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DIVERSICARE OF TUPELO	2273 SOUTH EASON BOULEVARD TUPELO, MS 38804

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and a complaint investigation (CI) MS #25787 at the facility from 9/16/24 through 9/19/24. During the survey, the SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements, and deficiencies were cited at M460, M500, M610, M640, M855, and M1570. The SA determined that the facility was in compliance related to CI MS #25787. The facility held a license for 120 beds at the time of the survey, and the facility census was 95.	M 000		
M 350	45.12.1 Reponsiblility 1. There shall be a licensed administrator with authority and responsibility for the operation of the facility in all its administrative and professional functions subject only to the policies enacted by the governing authority and to such orders as it may issue. The administrator shall be the direct representative of the governing authority in the management of the facility and shall be responsible to said governing authority for the proper performance of duties. 2. There shall be a qualified individual present in the facility responsible to the administrator in matters of administration who shall represent him during the absence. The persons shall not be a resident of the facility. This Statute is not met as evidenced by: Level II Widespread Based on observation, resident and staff	M 350	The Administrative Staff, Regional Director of Clinical Operations (RDOC) and the Regional vice President of Operations (RVP) met on 09/20/2024 to review the	10/28/24

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M 350	Continued From page 1 interviews, and record review, the facility failed to be administered in a manner that allowed it to use its resources effectively to ensure the well-being of its residents for four (4) of the four (4) days of the survey. Findings Include This tag is cross referenced to M 500, M610, M640, M1570. A review of the typed statement on facility letterhead revealed that the facility did not have an "Administration Policy" and was signed by the Administrator. F 565 On 9/17/24 at 3:05 PM, during the resident council meeting held Resident #25 revealed that the food is terrible. She has complained about it in the resident council before, but nothing has improved. Resident #3 confirmed that they have complained about the food in resident council meetings every month and nothing is done. Resident #25 and Resident #50 stated that they never know when the resident council meeting is going to be each month because it is not put on the monthly activity calendar During an interview on 9/17/24 at 3:40 PM, with the Administrator confirmed that all residents should be made aware of the time and date of the resident council meetings are being held, because this is their home and that is their right to participate. She stated that complaints during the resident council meetings do not necessarily get put on a grievance form. She revealed that if for example it was a complaint about the food then the dietary department would meet with the	M 350	survey findings of 09/19/2024 survey including a review of our repetitive citations from past surveys. Per direction of the RVP, the center developed a corrective action plan to include F550, F565, F584, F656, F677, F689, F761, and F880. On 09/20/2024, the RVP educated the Administrator on the process for Quality Assurance Performance Improvement (QAPI) to include identification of problems, root cause analysis, development of plans, monitoring, and continued re-evaluation. Education also included the duties and role of the administrator. A QAPI meeting was held on 09/27/2024 with the QAPI committee to address corrective actions going forward. The Administrator initiated a plan to assure that the center used all resources to ensure the well-being of the residents in the center. This was evidenced by the following: F 565-On 09/17/2024, Residents #27 and #50 were informed by the Activity Director of the next resident council meeting which is to be held on 09/25/2024. Each resident was informed that the resident council meetings will be scheduled and posted on the marquee calendar near the center lobby and they would also get a print out of the activity calendar for their rooms. The residents were appreciative. The Administrator educated the Activity Director on 09/20/2024 regarding the expectation that all residents would be	

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M 350	Continued From page 2 resident or residents that complained. Record review of the resident council meeting minutes confirmed that food was discussed in the resident council meeting minutes for 9/24, 8/24, 7/24, 6/24, 5/24, 3/24 and 2/24 food and menu concerns were mentioned. During an interview with the Administrator on 09/18/24 at 8:25 AM, confirmed that food had been a concern for a while. During an interview on 9/18/24 at 11:00 AM, the Administrator confirmed that food complaints have been ongoing and should have been resolved by now. F 677 Resident #7 During an observation on 9/17/24 at 8:15 AM, revealed Resident #7 was lying in bed with eyes open, alert but confused. It was noted when entering the room that there was a very strong odor of urine in the room. During an observation and interview with Certified Nurse Aide (CNA) #7 on 9/17/24 at 8:18 AM, confirmed the strong odor of urine in the room. She revealed the resident was incontinent and explained that she had not made a round on the resident since her shift started at 7 AM. CNA #7 revealed the last round would have been done on the 11-7 shift. CNA #7 pulled back the top cover and checked to see if the resident was wet. An observation revealed the resident had on 2 blue briefs. The top brief was heavily saturated in urine. CNA #7 confirmed the resident was not supposed to have on 2 briefs and agreed it gives	M 350	informed on the dates/times of each resident council meetings. On 09/20/2024, the Administrator educated the Activity Director and social Services Director on the grievance process with emphasis on resolution. On 09/20/2024. the Administrator educated the Activity Director on ensuring resident council is scheduled and residents are informed. 100% of all grievances received over the past three months were audited to assure resolution had been executed. No additional unresolved resolution noted. F677- On 09/17/2024, Resident #7 was provided incontinent care by the Certified Nursing Assistant. The nurse assessed the resident for emotional or physical harm/discomfort with no negative outcome noted. Body audit completed by the Director of Nursing (DON) with no noted skin concerns. Education was provided to C.N.A #7 by the Administrator on 09/17/2024 regarding incontinent care to assure understanding of double briefing as an unacceptable practice. The nurse assessed resident #58 on 09/17/2024 and assured the nails were trimmed. No skin tears or injuries noted. The nurse assessed resident #59 on 09/17/2024 and assured the nails were trimmed and cleaned. No skin tears or injuries noted. Care plans were reviewed by the Director of Nursing (DON) on 09/18/2024 for all three residents and updated as needed.	

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M 350	Continued From page 3 the impression that staff were not rounding and providing incontinent care, as they should be. She revealed she normally made rounds with the 11-7 shift, but she did not do it this morning and confirmed she should have. During an interview with the Director of Nursing (DON) on 9/17/24 at 11:00 AM, revealed not providing incontinent care timely and wearing 2 briefs could cause an increased risk for skin breakdown. She explained that using 2 briefs on a resident made it look like they were not wanting to make rounds on the residents. During an interview with the Administrator on 9/17/24 at 11:10 AM, revealed the aides were responsible for making rounds on the resident every 2 hours, and if the resident was a heavy wetter, they were to increase their rounds to hourly or every 30 minutes. F 689 Resident #22 During an observation of Resident #22 on 9/16/24 at 10:00 AM, revealed he was lying in bed. with a cigarette box lying at the foot of the bed in a white and blue pack. Resident #22 revealed he was a smoker and stated, "They don't let us keep cigarettes in our rooms. There's not anything in the pack." The box contained 1 cigarette and one-half (1/2) of a used cigarette butt. During an interview with the Director of Nursing (DON) on 9/17/24 at 11:00 AM revealed, the Administrator keeps the cigarettes locked up in her office and distributes 2 cigarettes in a zip lock baggies to each resident that was going to smoke at each break. She revealed, we tell the families	M 350	F689- On 09/16/2024, the Administrator secured cigarettes found in Resident #22's room. The resident was educated on the smoking policy by the Administrator. On 09/16/2024, the medications at bedside of resident #34 were removed and secured by registered nurse. Resident #34 was educated on storage of medications to assure understanding by the registered nurse. F761- On 09/16/2024, the Assistant Director of Nursing (ADNS) ensured the medication cart was attended and the medications inaccessible to other staff or residents until LPN #2 returned to the cart. Education was provided by the ADNS on 09/16/2024 to LPN#2 to assure understanding of correct medication storage. Education was provided by the Director of Nursing on 09/17/2024 with RN #1 to assure understanding of medication storage. There were no individual residents effected with this deficiency. All medications were accounted for. F880- Education was completed on 09/16/2024 by the Director of Nursing with CNA #8 to assure understanding of infection control practices and not placing soiled items on the floor. Housekeeping staff member was notified, and the floor was cleaned. This resident was assessed on 09/16/2024 by the nurse and no negative outcome was noted. Education was completed by the Director of Clinical Education on 09/19/2024 with LPN #6 on	

