with the Interim Director of Nursing (IDON), revealed the IDON remove the dressing to a reopened stage IV pressure ulcer on Resident #31's right hip. Resident #31 was observed flinching his arms and legs upward towards his chest, softly moaning, and squinting his eyes shut. The IDON asked Resident #31 if he was in any pain, and Resident #31 stated, "Yes, my butt hurts." The IDON replied to Resident #31 that she would tell his nurse when she was finished to get him something for pain. The IDON continued with wound care, cleaned the wound bed once. Resident #31 was observed making a frowning expression, moaned softly, and again flinched his arms and legs in an upward motion towards his chest. The IDON cleansed the wound bed again and then patted the wound dry. Resident #31 continued flinching his arms and legs and made a grimacing frowning facial expressions and squinting his eyes shut with each touch to the wound. The IDON finished wound care and told Resident #31 again she would tell the nurse he was in pain. During an interview with the Administrator on 7/29/24 at 2:40 PM, she revealed after review of the care plan related to pain, the care plan had not been revised to include the Stage IV pressure ulcer that reopened on 7/6/24. The Administrator revealed the purpose of the care plan was to teach the staff what the resident problem was and how to overcome the problem. Review of the "Admission Record" revealed	F 657	7/31/2024 to ensure pain risk care plans are developed. Administrator will report negative findings to the Quality Assurance Performance Improvement committee monthly beginning 8/23/2024 for 2 months for review and recommendations.	

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F 657	Continued From page 16 Resident #31 was admitted by the facility on 8/01/2018 with a diagnosis of Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the right dominant side, Polyneuropathy, Contractures to muscle of right and lower leg.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 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 provide the wound care treatment as ordered by the physician during wound care for one (1) of three (3) wound care observations. Resident #44 Findings Include: Record review of the facility policy titled "Wound Care Policy and Procedure" undated, revealed "Policy: Any resident identified with a wound skin concern will have a treatment in place to assist	F 686	1. On 7/29/2024 the regional clinical nurse observed the wound care treatment for resident #44 to ensure wound care treatment was provided as ordered by the physician. 2. 3 residents had the potential to be affected. 3. On 7/31/2024 the administrator observed wound care treatments for residents with the potential to be affected, including resident #44, to ensure wound care treatment was provided as ordered	8/26/24

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F 686	Continued From page 17 with healing of the wound/skin concern. Procedure: ... 4. Treatment Nurse or designee will perform wound care/skin care as ordered by the physician per the eTAR (Electronic Treatment Administration Record) ..." An observation and interview on 7/28/2024 at 1:21 PM, revealed Resident #44 sitting in her wheelchair in the hallway with bandages on both heels. Resident #44 stated she had wounds on both feet. Review of Resident #44's physician orders revealed an order dated 7/19/2024, "Clean left lateral ankle Stage 3 pressure ulcer with wound cleanser. Pat dry. Apply Mepilex AG to affected areas and cover with 4x4 gauze. Cover with ABD (abdominal) PAD and apply Kerlix (gauze wrap). Wrap wounds above ankles but not tight. Perform wound care every Monday, Wednesday and Friday daily..." An observation of Resident #44's wound care, on 7/29/2024 at 11:14 AM, with the Interim Director of Nursing (IDON) revealed, after cleaning the wound she applied derma blue foam to the wound bed, which was not ordered by the physician for treatment of the pressure ulcer to the left lateral ankle. An interview with the IDON on 7/29/2024 at 11:50 AM, confirmed that she did not use the correct treatment order on Resident #44's wound. She revealed they were out of the Mepilex, and she used the derma blue foam because it was the most compatible treatment the facility had on hand. She confirmed that she did not notify the doctor they were out of the prescribed treatment and revealed she should have because this could	F 686	by the physician with no negative findings. On 7/29/2024 regional clinical nurse educated clinical nurses to ensure wound care treatment was provided as ordered by the physician. On 8/12/2024, facilities wound care specialist vendor educated the Interim Director of Nursing to ensure wound care treatment was provided as ordered by the physician. 4. Administrator will observe wound care for 1 resident 3 x week for 2 months starting 7/31/2024 to ensure wound care treatment is provided as ordered by the physician. Administrator will report negative findings to the Quality Assurance Performance Improvement committee monthly for 2 months beginning 8/23/2024 for review and recommendations.	

