MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	06OG	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

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 7/28/24 through 7/30/24. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M225, M475, M500, M615, and M625.	M 000		
M 225	45.4.1 Nursing Facility Nursing Facility. To be classified as a facility, the institution shall comply with the following staffing requirements: 1. Minimum requirements for nursing staff shall be based on the ratio of two and eight-tenths (2.80) hours of direct nursing care per resident per twenty-four (24) hours. Staffing requirements are based upon resident census. Based upon the physical layout of the nursing facility, the licensing agency may increase the nursing care per resident ratio. 2. Each facility shall have the following licensed personnel as a minimum: a. Seven (7) day coverage on the day shift by a registered nurse. b. A registered nurse designated as the Director of Nursing Services, who shall be employed on a full time (five [5] days per week) basis on the day shift and be responsible for all nursing services in the facility. c. Facilities of one-hundred eighty (180) beds or more shall have an assistant director of nursing services, who shall be a registered nurse.	M 225		8/26/24

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M 225	Continued From page 1 d. A registered nurse or licensed practical nurse shall serve as a charge nurse and be responsible for supervision of the total nursing activities in the facility during the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shift. The nurse assigned to the unit for the 11:00 p.m. to 7:00 a.m. shift may serve as both the charge nurse and medication/treatment nurse. A medication/treatment nurse for each nurses' station shall be required on all shifts. This shall be a registered nurse or licensed practical nurse. e. In facilities with sixty (60) beds or less, the director of nursing services may serve as charge nurse. f. In facilities with more than sixty (60) beds, the charge nurse may not be the director of nursing services or the medication/treatment nurse. 3. Non-Licensed Staff. The non-licensed staff shall be added to the total licensed staff, to complete the required staffing requirements. 4. There shall be at least two (2) employees in the facility at all times in the event of an emergency. This Statute is not met as evidenced by: Level II Based on staff interview, record review, and facility policy review, the facility failed to meet the minimum (2.80) PPD (patient per day) requirement for staffing for seven (7) of the weekend days reviewed during the second (2nd) quarter 2024. Findings Include:	M 225	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.	

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M 225	Continued From page 2 Review of the facility policy titled "Staffing Hours, Monitoring of Policy and Procedure" undated, revealed under, "Purpose: To assure the facility staffing meet federal and state guidelines." Also revealed under, "Procedure: 1. Staffing hours will be monitored by DON (director of nursing) or designee daily or as applicable." On 7/28/2024 at 11:10 AM, an interview with Registered Nurse (RN) #1 revealed, she worked every other weekend and was aware the facility had some recent staff changes and turnover in the facility. On 7/28/2024 at 11:16 AM, an interview with Certified Nurse Aide (CNA) #1 revealed, she worked every weekend, and they do occasionally have 3 or 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. During an interview with the Administrator (ADM) on 7/29/2024 at 8:43 AM, revealed they tried to overly 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 due to the types of residents they housed. 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	M 225	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 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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M 225	Continued From page 3 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 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. Review of the "Staffing Grid" revealed the facility did not meet the minimum requirement for staffing on the following dates: 1/14/24, 1/27/24, 2/10/24, 2/24/24, 3/2/24, 3/10/24, 3/23/24. An interview and review of the staffing grid with the Administrator (ADM), confirmed the insufficient staffing numbers on 7/30/2024 at 9:12 AM.	M 225		
M 475	45.16.6 Employee Testing for Tuberculosis Employee Testing for Tuberculosis 1. Each employee, upon employment of a licensed entity and prior to contact with any patient/resident, shall be evaluated for tuberculosis by one of the following methods: a. IGRA (blood test) and an evaluation of the individual for signs and symptoms of tuberculosis by medical personnel; or	M 475		8/26/24