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M 350	Continued From page 4 that the residents can't have them and if they buy them, they must leave them with the Administrator. She revealed Resident #22 did go out with a friend and could be getting them that way. The DON explained that the aides and nurses know that when they see cigarettes' or a lighter on a resident, they cannot have it. She stated, "We cannot search the resident's room or the resident for the items." During an interview with the Administrator (ADM) on 9/17/24 at 11:10 AM revealed, the facility did not allow the residents to keep smoking paraphernalia and Resident #22 knew that. She revealed the resident had one friend that he went out of the facility with, but he knew the resident could not have them. She stated, "I use the honor system. I can't go into his room and search or shake him down." She confirmed the resident could set something on fire in the building by keeping smoking materials. Resident #34 During an observation of Resident #34's bedside dresser on 9/16/24 at 10:15 AM revealed a bottle of Rolaids Antacid Ultra Strength #72 count, Magnesium 200 mg (milligrams) #60 count, and a bottle of Multivitamin tablets #200 count. An interview with the resident revealed, he brought them from home and stated, "I just take them when I think about it." An interview with the ADM on 9/17/24 at 12:10 PM, revealed that they (the staff) were not aware that Resident #34 had the medication in his room and was taking it. She revealed that the resident did not have an order to self-administer meds and confirmed that he could potentially get overmedicated if he was receiving the same	M 350	enhanced barrier precautions (EBP) to assure use of appropriate personal protective equipment while administering PEG medications/care. The resident was assessed by the registered nurse on 09/16/2024 with no negative outcomes. All residents have the potential to be affected. Systemic actions and/or education completed included that on 09/20/2024, the Administrator was educated by the Vice President of Operations regarding the importance of operating the center to assure the well-being of each resident in the center. Education provided regarding the Quality Assurance Performance Improvement program, Dignity, Resident rights, the Grievance Policy, Resident Council policy, Infection Control (EBP), Accidents/Hazards (Smoking/Equipment safety), Medication Storage, Care Plan/Care Plan revision, Side Rail Use, Resident Choice, Professional Standards (documentation), and Dietary Services (appearance, therapeutic diets, palatability) A focused QAPI meeting addressing the findings of the annual survey was completed on 09/27/2024 with the attendance of the Administrator, Medical Director, Human Resource Coordinator, Director of Nursing, Assistant Director of Nursing, Registered Nurse Unit Manager(s), Minimum Data Set Nurses(s), Health Information Management Director, Activity Director, Social Services Director, Maintenance Director, Dietary Services	

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M 350	Continued From page 5 medications from the nurses. F 761 During an observation on 9/16/24 at 9:04 AM, revealed an unattended medication cart sitting outside the dining room near the beginning of the B Hall. The top of the cart contained a medicine cup full of a red liquid, a bottle of magnesium, Colace and calcium sitting on the top of the medication cart. During an observation and interview on 9/16/24 at 9:06 AM, with the Assistant Director of Nurses (ADON) confirmed there was a medicine cup full of a red liquid, and three bottles of over-the-counter medication that included magnesium, Colace and a bottle of calcium. She stated that medication should never be left out on the medication cart while there is no nurse at the cart. She stated this is to prevent other residents from ingesting the medication that could lead to an accident or harm. She revealed that this medication cart belonged to Licensed Practical Nurse (LPN) #2 and she was not sure where she was. During an observation and interview on 09/17/24 at 12:40 PM, revealed Registered Nurse (RN) #1 standing at the B wing medication cart. RN #1 had medication cards in her hand. She opened the red narcotic binder and placed the medication cards inside the binder. RN #1 then closed the top of the binder, left the cart, and went down the hall. The medication card edges were visible and accessible to anyone passing the medication cart. RN #1 returned to the unattended medication cart at 12:43 PM. She confirmed four (4) medication cards, including Baclofen, Buspar, Augmentin, and Cyproheptadine, were left on the medication	M 350	Manager, and Workforce Manager. The QAPI meeting conducted a root cause analysis of the findings and developed the plans of corrections. The facility QAPI committee to initiate weekly meetings over the next eight weeks beginning the week of 10/01/2024, then monthly thereafter to ensure continued focus and review of audits to ensure plan is being adjusted accordingly as identified and needed.	

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M 350	Continued From page 6	M 350		

cart unattended and unsecured. She revealed she should not have left the medication on the cart unattended and confirmed it could have been a hazard for other residents who could have gotten into the medications.

During an interview with the Director of Nurses (DON) on 9/18/24 at 9:10 AM confirmed that medication should never be left on top of a medication cart unattended. She stated that any resident could have come by and drank or took that medication.

F 880

An observation outside Resident #20's room on 9/16/24 at 9:18 AM, revealed, the door was open. Upon entering the room, the privacy curtain was pulled in the middle of the room, and a blue and white soiled disposable bed pad could be seen lying on the floor with a dark brown substance on it. Certified Nurse Aide (CNA) #8 was assisting the resident and revealed she was helping the resident with her colostomy bag. She confirmed the bed pad was soiled and revealed it should not be placed on the floor and should be bagged and disposed of. She revealed this action could spread germs throughout the facility.

An interview with the Administrator (ADM) on 9/17/24 at 12:10 PM, revealed, soiled trash should never be placed on the floor and should be placed in a bag and transported out of the room. She confirmed placing soiled trash on the resident's floor was an infection control concern.

During an observation of the facility on 09/16/24 from 10:00 AM until 11:30 AM revealed there was one (1) EBP sign on room A4 on the A-Hall. The tour of the B-Hall revealed there were (2) signs

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M 350	Continued From page 7 on (2) different rooms, and no signs were observed on the C- Hall or D- Hall. During an interview on 09/16/24 3:13 PM, with Certified Nurse Assistant (CNA) #3 revealed she is not familiar with EBP. She stated she has never been told anything about it and has no idea what it means. During an interview on 09/16/24 3:24 PM, with Licensed Practical Nurse (LPN) #3 confirmed she has never heard of EBP and could only guess what it was. During an interview on 09/16/24 at 3:35 PM, with Registered Nurse (RN)/Infection Preventionist revealed she thinks enhance barrier precautions means that she would like for staff to wear gloves if there is a suspicion on an infection and if it is air born then she would want them to wear a mask. During an interview on 09/16/24 at 3:56 PM, with CNA #4 on A Hall revealed she was aware of what EBP, because she works in another facility, but has not been told anything about it at this facility. During an interview on 09/16/24 at 3:58 PM, with CNA #5 on the B Hall revealed she may have attended an in-service about EBP, but she is not certain. She stated she thinks it means that they use extra precautions for residents with a EBP sign on their door. She confirmed that if there were two residents in a room with a EBP sign then she would not know which resident was on EBP. She revealed since she would not know which resident needed EBP then she would use precautions with both. She confirmed she does not know the purpose of EBP.	M 350		