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F 686	Continued From page 18 cause the wound to worsen. An interview with the Administrator on 7/29/2024 at 12:14 PM, confirmed not using the physician prescribed treatment order for Resident #44's wound could cause the wound to worsen. Review of the "Admission Record" revealed the facility admitted Resident #44 on 6/10/21, with current medical diagnoses that included Non-pressure chronic ulcer of left ankle, Cerebrovascular disease and Hemiplegia affecting the left dominant side.	F 686		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to provide the services to	F 688	1. On 7/29/2024 the administrator verified the placement of hand roll to the right	8/26/24

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F 688	Continued From page 19 assure a resident maintained his/her highest level of range of motion (ROM) and mobility for one (1) of four (4) residents for positioning and mobility. (Resident # 31) Findings include: Record review of a typed statement on facility letterhead, dated 7/30/24 and signed by the Nursing Home Administrator (NHA) revealed "(Proper name of facility) does not have a policy for devices." An observation of Resident #31 on 7/28/24 at 11:00 AM, revealed a contracture to the right hand with no device in place. Record review of the "Order Summary Report" with active orders as of 7/29/24 revealed an order dated 5/31/23 "Remove palm guards at bedtime." An observation on 7/28/24 at 2:52 PM, revealed Resident #31 lying in bed with no palm guard observed to right hand. An observation and interview on 7/29/24 at 9:45 AM, with Certified Nurse Assistant (CNA) #6 revealed no palm guard to Resident #31's hands. CNA #6 revealed she was assigned to Resident #31. She stated she was unable to find the palm guard for Resident #31 and stated it must be in laundry. She confirmed that Resident #31 should have been wearing the palm guard to his right hand on 7/28/24 and should also be wearing it at this time. In an interview with the Interim Director of Nursing (IDON) on 7/29/24 at 9:50 AM, she confirmed Resident #31 should be wearing a	F 688	hand of resident #31. 2. 1 resident had the potential to be affected. 3. On 7/29/2024 the administrator reviewed doctors orders and verified no other resident had orders for a contracture device. On 7/29/2024 regional clinical nurse educated clinical staff on ensuring hand roll placed on any resident that has an order for it. 4. Director of Nursing will observe 1 resident 3 x weekly x 2 months starting 7/31/2024 to ensure contracture device is in place. Director of Nursing will report negative findings to the Quality Assurance Performance Improvement committee monthly for 2 months beginning 8/23/2024 for review and recommendations.	

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F 688	Continued From page 20	F 688		

palm guard on his right hand because it is contracted. She then stated that the purpose of the palm guard is to prevent the contracture from worsening.

In an interview with Licensed Practical Nurse (LPN) #2 on 7/29/24 at 9:55 AM, she revealed that the CNAs are supposed to be applying the palm guard to Resident #31 to prevent worsening of the contracture to the right hand.

In an interview with the Administrator on 7/29/24 at 11:00 AM, she confirmed Resident #1 should have been wearing the palm guard on the right hand to prevent the worsening of the contractures. She revealed the previous DON was aware of the splints not being applied and had the Occupational Therapist staff in-service to the nursing staff a few months ago. She then revealed the previous DON did not follow up to ensure the splinting devices were applied because the problem of the devices not being applied continued.

A phone interview with Occupational Therapist #1 on 7/29/24 at 12:54 PM, she stated about two months ago she noticed that staff were not applying Resident #31's palm guard. She stated she notified the previous Director of Nurses (DON) and provided an in-service on splint application with the nursing staff, but confirmed she continued to find residents without their splints in place.

In a continued interview with the Administrator on 7/29/24 at 3:50 PM, she revealed after review of the physician's orders related to palm guards for Resident #31 that the order did not reflect when to apply the palm guard and who was to apply it.