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M 475	Continued From page 4 b. A two-step Mantoux tuberculin skin test administered and read by a licensed medical/nursing person certified in the techniques of tuberculin testing and an evaluation of the individual for signs and symptoms of tuberculosis by a licensed Physician, Physician ' s Assistant, Nurse Practitioner or a Registered Nurse. 2. The IGRA/Mantoux testing and the evaluation of signs/symptoms may be administered/conducted on the date of hire or administered/read no more than 30 days prior to the individual ' s date of hire; however, the individual must not be allowed contact with a patient or work in areas of the facility where patients have access until receipt of the results of the IGRA/assessment or at least the first of the two-step Mantoux test has been administered,/read and assessment for signs and symptoms completed. 3. If the Mantoux test is administered, results must be documented in millimeters. Documentation of the IGRA/TB skin test results and assessment must be documented in accordance with accepted standards of medical/nursing practice and must be placed in the individual ' s personnel file no later than 7 days of the individual ' s date of employment. If an IGRA is performed, results and quanitive values must be documented. 4. Any employee noted to have a newly positive IGRA, a newly positive Mantoux skin test or signs/symptoms indicative of tuberculin disease (TB) that last longer than three weeks (regardless of the size of the skin test or results of the IGRA), shall have a chest x-ray interpreted by a board certified Radiologist and be evaluated for active	M 475		

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M 475	Continued From page 5	M 475		

tuberculosis by a licensed physician within 72 hours. The employee shall not be allowed to work in any area where residents have routine access until evaluated by a physician/nurse practitioner/physician assistant and approved to return. Exceptions to this requirement may be made if the employee is asymptomatic and;

a. The individual is currently receiving or can provide documentation of having received a course of tuberculosis prophylactic therapy approved by the Mississippi State Department of Health (MSDH) Tuberculosis Program for tuberculosis infection, or

b. The individual is currently receiving or can provide documentation of having received a course of multi-drug chemotherapy approved by the MSDH Tuberculosis Program; or

c. The individual has a documented previous significant tuberculin skin reaction or IGRA reaction.

4. For individuals noted to have a previous positive to either Mantoux testing or the IGRA, annual re-evaluation for the signs and symptoms must be conducted and must be maintained as part of the employee ' s annual health screening. A follow-up annual chest x-ray is NOT required unless symptoms of active tuberculosis develop.

5. If using the Mantoux method, employees with a negative tuberculin skin test and a negative symptom assessment shall have the second step of the two-step Mantoux tuberculin skin test performed and documented in the employees ' personal record within fourteen (14) days of employment.

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M 475	Continued From page 6 6. The IGRA or the two-step protocol is to be used for each employee who has not been previously skin tested and/or for whom a negative test cannot be documented within the past 12 months. If the employer has documentation that the employee has had a negative TB skin test within the past 12 months, a single test performed thirty (30) days prior to employment or immediately upon hire will fulfill the two-step requirements. As above, the employee shall not have contact with residents or be allowed to work in areas of the facility to which residents have routine access prior to reading the skin test, completing a signs and symptoms assessment and documenting the results and findings. 7. All staff noted as negative per the IGRA blood test or who do not have a significant Mantoux tuberculin skin test reaction (reaction of less than 5 millimeters in size) shall be retested annually within thirty (30) days of the anniversary of their last IGRA or Mantoux tuberculin skin test. Staff exposed to an active infectious case of tuberculosis between annual tuberculin skin tests shall be treated as contacts and be managed appropriately. Individuals found to have a significant Mantoux tuberculin skin test reaction and a chest x-ray not suggestive of active tuberculosis, shall be evaluated by a physician or nurse practitioner/physician assistant for treatment of latent tuberculin infection. This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to administer a second step tuberculin skin test to employees prior to working in the facility for four (4) of five (5) employees reviewed. Certified Nursing Assistant (CNA) #4 and CNA #5, Interim Director of Nurses (IDON),	M 475	1. On 8/20/2024 administrator scheduled Interferon Gamma Release Assay testing for 8/21/2024 and 8/22/2024 for staff without the administration of the second step tuberculin skin test to CNA #4, CNA #5, Interim Director of Nurses & LPN #3	