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M 350	Continued From page 8 During an interview on 9/17/24 at 11:40 AM, with the Administrator revealed she is not sure why after in servicing two months ago that EBP that it was not known by staff and implemented or why the signs were not on the doors like they should have been. She confirmed that someone should have audited staff after the in-service and implementation of EBP to make sure it was going correctly. She revealed the purpose of EBP is to prevent the staff from giving the resident an infection and from the staff bringing an infection out and giving it to someone else. An observation of medication pass on 9/18/24 at 8:15 AM, with Licensed Practical Nurse (LPN) #6, revealed she prepared Resident #2's PEG (Percutaneous Endoscopic Gastrostomy) medication and stopped at the resident's door to read the sign posted that read, "Enhanced Barrier Precautions." LPN #6 entered the room and administered Resident #2's medications via PEG tube without donning (putting on) a gown. An interview with LPN #6 on 9/18/24 at 8:35 AM, confirmed she did not put on a gown to practice EBP while administering Resident #2's medications. She revealed that she did stop and read the sign on the door, but the sign did not specify that she needed to practice precautions while giving peg (Percutaneous Endoscopic Gastrostomy) meds. LPN #6 revealed she had been in-serviced on the measures, but she "must have missed the part about the need to dress out with PEG meds." She confirmed that a peg tube was considered an indwelling medical device and stated, "It makes sense."	M 350		
M 460	45.16.3 Criminal History Record Checks	M 460		10/28/24

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M 460	Continued From page 9 Criminal History Record Checks. Pursuant to Section 43-11-13, Mississippi Code of 1972, the covered entity shall require to be preformed a disciplinary check with the professional licensing agency, if any, for each employee to determine if any disciplinary action has been taken against the employee by the agency, and a criminal history record check on: 1. Every new employee of a covered entity who provides direct patient care or services and who is employed on or after July 01, 2003, and 2. Every employee of a covered entity employed prior to July 01, 2003, who has documented disciplinary action by his or her present employer. 3. Except as otherwise provided in this paragraph, no employee hired on or after July 01, 2003, shall be permitted to provide direct patient care until the results of the criminal history record check revealed no disqualifying record or the employee has been granted a waiver. Provided the covered entity has documented evidence of submission of fingerprints for the background check, any person may be employed and provide direct patient care on a temporary basis pending the results of the criminal history record check but any employment offer, contract, or arrangement with the person shall be voidable, if he/she receives a disqualifying criminal record check and no waiver is granted. 4. If such criminal history record check discloses a felony conviction; a guilty plea; and/or a plea of nolo contendere to a felony for one (1) or more of the following crimes which has not been reversed on appeal, or for which a pardon has not been granted, the applicant/employee shall not be	M 460		

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M 460	Continued From page 10 eligible to be employed at the licensed facility: a. possession or sale of drugs b. murder c. manslaughter d. armed robbery e. rape f. sexual battery g. sex offense listed in Section 45-33-23(g), Mississippi Code of 1972 h. child abuse i. arson j. grand larceny k. burglary l. gratification of lust m. aggravated assault n. felonious abuse and/or battery of vulnerable adult 5. Documentation of verification of the employee ' s disciplinary status, if any, with the employee ' s professional licensing agency as applicable, and evidence of submission of the employee ' s fingerprints to the licensing agency must be on file and maintained by the facility prior to the new employees first date of employment. The covered entity shall maintain on file evidence of verification of the employee ' s disciplinary status from any applicable professional licensing agency and of submission and/or completion of the criminal record check, the signed affidavit, if applicable, and/or a copy of the referenced notarized letter addressing the individual ' s suitability for such employment. 6. Pursuant to Section 43-11-13, Mississippi Code of 1972, the licensing agency shall require every employee of a covered entity employed prior to July 01, 2003, to sign an affidavit stating	M 460		

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M 460	Continued From page 11 that he or she does not have a criminal history as outlined in paragraph (3) above. 7. From and after December 31, 2003, no employee of a covered entity hired before July 01, 2003, shall be permitted to provide direct patient care unless the employee has signed an affidavit as required by this section. The covered entity shall place the affidavit in the employee ' s personnel file as proof of compliance with this section. 8. If a person signs the affidavit required by this section, and it is later determined that the person actually had been convicted of or pleaded guilty or nolo contendere to any of the offenses listed herein, and the conviction or pleas has not been reversed on appeal or a pardon has not been granted for the conviction or plea, the person is guilty of perjury as set out in Section 43-11-13, Mississippi Code of 1972. The covered entity shall immediately institute termination proceedings against the employee pursuant to the facility ' s policies and procedures. 9. The covered entity may, in its discretion, allow any employee unable to sign the affidavit required by paragraph (7) of this subsection or any employee applicant aggrieved by the employment decision under this subsection to appear before the covered entity ' s hiring officer, or his or her designee, to show mitigating circumstances that may exist and allow the employee or employee applicant to be employed at the covered entity. The covered entity, upon report and recommendation of the hiring officer, may grant waivers for those mitigating circumstances, which shall include, but not be limited to: (1) age at	M 460		

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M 460	Continued From page 12 which the crime was committed; (2) circumstances surrounding the crime; (3) length of time since the conviction and criminal history since the conviction; (4) work history; (5) current employment and character references; and (6) other evidence demonstrating the ability of the individual does not pose a threat to the health or safety of the patients in the licensed facility. 10. The licensing agency may charge the covered entity submitting the fingerprints a fee not to exceed Fifty Dollars ($50.00). 11. Should results of an employee applicant ' s criminal history record check reveal no disqualifying event, then the covered entity shall, within two (2) weeks of the notification of no disqualifying event, provide the employee applicant with a notarized letter signed by the chief executive officer of the covered entity, or his or her authorized designee, confirming the employee applicant ' s suitability for employment based on his or her criminal history record check. An employee applicant may use that letter for a period of two (2) years from the date of the letter to seek employment at any covered entity licensed by the Mississippi State Department of Health without the necessity of an additional criminal record check. Any covered entity presented with the letter may rely on the letter with respect to an employee applicant ' s criminal background and is not required for a period of two (2) years from the date of the letter to conduct or have conducted a criminal history check as required in this subsection. 12. For individuals contacted through a third party who provide direct patient care as defined herein, the covered entity shall require proof of a criminal history record check.	M 460		

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M 460	Continued From page 13 13. Pursuant to Section 43-11-13, Mississippi Code of 1972, the licensing agency, the covered entity, and their agents, officer, employees, attorneys, and representatives, shall be presumed to be acting in good faith for any employment decision or action taken under this section. The presumption of good faith may be overcome by a preponderance of the evidence in any civil action. No licensing agency, covered entity, nor their agents, officers, employees, attorneys and representatives shall be held liable in any employment discrimination suit in which an allegation of discrimination is made regarding an employment decision authorized under this section. This Statute is not met as evidenced by: Level II Based on staff interview, record review and facility policy review, the facility failed to ensure that a new employee had a background check completed prior to working for one (1) of five (5) new employee personnel records reviewed. Findings Include: Review of the facility policy titled, "(Facilities Proper Name) Background Check Policy" with a revision date of 2/13/17 revealed under, "Policy...It is the policy of (Facilities Proper Name) Management Services, as part of its hiring procedures, to conduct criminal background checks on all applicants offered employment to support workplace productivity, safety and security". Record review of Registered Nurse (RN) Unit Manager's personnel file revealed she was hired by the facility on 8/13/24 and her background	M 460	A completed background check was submitted, and the Registered Nurse Unit Manager (UM) was placed on administrative leave pending the completion of a background check on 09/19/2024. All residents have the potential to be affected by this practice. Regional Director of Human Resources (DHR) educated Administrator and Human Resources Director on 09/20/2024 that all employees should have proof of a background check completed and in the personnel file before resident contact. The Regional Director of Human Resources completed an audit of all associate personnel files to ensure the fingerprints and letter are obtained and filed for each associate on 09/20/2024.	