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F 688	Continued From page 21 Record review of a typed document dated 7/30/24 and signed by the Occupational Therapist (OT) #2 revealed, " ... Pt (Patient) presents with some decline in PROM (Passive Range of Motion). Pt comorbidities and significant decline in functional use of RUE (Right upper extremity) is a contributing factor as well as proper maintenance schedule with periodic orthosis examination. PROM is difficult ...Palmar guard seems appropriate ..." In an interview with OT #2 on 7/30/24 at 9:37 AM, he revealed he assessed Resident #31's right-hand contracture earlier in the morning. He confirmed that after review of an occupational assessment of Resident #31's hand completed on 3/30/24 and the assessment completed today, that Resident #31 did have a decline in passive range of motion (PROM) to his right hand. OT#2 confirmed that failure to apply the palm guard as ordered for proper maintenance may have contributed to the decline in range of motion in Resident #31's right hand. Review of the "Admission Record" revealed Resident #31 was admitted by the facility on 8/01/2018 with diagnoses that included Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the right dominant side. Record review of Resident #31's Annual Minimum Data Set (MDS) with an Assessment Reference date of 6/27/24, revealed Section GG0115: coded 2.) Impairment on both sides to upper extremities.	F 688		
F 697 SS=G	Pain Management CFR(s): 483.25(k)	F 697		8/26/24

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F 697	Continued From page 22 §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident verbally expressing pain and showing physical nonverbal signs of pain was provided pain management during an observation of wound care for (1) one of 16 sampled residents. (Resident #31) Findings include: Record review of the facility policy titled, "Pain Management Policy and Procedure," revealed, "Purpose: To maintain the resident as pain free as possible with the least amount of medication required. Policy: Resident is to be assessed and addressed to meet individual needs ..." An observation of wound care for Resident #31 on 7/29/24 at 9:50 AM, with the Interim Director of Nursing (IDON), revealed the IDON remove the dressing to a reopened Stage IV pressure ulcer on Resident #31's right hip. Resident #31 was observed flinching his arms and legs upward towards his chest, softly moaning, and squinting his eyes shut. The IDON asked Resident #31 if he was in any pain, and Resident #31 stated, "Yes, my butt hurts." The IDON replied to Resident #31 that she would tell his nurse when she was finished to get him something for pain. The IDON continued with wound care, cleaned the wound bed once. Resident #31 was observed	F 697	1. On 7/29/2024 Medications were reviewed and adjusted by Nurse Practitioner and Licensed Practical nurse administered as needed medication to resident # 31 after treatment. 2. 3 residents had the potential to be affected that require wound care. 3. On 7/31/2024 administrator observed for indicators or complaints of pain during wound care for residents with the potential to be affected, including resident #31 with no negative findings. On 7/29/2024 administrator and regional nurse consultant educated nurses to ensure a resident verbally expressing pain and showing physical nonverbal signs of pain was provided pain management during wound care. On 8/12/2024 facilities wound care specialist vendor educated Interim Director of Nursing to ensure residents who verbally express pain or are showing nonverbal signs of pain are provided pain management during wound care. 4. Administrator will observe resident wound care for 3 residents weekly x 2 months starting 7/31/2024 to ensure pain management is being provided.	

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F 697	Continued From page 23 making a frowning expression, moaned softly, and again flinched his arms and legs in an upward motion towards his chest. The IDON cleansed the wound bed again and then patted the wound dry. Resident #31 continued flinching his arms and legs and made a grimacing frowning facial expressions and squinting his eyes shut with each touch to the wound. The IDON finished wound care and told Resident #31 again she would tell the nurse he was in pain. An interview with the Licensed Practical Nurse (LPN) #2 on 7/29/24 at 10:02 AM, she revealed she gave Resident #31 had a pain pill last at 7:30 AM because he stated he was in pain, she confirmed that Resident #31 has as needed pain medications. Record review of the July 2024 Medication Administration Record revealed Resident #31 last received Tramadol 50 mg at 7:31 AM on 7/29/24. In an interview with the IDON on 7/29/24 at 10:03 AM, she confirmed she should have stopped doing wound care on Resident #31 when he stated he was in pain. She revealed she was unaware if Resident #31 had any pain medications ordered. She confirmed by continuing the treatment when the resident verbalized, he was in pain and had physical signs of pain she placed the Resident #31 at risk for worsening pain. In an interview with the Administrator on 7/29/24 at 11:00 AM, she confirmed the IDON should have stopped the treatment to the pressure sore and provided pain management and comfort. She stated that by failing to do so placed Resident #31 at risk of his pain escalating. She then revealed it	F 697	Administrator will report negative findings to the Quality Assurance Performance Improvement committee monthly for 2 months beginning 8/23/2024 for review and recommendations.	