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M 475	Continued From page 7 Licensed Practical Nurse (LPN) #3 Findings Included: Record review reviewed a typed statement on facility letterhead, undated, and signed by the Nursing Home Administrator (NHA) revealed "(Proper name of facility) does not have a policy specific for tuberculosis testing. (Proper name of facility) follows state guidelines for testing and reporting." Record review of CNA #4's Employee "Tuberculin Record" revealed that she received a step-one (1) Tuberculin (TB) purified protein derivative (PPD) skin test on 12/12/23 with a reading of 00 millimeters (mm) on 12/14/23. There was no documented evidence that CNA #4 was offered or received a second step TB skin test. Record review of CNA #5's Employee "Tuberculin Record" revealed that she received a step-one (1) PPD Tuberculin (TB) Skin Test on 03/01/24 with a reading of 00mm on 03/03/24. There was no evidence that CNA #5 was offered or received a second step TB skin test. Record review of the IDON's Employee "Tuberculin Record" revealed that she received a step-one (1) Tuberculin PPD skin test on 5/15/24 with a reading of 00 millimeters (mm) on 5/17/24. There was no evidence that the Interim Director of Nursing was offered or received a second step TB skin test. Record review of LPN #3's Employee "Tuberculin Record" revealed she received a step-one TB skin test on 05/28/24 with negative results on 05/30/24. There was no evidence that LPN #3 was offered or received a second step TB skin	M 475	employees. 2. All residents had the potential to be affected. 3. On 8/20/2024 administrator audited employee files, to ensure a second step tuberculin skin test was administered to employees prior to working in the facility. Any staff without proper tuberculin documentation was scheduled for Interferon Gamma Release Assay testing. On 8/20/2024 administrator educated human resources director to ensure a second step tuberculin skin test was administered to employees prior to working in the facility. 4. Administrator will observe new employee files to ensure a second step tuberculin skin test was administered to employees prior to working in the facility weekly x 2 months starting 8/21/2024. 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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M 475	Continued From page 8 test. Record review of the Facility "Active Employee Report" dated 07/28/24 revealed the IDON, LPN #3, CNA #4, and CNA #5 were all currently employed. On 07/30/24 at 8:45 AM, an interview with Administrator (ADM) revealed the Director of Nursing was responsible for getting their newly hired employees the two-step Tuberculosis Tests. She revealed that the DON was no longer working there and ADM was unable to locate the documentation. On 07/30/24 at 10:04 AM, an interview with Licensed Practical Nurse (LPN) #1 who was the previous Infection Preventionist, revealed all newly hired employees were required to receive the two step Tuberculosis Skin Tests. He revealed if employees came from other facilities, they looked at their previous TB Skin test results and if they were not within the timeframe, they started the process over with the two step testing. LPN #1 revealed that failure to provide TB skin tests to their employees could result in a TB outbreak in the facility. LPN #1 revealed he thought the TB skin tests were completed by the previous Director of Nursing but they couldn't find the documentation.	M 475		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of	M 500		8/26/24

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M 500	Continued From page 9	M 500		

admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents;

2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;

3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in

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M 500	Continued From page 10 writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his	M 500		

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M 500	Continued From page 11	M 500		

personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

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M 500	Continued From page 12 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level III 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	M 500	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	

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	06OG	A. BUILDING: _____ B. WING _____	07/30/2024

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M 500	Continued From page 13 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. 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.	M 500	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. 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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M 500	Continued From page 14 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 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.	M 500		
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Level II	M 615	1. On 7/29/2024 the regional clinical nurse	8/26/24

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M 615	Continued From page 15 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 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	M 615	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 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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M 615	Continued From page 16 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 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.	M 615		
M 625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This Statute is not met as evidenced by: Level III Based on observation, staff interview, and record	M 625	1. On 7/29/2024 the administrator verified the placement of hand roll to the right hand of resident #31.	8/26/24

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M 625	Continued From page 17 review, the facility failed to provide the services to 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	M 625	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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M 625	Continued From page 18	M 625		

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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M 625	Continued From page 19 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.	M 625		