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M 460	Continued From page 14 check was completed on 6/10/22 and was outdated. An interview on 9/19/24 at 11:10 AM, with the Administrator confirmed that new staff's background checks have to have been done within the last two years. She stated we have called to see if we could get a more up to date one but have not received an answer. An interview on 9/19/24 at 12:00 PM, with the Assistant Director of Nurses (ADON) revealed that the purpose of a background check is to make sure there are no allegations or disqualifying events that would prevent the staff member from working at this facility. An interview on 09/19/24 12:51 PM, with Human Resources confirmed that she knew that the background check needed to be within 2 years of hire and failed to realize RN Unit Manager's was out of date.	M 460	Any negative findings were addressed at that time. Beginning 09/27/2024, background check completion will be reviewed and discussed daily by the Human Resources Coordinator with the Administrator for all new applicants until finalized. Beginning 09/30/2024, criminal background check audits will be conducted weekly to ensure background checks are conducted prior to hire and orientation and filed in personnel file. Audits of all new hires will occur weekly for eight weeks, then monthly for three months and will be completed by the Director of Human Resources and reviewed by the Administrator. Audit findings will be brought to the Quality Assurance Performance Improvement Committee on 10/25/2024 for review and recommendaton, then monthly for a minimum of three months.	
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 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;	M 500		10/28/24

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M 500	Continued From page 15 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 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	M 500		

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M 500	Continued From page 16 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 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;	M 500		

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M 500	Continued From page 17 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); 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	M 500		

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M 500	Continued From page 18 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 II Based on observation, resident and staff interviews, record review, meal ticket review, and facility policy review, the facility failed to provide dignity to residents, as evidenced by leaving urinary catheter bags uncovered for two (2) of four (4) residents with a catheter, (Resident #52 and Resident #190) and the facility failed to honor a resident's choice for sweet tea with meals for one (1) of twenty-two sampled residents. Resident #44. Findings include: A review of the facility policy, "Resident's Rights and Quality of Life" dated 05/01/2012, revealed "..... all residents have the right to a dignified existence, self-determination, and communication with an access to people and services inside and outside the facility." Resident #52 An observation on 09/16/24 at 9:25 AM and again at 10:25 AM, revealed Resident #52 lying in bed, with the bed against the right wall. Resident #52's urinary catheter bag and tubing were exposed with approximately 100 cc (cubic centimeters) of urine in the catheter bag with no privacy covering over the urinary drainage bag.	M 500	Urinary catheter bags on resident #52 and resident #190 were assessed by the Director of Nursing (DON) to ensure privacy devices were present with appropriate application on 09/16/2024. All residents with indwelling foley catheters have the potential to be affected. On 09/16/2024 the DON completed a 100% audit of all residents with urinary catheters to assure privacy devices in place. Any discrepancies were corrected immediately. On 09/20/2024, education was provided by the DON to the nursing team and therapy team on resident's rights to ensure understanding of maintaining the dignity of residents with urinary catheter bags by usage of properly placed catheter cover devices. A review of all residents with urinary catheter devices was completed on 09/19/2024 by the Minimum Data Set (MDS) nurse to ensure capture of resident's refusal of urinary bag dignity device and/or history of adjusting or removing privacy bag device.	

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M 500	Continued From page 19 An observation and interview on 09/16/24 at 3:15 PM with the Assistant Director of Nurses (ADON) revealed all urinary catheter bags are to always be in a covered privacy bag. She confirmed that the urinary catheter bag without a privacy bag is a dignity issue, and the resident should have had a privacy bag over it when it was observed uncovered this morning. A record review of Resident #52's Admission Record revealed the resident was admitted to the facility on 09/16/2022 with diagnoses including Seizures, Urinary Tract Infection, and cognitive communication deficit. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/20/24, revealed under Section H- Bladder and Bowel That Resident #52 had an indwelling catheter. Resident #190 On 09/16/24 at 9:45 AM, an observation in Resident #190's room, revealed a catheter bag hanging on the left side of the bed with no privacy bag covering and it was observed with 350 milliliters (mls) of yellow urine in the drainage bag and it was facing the door. On 09/16/24 at 10:30 AM an observation and interview with Resident #190 revealed a urinary catheter bag hanging on the left side of the bed facing the doorway with no privacy bag in place. There was yellow urine draining into the catheter bag. Resident #190 revealed that therapy staff wheeled her down the hall to physical therapy with the uncovered catheter bag attached to her wheelchair nearly every day. Resident #190 revealed that she worried that other people would	M 500	On 09/23024, the Administrator began an audit of a minimum of five residents weekly for four weeks, then monthly for two months of residents with urinary catheters to ensure privacy devices are present and appropriately applied. Audit findings were brought to the Quality Assurance Performance Improvement Committee on 10/25/2024 for review and recommendations and will be brought monthly for three months to assure continued compliance. On 09/17/2024, the Dietary Services Manager met with Resident #44 to update preferences. On 09/17/2024, the Dietary Services Manager in-serviced dietary staff regarding tray ticket accuracy with meal tray preparation. All residents have the potential to be affected. On 09/20/2024, the Administrator began education with direct care staff regarding meal tray ticket accuracy and resident choice. An audit of resident meal tray ticket accuracy was completed by the Dietary Service Manager on 09/30/2024. Any negative findings were addressed at that time. Beginning 09/30/2024, the Dietary Service Manager began an audit of ten trays per day for five days a week to assure accuracy of meal tray before tray delivery.	

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M 500	Continued From page 20 stare at her catheter and she stated, "It makes me feel nasty." On 09/16/24 at 11:08 AM, an interview with Registered Nurse (RN) Unit Manager revealed that she walked through the facility this morning, saw that Resident #190's catheter bag was not in a privacy bag. RN Unit Manager revealed that having a urinary catheter bag uncovered was a privacy issue and that all catheter bags should be covered. On 09/17/24 at 10:15 AM, an interview with Director of Nursing (DON), revealed that all urinary catheter drainage bags should be covered due to privacy and dignity issues that it may cause the resident. She agreed that not having a privacy bag over Resident #190's urinary catheter bag was a dignity issue. On 09/16/24 at 10:20 AM, an interview with Physical Therapy Assistant (PTA), revealed that she had Resident #190 on her caseload and she received therapy services five days a week. PTA revealed that she transported Resident #190 to therapy in her wheelchair and that she hadn't paid much attention to her catheter bag. She revealed that she normally took the catheter bag from the bed, hooked it on the wheelchair and just "went with it" during transport to therapy. PTA agreed that transporting a resident with a catheter bag without a privacy bag was a dignity issue and the bag should be covered. She revealed that she would make sure from now on that all catheter bags were covered before transport to therapy. Record review of Resident #190's "Admission Record" revealed an admission date of 09/06/24 and that she had diagnoses that included Obstructive and Reflux of Uropathy,	M 500	This audit will occur five times a week for four weeks, then three times a week for four weeks, then weekly for four weeks. Beginning 10/01/2024, the Administrator/Director of Nursing will conduct resident interviews of ten residents weekly for eight weeks to assure meal tray accuracy and resident preferences are acknowledged. All audit findings will be brought to the Quality Assurance and Performance Improvement Committee on 10/25/2024 for review and recommendations monthly for three months.	