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F 697	Continued From page 24 is the practice of the facility to ensure residents with wounds are assessed for pain and medicated before treatment. Review of the "Admission Record" revealed Resident #31 was admitted by the facility on 8/01/2018 with a diagnosis of Hemiplegia and Hemiparesis following a Cerebral Infarction affecting the right dominant side, Polyneuropathy, Contractures to muscle of right and lower leg. Record review of Resident #31's Annual Minimum Data Set (MDS) with an Assessment Reference date of 6/27/24, revealed Section GG0115: coded 2.) Impairment on both sides to upper extremities. Section J indicated Resident #31 had pain at "06" on a scale of "00-10" over the last 5 days, with 0 indicating no pain and 10 as the worse pain you can imagine.	F 697		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide	F 725		8/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25E115	A. BUILDING _____ B. WING _____	07/30/2024

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F 725	Continued From page 25 nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to provide sufficient weekend staffing to meet the individualized needs of the residents for seven (7) of the weekend days reviewed during the second (2nd) quarter 2024. Findings Include: Review of the facility policy titled "Staffing Hours, Monitoring of Policy and Procedure" undated, revealed "Purpose: To assure the facility staffing meet federal and state guidelines ....Procedure: 1. Staffing hours will be monitored by DON (Director of Nursing) or designee daily or as applicable." Review of the "Payroll-Based Journal (PBJ) Staffing Data Report" for Quarter 2 (two) 2024, (January 1-March 31) revealed the facility submitted excessively low weekend staffing. An interview with Registered Nurse (RN) #1 on 7/28/2024 at 11:10 AM, revealed she worked every other weekend and was aware the facility had some recent staff changes and turnover in	F 725	1. On 7/28/2024 Administrator immediately on notification reviewed current staffing to ensure staff present to meet the individualized needs of the residents. On 7/28/2024 Administrator reviewed staffing schedule for upcoming weekend to ensure sufficient weekend staffing to meet the individualized needs of the residents. 2. All residents had the potential to be affected. 3. On 7/29/2024 administrator educated Interim Director of Nursing and Weekend Registered Nurse Supervisors to ensure sufficient weekend staffing to meet the individualized needs of the residents. Staffing on-call rotation for clinical managers initiated to ensure sufficient staffing is present. 4. Administrator will monitor schedule to ensure sufficient weekend staff are present to meet the individualized needs	

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F 725	Continued From page 26 the facility. An interview with Certified Nurse Aide (CNA) #1 on 7/28/2024 at 11:16 AM, revealed she worked every weekend, and they do occasionally have three (3) or four (4) aides on day shift. She explained they do try to call and get someone to come in, but they cannot always find someone. CNA #1 revealed the assignments were difficult with 3 aides, but they work together and do their best to get the job done. An interview with the Administrator (ADM) on 7/29/2024 at 8:43 AM, revealed they tried to over staff and have extra, but that did not always work out. She revealed the Director of Nursing (DON) had been coming in to work when someone called in and stated, "Unfortunately, it is almost every weekend." The ADM confirmed they had been short on Certified Nurse Aides (CNAs) and had a lot of staff turnover. She revealed that maintaining staff at the facility was difficult. An interview on 7/29/2024 at 10:10 AM, with the Administrator (ADM) revealed the acuity of the residents, determined their staffing needs. She confirmed that call-ins were the biggest issue they were facing with staffing. She revealed the staff member on call takes the call ins and they are responsible for calling to find a replacement. Furthermore, she explained that if they could not find a replacement and the care hours PPD (per patient day) was too low, they were required to come to the facility and work the shift. The ADM confirmed they do have trouble finding and keeping staff. She explained that they recently introduced changes to the staffing schedule to accommodate employees, in which they implemented the Baylor (weekend) shift. The staff	F 725	of the residents each week x 2 months starting 7/31/2024. Administrator will report negative findings to the Quality Assurance Performance Improvement committee monthly for 2 months beginning 8/23/2024 for review and recommendations.	

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F 725	Continued From page 27 could choose if they wanted to work during the week or the weekend. She revealed, even after the staff decided to work the weekends, they continued to have call ins.	F 725		