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M 500	Continued From page 21 Rhabdomyolysis, and Paraplegia. Record review of Resident #190's MDS with ARD of 09/13/24 under Section C revealed a BIMS Score of 14 which indicated that she was cognitively intact. Section H revealed that she had an indwelling catheter. Resident #44 An interview with Resident #44 on 9/16/24 at 11:06 AM revealed, she wanted sweet tea with meals, and it had been over a month since she had gotten it. She stated she had told them, but they keep sending unsweet tea and she just cannot drink it. An observation and interview with Resident #44 on 9/16/24 at 12:42 PM revealed, she received a glass of tea with her lunch meal. The resident revealed the tea was unsweet. The meal ticket provided with the lunch tray dated 9/17/24 read, "Sweetened Iced Tea- 8 oz (ounces)". An observation of the lunch meal on 9/17/24 at 12:48 PM revealed, Resident #44 received a glass of tea. The tea was sampled by the resident and the tea was confirmed to be unsweet. An interview with the Dietary Manager (DM) on 9/17/24 at 12:51 PM revealed the kitchen staff followed the meal cards to prepare the meal trays. She confirmed Resident #44's meal ticket listed sweet tea, and the resident did not receive it. She revealed the resident should be able to make choices regarding things she likes to eat and drink, and her preferences should be honored. Record review of the Minimum Data Set (MDS)	M 500		

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M 500	Continued From page 22 with an Assessment Reference Date (ARD) of 7/1/24 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #44 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #44 on 11/10/22 with a medical diagnosis of Chronic Obstructive Pulmonary Disease.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Pattern Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide the necessary assistance with Activities of Daily Living (ADL) care for a resident requiring nail care (Resident #58, #59) and incontinent care (Resident #7) for three (3) of 22 sampled residents. Findings Include:	M 610	On 09/17/2024,incontinent care was provided to Resident #7 by C.N.A. #8. The nurse assessed the resident for emotional or physical harm/discomfort with no negative outcome noted. There was no evidence of any skin breakdown. Education was provided to C.N.A #7 by the Administrator on 09/17/2024 on incontinent care to assure understanding of double briefing as an unacceptable practice.	10/28/24

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M 610	Continued From page 23 Review of the facility policy "ADL's (Activities of Daily Living)" dated August, 2021, revealed, "Policy: Ensure ADL's are provided in accordance with accepted standards of practice, the care plan, and reasonable accommodation of the resident's choices and preferences." An observation on 9/17/24 at 8:15 AM, revealed Resident #7 was lying in bed with eyes open, alert but confused and it was noted a very strong odor of urine in the room. An observation and interview with Certified Nurse Aide (CNA) #7 on 9/17/24 at 8:18 AM, confirmed the strong odor of urine in the room and confirmed the resident was incontinent and explained that she had not made a round on the resident since her shift started at 7 AM. The CNA revealed the last round would have been done on the 11-7 shift. The CNA pulled back the top cover and checked to see if the resident was wet. An observation revealed the resident had on two (2) blue incontinent briefs. The top brief was heavily saturated in urine. CNA #7 confirmed the resident was not supposed to have on 2 briefs and agreed it gives the impression that staff were not rounding and providing incontinent care, as they should be. She revealed she normally made rounds with the 11-7 shift, but she did not do it this morning and confirmed she should have. An interview with CNA #8 on 9/17/24 at 8:22 AM, revealed they were supposed to round on the residents every 2 hours or more if needed. She revealed they were required to make rounds with the off going shift to ensure the residents were clean and dry. An interview with the Director of Nursing (DON) on 9/17/24 at 11:00 AM, revealed not providing	M 610	The nurse assessed resident #58 on 09/17/2024 and assured the nails were trimmed. No skin tears or injuries were noted. The nurses assessed Resident #59 on 09/17/2024 and assured nails were trimmed and cleaned. No skin tears or injuries noted. Care plans were reviewed by the Minimum Data Set Nurse on 09/17/2024 for all three residents and updated as needed. All residents requiring assistance with incontinent care and nail care have the potential to be affected by this practice. On 09/17/2024, the Director of Nursing (DON) assured nursing staff conducted 100% audit with all other incontinent residents to assure no other concerns for the unacceptable practice. No other issues identified. An audit was conducted by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Treatment nurse, Health Information Management Nurse and Registered Nurse (RN) Unit Manager of all residents to assess for dirty, jagged, or long nails and completed on 09/27/2024. Any residents identified with long/jagged or dirty nails were immediately addressed. Any resident refusing nail care was care planned and charted as such. Any resident with personal choice for long nails was care planned. Education was initiated by the Administrator on 09/20/2024 with nursing	

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M 610	Continued From page 24 incontinent care timely and wearing 2 briefs could cause an increased risk for skin breakdown. She explained that using 2 briefs on a resident made it look like they were not wanting to make rounds on the residents. An interview with the Administrator on 9/17/24 at 11:10 AM, revealed the aides were responsible for making rounds on the resident every 2 hours, and if the resident was a heavy wetter, they were to increase their rounds to hourly or every 30 minutes. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/13/24 revealed under, bladder and bowel in section H, Resident #7 was always incontinent of bladder. Also revealed under section GG, the resident was dependent on staff for toileting hygiene. Record review of the "Admission Record" revealed the facility admitted Resident #7 on 2/19/23 with a medical diagnosis of Unspecified Dementia. Resident #58 On 09/16/24 at 10:50 AM, an observation and interview with Resident #58 revealed long jagged fingernails approximately one-half to three-fourths inch long on his bilateral hands. Resident #58 stated, "They're slow on checking fingernails." He revealed that his shower days were Tuesday, Thursday, and Saturday and he confirmed that they did not take care of his fingernails like they were supposed to. On 09/17/24 at 9:07 AM, an observation in Resident #58's room revealed long jagged	M 610	to assure understanding of incontinent care practices. Competencies/check offs for providing incontinent care were initiated on 10/01/2024 with Certified Nursing Assistants by the Director of Clinical Education and Administrator. Systemic changes implemented on 09/30/2024 to avoid this nail care concern included implementing daily environmental rounds check list to include observation of nails. Any resident with long/jagged or dirty nails should be evaluated immediately and corrected based on the resident's preferences. An in-service was conducted by the Administrator on 09/30/2024 with team members regarding updated environmental rounds along with implementation. Education initiated on 09/20/2024 with staff on Activities of Daily Living to assure understanding and importance of checking resident appearance, nails, hair and overall grooming needs by the Administrator. On 10/01/2024, the Director of Nursing began an audit of a minimum of five residents weekly for four weeks, then monthly for two months of residents requiring incontinent care assistance to ensure appropriate incontinent care practices are followed. On 10/01/2024, the Director of Nursing began an audit of a minimum of five residents weekly for four weeks then monthly for an additional two months to assure that nails are clean and trimmed in	

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M 610	Continued From page 25 fingernails on both of his hands. He revealed that he had his shower on Saturday night and revealed that they had not provided nail care. On 09/17/24 at 11:27 AM, an observation and interview with CNA#2 in Resident #58's room confirmed that he had long jagged fingernails on both of his hands. She revealed that long jagged fingernails could scratch him on his skin and cause a possible infection. On 09/18/24 at 9:35 AM, an interview with Licensed Practical Nurse (LPN) #4, revealed that the CNAs were supposed to check fingernails with every bath and as needed. On 09/17/24 at 11:45 AM, the Assistant Director of Nursing (ADON) confirmed that Resident #58's fingernails were long and jagged and needed to be cut. On 09/18/24 at 11:15 AM an interview with Administrator (ADM) revealed that nail care was supposed to be done during resident baths and showers. She revealed that the CNAs were also supposed to be checking nails every day and cleaning them as needed. She revealed that ADL concerns had been on-going and they were working on trying to fix issues. ADM confirmed that they should have identified these ADL concerns regarding the nails and fixed the problem. Record review of Resident #58's "Admission Record" revealed an admission date of 05/02/22 and that he had diagnoses that included Cervical Disc Disorder with Myelopathy, Need for Assistance with Personal Care, and Muscle Weakness.	M 610	accordance with the resident wishes. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 10/25/2024 and then monthly for a minimum of three months to assure continued compliance. Any variance will be addressed immediately.	

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M 610	Continued From page 26 Record review of Resident #58's MDS with ARD of 07/01/24 under Section C revealed a BIMS Score of 15 which indicated that he was cognitively intact. Record review of Resident #58's "Task Care Record" revealed that a staff member signed that he received his shower on Saturday evening, 09/14/24. Record review of Resident #58's MDS with ARD of 7/01/24 under Section GG revealed that he required partial to moderate assistance with showering and bathing himself and required substantial/maximal assistance with personal hygiene. Resident #59 On 09/16/24 at 10:40 AM, an observation and interview with Resident #59 revealed long jagged fingernails on both hands and he had three fingernails on his right hand with brown substance underneath. He revealed that the aides helped with his baths every other day but they had not checked his fingernails in a while. Resident #59 revealed that he couldn't see that well and he needed help to keep them cleaned and trimmed. On 09/17/24 at 11:25 AM, an interview with CNA #2 revealed that they had scheduled times for resident baths or showers and that they were supposed to check, clean and clip fingernails during that time. She revealed that personal hygiene included mouth care, nail care, peri-care and shaving. She confirmed that Resident #59's fingernails were long and jagged and should have already been taken care of.	M 610		

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M 610	Continued From page 27 An observation and interview on 09/17/24 at 11:33 AM, with Registered Nurse (RN) #1 confirmed that Resident #59 had long jagged fingernails and brown substance underneath three fingernails on his right hand. She revealed that fingernails carried germs and could cause infection if Resident #59 scratched himself. Record review of Resident #59's "Admission Record" revealed an admission date of 06/12/24 and that he had diagnoses that included Hemiplegia, Cerebral Infarction, and Generalized Muscle Weakness. Record review of Resident #59's MDS with ARD of 09/09/24 under Section C revealed a BIMS score of 15 which indicated that he was cognitively intact. Section B revealed that his vision was highly impaired. Section GG revealed that he required setup or clean up assistance with personal hygiene needs. Record review of Resident #59's "Task Care Record" revealed that a staff member signed that he received his shower on Monday evening, 09/16/24.	M 610		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Pattern	M 640	On 09/16/2024, the Administrator secured	10/28/24

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M 640	Continued From page 28 Based on observation, resident and staff interview, and facility policy review, the facility failed to ensure that a residents' environment was free from accident hazards, as evidenced by, medications left at bedside and smoking paraphernalia in rooms for two (2) of 22 sampled residents. Resident #22 and #34 Findings include: Review of the facility policy titled "Safe Smoking" with an effective date of 11/1/16 revealed under, "Purpose: 1. To maximize our ability to provide a safe environment for all residents/patients who smoke, while taking into account non-smoking residents..." Record review of a typed statement on facility letterhead, dated September 17, 2024, and signed by the Administrator revealed "(Proper name of the facility) does not have a policy for "Medication Left at Bedside." The center utilizes the Medication Administration Clinical Competency." An observation of Resident #22 on 9/16/24 at 10:00 AM, revealed he was lying in bed. with a cigarette box lying at the foot of the bed in a white and blue pack. Resident #22 revealed he was a smoker and stated, "They don't let us keep cigarettes in our rooms. There's not anything in the pack." The box contained 1 cigarette and one-half (1/2) of a used cigarette butt. An interview with the Director of Nursing (DON) on 9/17/24 at 11:00 AM, revealed the Administrator keeps the cigarettes locked up in her office and distributes 2 cigarettes in a zip lock baggie to each resident that was going to smoke	M 640	cigarettes found in Resident #22's room. The resident was educated on the smoking policy by the Administrator. On 09/16/2024, the medications at the bedside of resident #34 were removed and secured by the registered nurse. resident #34 was educated on storage of medications to assure understanding by the registered nurse. All residents have the potential to be affected by this practice. On 09/16/2024, the Administrator conducted an audit of all residents who smoke to assure no residents were in possession of smoking materials with no negative findings. On 09/16/2024, the Director of Nursing conducted an audit of all residents rooms to assure no residents were in possession of medications. No other concerns identified. Education initiated by the Administrator with all staff on 09/20/2024 regarding the smoking policy to assure smoking paraphernalia is secured and not in the resident's possession by the Administrator. On 09/27/2024, education was completed with nursing staff to assure understanding of medication storage by the Director of Nursing. Systemic changes implemented on 09/30/2024 to avoid these issues included	

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M 640	Continued From page 29 at each break. She revealed, we tell the families that the residents can't have them and if they buy them, they must leave them with the Administrator. She revealed Resident #22 did go out with a friend and could be getting them that way. The DON explained that the aides and nurses know that when they see cigarettes' or a lighter on a resident, they cannot have it. An interview with the Administrator (ADM) on 9/17/24 at 11:10 AM, revealed the facility did not allow the residents to keep smoking paraphernalia and Resident #22 knew that. She revealed the resident had one friend that he went out of the facility with, but he knew the resident could not have them. She stated, "I use the honor system. I can't go into his room and search or shake him down." She confirmed the resident could set something on fire in the building by keeping smoking materials. An interview on 9/19/24 at 10:50 AM, with the ADM revealed, she spoke to Resident #22 about having cigarettes in his room and the resident stated, "When I go out to smoke, I need my cigarettes." She revealed all she could do to control the issues was the honor system. She explained on the weekends, if cigarettes were brought into the facility by families, they were given to the nurses and locked up. The ADM revealed the nurses give 2 cigarettes to the aides for smoke break, so the residents do not have access to the materials. Record review of the "Admission Record" revealed the facility admitted Resident #22 on 2/24/24 with a medical diagnosis that included Personal history of nicotine dependence. Record review of the Minimum Data Set (MDS)	M 640	implementing daily environmental rounds check list to include observation for smoking paraphernalia and medications in the resident room. Staff to immediately notify administration if smoking materials or medications are in a resident's room. Any resident with smoking paraphernalia should be evaluated immediately and corrected based on the resident's preferences. Notification of the smoking policy and medication storage was provided to the residents and families on 10/01/2024 by the Administrator. On 09/30/2024, the Administrator began an audit of a minimum of five residents weekly for four weeks then monthly for two months to ensure no smoking paraphernalia or medications in resident rooms. The results of the audits will be addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 10/25/2024 and then monthly for a minimum of three months to assure continued compliance. Any variance will be addressed immediately.	

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M 640	Continued From page 30	M 640		

with an Assessment Reference Date (ARD) of 7/10/24 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 14, which indicated Resident #22 was cognitively intact.

Resident #34

An observation of Resident #34's bedside dresser on 9/16/24 at 10:15 AM, revealed a bottle of Rolaids Antacid Ultra Strength #72 count, Magnesium 200 mg (milligrams) #60 count and a bottle of Multivitamin tablets #200 count. An interview with the resident revealed, he brought them from home and stated, "I just take them when I think about it."

An observation and interview with Registered Nurse (RN) #2 on 9/16/24 at 10:30 AM, revealed Resident #34 should not have medication in his room because he did not have an order to self-administer the medication. She confirmed anything could happen with the resident having bottles of medication at bedside. She revealed we could be double dosing him, causing a medication error.

An interview with the ADM on 9/17/24 at 12:10 PM, revealed the facility was not aware Resident #34 had the medication in his room and was taking it. She revealed the resident did not have an order to self-administer meds, and confirmed he could potentially get overmedicated if he was receiving the same medications by the nurses.

Record review of the "Admission Record" revealed the facility admitted Resident #34 on 1/11/24 with a medical diagnosis that included Atherosclerotic heart disease.

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M 640	Continued From page 31 Record review of the MDS with an ARD of 7/9/24 revealed, under section C, a BIMS summary score of 15, which indicated Resident #34 was cognitively intact.	M 640		
M 855	45.30.7 Food Preparation Food Preparation. Foods shall be prepared by methods that conserve optimum nutritive value, flavor, and appearance. Also, the food shall be acceptable to the individuals served. A file of tested recipes shall be maintained to assure uniform quantity and quality of products. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to serve food that met the residents' choices and failed to serve the food in an attractive and palatable manner for four (4) of twelve residents reviewed for dining. Resident #20, #27, #43, and #50. Findings Include: CROSS REFERENCE F565 Record review of the facility policy "Menus" revised 10/2022 revealed "Menus will be planned in advance to meet the nutritional needs of the residents ...6. Menus will be served as written, unless a substitution is provided in response to preference ..." Resident #20 An interview on 9/16/24 at 10:57 AM, with	M 855	Residents #20, #27, #43, and #50 were each assessed by the nurse on 09/17/2024, with no negative findings. All residents were interviewed by 09/30/2024 by the Dietary Department Manager to identify other residents that might be affected by this practice. Any resident with concerns were addressed immediately. All residents have the potential to be affected by this practice. System changes to address the concern, beginning 10/01/2024, the Dietary Manager will assure that scaled recipes will be utilized to ensure consistent quality and quantity production. Beginning 10/01/2024, Production sheets to be reviewed by the dietary manager prior to production to ensure appropriate quality and quantity is prepared.	10/28/24

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M 855	Continued From page 32 Resident #20 revealed, she did not like the food that she was served. An observation of the lunch meal on 9/16/24 at 12:50 PM revealed, Resident #20's meal ticket read, "Renal" and listed the foods as, "Baked chicken breast on a bun, grilled cheese sandwich, garden pasta salad, green peas, apple crisp, soup, unsweetened tea 8 ounces." The food on the tray was untouched, and the resident revealed she could not eat it. Resident #20 reported the food did not look appealing and revealed she had the same thing every day. An observation of the chicken breast reveled it was thick, gray, was not moist, and did not resemble the look of a chicken breast or patty. The chicken was in between a dry bun. The garden pasta salad included mushy white noodles in sauce with green broccoli granules. An observation of Resident #20's lunch meal with the Dietary Manger (DM) on 9/16/24 at 12:55 PM, revealed the meat was a chicken breast and was cooked today. She acknowledged the garden pasta salad was mushy and revealed it should not be like that. She stated the broccoli looked that way because of the type of broccoli they used. The DM explained she was aware the resident did not like the food and revealed she had many dislikes. An observation of the lunch meal on 9/17/24 at 12:50 PM, for Resident #20 revealed, the meal consisted of steamed white rice, a bowl of green peas, a roll, peanut butter cookie and unsweetened tea. The resident was unhappy with the meal and stated, "I can't just eat a pile of rice with nothing on it, and I had the same green peas yesterday."	M 855	Beginning 10/01/2024, food temperatures to be checked before each meal service and documented on a temperature recording log-Tray-line checklist three times a day for seven days per week for four weeks. Food temp findings will be reviewed at the Quality Assurance Performance Improvement Committee meeting on 10/25/2024, to determine if revisions need to be made to this plan. Beginning 10/01/2024, a Resident Food Committee will be initiated weekly for four weeks, then bi-weekly for two months to address resident concerns and follow up with identified dietary concerns. The dietary manager is to document all resident concerns and follow up on each concern within 48 hours of the received date. Beginning 10/07/2024, the dietary manager will audit food preferences by means of interviews of ten residents weekly for four weeks, then bi-weekly for four weeks to assure Meal Tracker accuracy. Beginning on 10/01/2024, the Administrator or Director of Nursing will receive a test tray five days per week of two meals daily for one month, three days per week for one meal for two months. Beginning the week of 10/01/2024, the Administrator will audit food committee notes weekly for four weeks then bi-weekly for two months, then monthly thereafter to ensure all grievances are resolved. The results of the audits will be	

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M 855	Continued From page 33 An observation and interview on 9/17/24 at 12:57 PM, of Resident #20's lunch meal with the DM revealed the lunch meal looked that way because the resident had so many dislikes. An interview with the Registered Dietician (RD) on 9/18/24 at 10:49 AM, revealed she had been working at the facility for about 3 months. She revealed the menu was given to them from corporate. The RD explained that she or the Dietary Manager update the resident preferences quarterly and on admit. The RD was made aware of the lunch meal served to Resident #20 on 9/16/24 and 9/17/24 and confirmed someone should have intervened and asked the resident about getting her something else to eat. An interview with the Director of Nursing (DON) on 9/18/24 at 2:25 PM, revealed she was aware Resident #20 refused many foods that were sent down to her. She revealed the resident did not comply with a renal diet, and the kitchen did try and accommodate for her choices by sending a grilled cheese sandwich and soup with lunch and supper. Record review of the "Admission Record" revealed the facility admitted Resident #20 on 6/23/24 with medical diagnoses that included urinary tract infection and dependence on renal dialysis. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/9/24, revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #20 was cognitively intact. Resident #27	M 855	addressed in the Quality Assurance and Performance Improvement (QAPI) meeting on 10/25/2024, then monthly for a minimum of three months to assure continued compliance.	

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M 855	Continued From page 34 An interview on 9/16/24 at 10:00 AM, with Resident #27 stated the food is terrible and the chicken was too hard to chew. Resident #27 revealed that she has received hash-browns that were still frozen inside and when she ask for an alternate meal then she got the same meal. She admitted she has complained to the aides, but that's the only people she knows to tell because that's who brings the meals in. An observation and interview with Resident #27 of the lunch meal on 9/17/24 at 12:44 pm revealed the resident received hamburger steak with gravy, fried potatoes and a roll. The hamburger patty was approximately and 1/8 inch thick and the brow gravy was watery and poured over the top of the hamburger patty. She stated its not good, but at least I can chew it. Record review of Resident #27's "Admission Record" revealed the resident was admitted to the facility on 2/7/24 with medical diagnoses that included Type 2 Diabetes Mellitus. Record review of Resident #27's Minimum Data Set with an Assessment Reference Date of 7/25/24 revealed under Section C a Brief Interview for Mental Status score of 15, which indicates the resident is cognitively intact. Resident #43 On 9/16/24 at 10:03 AM, an interview with Resident #43 confirmed that the chicken taste like it's been cooked for weeks and is too hard to chew. He stated he has gone to the cook's multiple times and complained, but nothing has improved.	M 855		

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M 855	Continued From page 35 An observation of the lunch meal on 9/17/24 at 12:44 PM, revealed that Resident #27 received a hamburger steak with gravy, fried potatoes and a roll. The hamburger patty was approximately an 1/8 inch thick, and the brown gravy was watery and thin and poured over the top of the hamburger patty. Record review of Resident #43's "Admission Record" revealed he was admitted to the facility on 4/2/24 with medical diagnoses that included Alzheimer's Disease. Record review of Resident #43's MDS with an ARD of 7/23/24 revealed no score for his BIMS score in Section C. Resident #50 An observation of the lunch meal on 9/16/24 at 12:25 PM, revealed Resident #50 stated "the food is terrible" and that she has received hashbrowns that were still frozen inside. Resident #50 stated that the chicken for example is cooked to where it is too hard to even chew and the food is always cold. She revealed that she has asked for an alternate when she gets something she does not like or can't chew and she does not get the alternate, she gets a replacement of the same meal. Resident #50 she has complained to the aides about the food, because that was all she knew to do. Record review of Resident #50's "Admission Record" revealed the resident was admitted to the facility on 6/6/24 with medical diagnoses that included Chronic Obstructive Pulmonary Disease. Record review of Resident #50's MDS with an ARD of 6/13/24 revealed under Section C a BIMS	M 855		

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M 855	Continued From page 36 score of 14, which indicated the resident is cognitively intact. An interview on 09/18/24 at 8:25 AM, with the Administrator confirmed that food has been a concern for a while. We met once a month for a while, but when the Dietary Manager went out on maternity leave in March 2024 "the committee dwindled away." She stated that residents were allowed to come to the meetings when they had them. On 9/18/24 at 9:30 AM, an interview with the DM and the District Dietary Manager they confirmed they have had complaints about food for a while. The DM stated that some of the complaints they have received have been about the residents not liking the chicken. She stated that she was off on maternity leave from March 2024 through May 2024 and confirmed that the food committee meetings that were being held once a month stopped after she left on maternity leave. She admitted that she still gets repetitive complaints about food. On 9/18/24 at 11:00 AM, an interview with the Administrator confirmed that food complaints have been ongoing and should have been resolved by now.	M 855		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and	M1570		10/28/24

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M1570	Continued From page 37 communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Pattern Based on observation, staff interviews, record review and facility policy review, the facility failed to fully implement Enhanced Barrier Precautions (EBP) precautions and failed to follow infection control measures while providing resident care for two (2) of four (4) survey days that had the potential to affect 11 residents on EBP and Resident #2 and Resident #20. Findings Include Review of the facility policy titled, "Policies and Practices - Infection Control" with an effective date of 11/1/17 revealed ..."Policy Statement: This center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of	M1570	On 09/16/2024, education was completed by the Director of Nursing (DON) and C.N.A #8 to assure understanding of infection control practices and not placing soiled items on the floor. Housekeeping was notified at that time and the floor was mopped. The Director of Nursing evaluated the resident on 09/16/2024, and no negative outcomes were noted. On 09/18/2024, education was completed by the Director of Clinical Education with LPN #6 on Enhanced Barrier Precautions (EBP) to assure use of appropriate personal protective equipment while administering PEG medications/care. The resident was assessed by the Director of Nursing(DON) on 09/18/2024 with no negative outcomes.	

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M1570	Continued From page 38 diseases and infections ..." Record review of a typed statement on facility letterhead, dated September 18, 2024 and signed by the Administrator, revealed "(Proper name of facility) uses the CDC (Centers of Disease Control) guidelines for the implementation of Enhanced Barrier Precautions." An observation of the facility on 09/16/24 from 10:00 AM until 11:30 AM revealed there was one (1) EBP sign on room A4 on the A-Hall. The tour of the B-Hall revealed there were (2) signs on (2) different rooms, and no signs were observed on the C- Hall or D- Hall. An interview on 09/16/24 3:13 PM, with Certified Nurse Assistant (CNA) #3 revealed she is not familiar with EBP and stated she has never been told anything about it and has no idea what it means. An interview on 09/16/24 3:24 PM, with Licensed Practical Nurse (LPN) #3 confirmed she has never heard of EBP and could only guess what it was. An interview on 09/16/24 at 3:35 PM, with Registered Nurse (RN)/Infection Preventionist revealed she thinks enhance barrier precautions means that she would like for staff to wear gloves if there is a suspicion on an infection and if it is air born then she would want them to wear a mask. An interview on 09/16/24 at 3:56 PM, with CNA #4 on A Hall revealed she was aware of what EBP is because she works in another facility, but has not been told anything about it at this facility. An interview on 09/16/24 at 03:58 PM, with CNA	M1570	An audit of all residents was completed on 09/16/2024 to determine appropriate signage needed for residents requiring EBP by the Director of Clinical Education. Signage was immediately placed to the resident doors. All residents have the potential to be affected by this practice. Education was initiated by the Administrator and Director of Clinical Education on 09/20/2024 with direct care staff to assure staff understanding and implementation of Enhanced Barrier Precautions (EBP) and appropriate handling of soiled items. Beginning 10/01/2024, the facility will conduct environmental rounds daily for observation of required EBP signage. Any missing signage will be immediately addressed and corrected. An in-service was conducted by the Administrator on 09/20/2024 with team members regarding updated environmental rounds along with implementation. All new admits and readmits will be reviewed to determine if diagnosis, treatment orders or devices ordered would need EBP signage by the Director of Nursing (DON) ad Director of Clinical Education (DCE). On 10/07/2024, the Director of Nursing began an audit by means of observation rounds of a minimum of five residents weekly for four weeks then monthly for two months of residents to ensure implementation of EBP and appropriate	

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M1570	Continued From page 39 #5 on the B Hall revealed she may have attended an in-service about EBP, but she is not certain. She stated she thinks it means that they have to use extra precautions for residents with a EBP sign on their door. She confirmed that if there were two residents in a room with a EBP sign on the door, then she would not know which resident was in EBP. She revealed since she would not know which resident needed EBP then she would use precautions with both and confirmed she does not know the purpose of EBP. An interview and observation on 09/17/24 at 11:05 AM, with CNA #2 revealed she was performing incontinent care on a resident on the C- Hall that had a EBP sign on their door. On interview she stated that they in serviced her yesterday about EBP and why it needs to be done. She stated that she did not know about EBP prior to yesterday, but now they have signs on the resident's doors that need it and to wear a gown and gloves when performing care. An interview on 09/17/24 at 11:10 AM with RN/Infection Preventionist confirmed that an in-service was done with the employees one on one yesterday. She admitted that additional residents were added for EBP after she learned more about it and signs were put on their doors. An interview on 9/17/24 at 11:20 AM, with the Director of Nurses (DON) stated that they did an in-service on EBP two months ago. She stated that they had a different infection control nurse then and knows that she put signs on the resident's doors and educated the staff. She confirmed that more than three resident rooms should have had signs for EBP. She stated that the actual follow-up to the in-service auditing	M1570	handling of soiled items are followed. Audit findings will be brought to the Quality Assurance and Performance Improvement Committee meeting on 10/25/2024 and monthly for a minimum of three months.	

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performance would have been done by the infection control nurse that was here when we implemented it. She agreed she should have been aware that it was not being implemented and felt like the infection control nurse would have told her.

An interview on 9/17/24 at 11:40 AM with the Administrator confirmed she is not sure why after in servicing two months ago that EBP was not known by staff and implemented or why the signs were not on the doors like they should have been She confirmed that someone should have audited staff after the in-service and implementation of EBP to make sure it was going correctly. She revealed the purpose of EBP is to prevent the staff from giving the resident an infection and from the staff bringing an infection out and giving it to someone else.

Record review of a typed list of residents on EBP dated 9/17/24 and signed by the Administrator revealed on 9/16/24 upon the State Agency (SA) entrance to the facility there were four (4) residents listed on EBP. On 9/17/24 the list was revised and included 11 residents listed on EBP.

Resident #20

An observation and interview outside Resident #20's room on 9/16/24 at 9:18 AM, revealed the door was open. Upon entering the room, the privacy curtain was pulled in the middle of the room, and a blue and white soiled disposable bed pad could be seen lying on the floor with a dark brown substance on it. Certified Nurse Aide (CNA) #8 was assisting the resident and revealed she was helping the resident with her colostomy bag. She confirmed the bed pad was soiled and revealed it should not be placed on the floor and

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should be bagged and disposed of. She revealed this action could spread germs throughout the facility.

An interview with the Administrator (ADM) on 9/17/24 at 12:10 PM, revealed soiled trash should never be placed on the floor and should be placed in a bag and transported out of the room. She confirmed placing soiled trash on the resident's floor was an infection control concern.

Resident #2

During an observation of medication pass on 9/18/24 at 8:15 AM, with LPN #6, she prepared Resident #2's PEG (Percutaneous Endoscopic Gastrostomy) medication and stopped at the resident's door to read the sign posted that read, "Enhanced Barrier Precautions." LPN #6 entered the room and administered the residents' medications via PEG tube without donning (putting on) a gown.

An interview with LPN #6 on 9/18/24 at 8:35 AM, confirmed she did not put on a gown to practice enhanced barrier precautions while administering Resident #2's medications. She revealed that she did stop and read the sign on the door, but the sign did not specify that she needed to practice precautions while giving PEG meds. LPN #6 revealed she had been in-serviced on the measures, but she "must have missed the part about the need to dress out with peg meds." She confirmed that a peg tube was considered an indwelling medical device and stated, "It makes sense."

An interview with the Director of Nursing (DON) on 9/18/24 at 9:10 AM, confirmed staff should be using EBP with the medications given by feeding

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M1570	Continued From page 42 tube and revealed the staff have all been in-serviced on that. Record review of the "Admission Record" revealed the facility admitted Resident #2 on 5/19/23 with medical diagnoses that included Unspecified dementia and Encounter for fitting and adjustment of other gastrointestinal appliance and device.	M1570		