STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255148	A. BUILDING _____ B. WING _____	C 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLANDS REHABILITATION AND HEALTHCARE CENTER	102 WOODCHASE PARK DRIVE CLINTON, MS 39056

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted two (2) Complaint Investigations (CI MS #26320 and CI MS #25758), at the facility from 9/23/24 through 9/25/24. CI MS #26320 was investigated related to Quality of Care/Treatment related to medication and feeding assistance, Physician Services, and Dietary Services related to therapeutic diets, with no deficiencies cited. CI MS #25758 was investigated related to Quality of Care related to notification and medications, Physical Environment related to equipment maintenance, and Quality of Life related to resident's environment. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F584, F656, F677 and F908 related to CI MS # 25758. The facility held a license for 145 beds, with a census of 133 residents.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident	F 584		10/25/24

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

Electronically Signed | 10/18/2024

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F 584	Continued From page 1 independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, facility policy review, and record review, the facility failed to ensure a clean, homelike environment for three (3) of five (5) sampled residents, Residents #2, #3, and #4. Findings Include: A review of the facility's policy titled "Homelike Environment," revised February 2021, revealed "Residents are provided with a safe, clean, comfortable, and homelike environment ...1. Staff	F 584	On 9/23/24, Resident #2 room was stripped, waxed, and deep cleaned by the Housekeeping Manager. The wet incontinence brief was discarded appropriately by the Nurse Supervisor, and the trash can was emptied and sanitized by the Housekeeping Manager. ¿ Certified Nursing Assistant (CNA) #1 was educated by the Staff Development Coordinator (SDC) on 9/25/24 for ensuring proper immediate reporting of any extremely strong odors to the	

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F 584	Continued From page 2 provides person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized homelike setting. These characteristics include: a. clean, sanitary, and orderly environment ...f. pleasant, neutral scents..." On 09/23/24 at 1:25 PM, during an observation of Resident #2's room, an extremely strong urine odor was noted. A wet incontinence brief was found in a plastic bag inside the room's trash can. On 09/23/24 at 1:30 PM, during an interview, Licensed Practical Nurse (LPN) #1 agreed Resident #2's room had a very strong odor of urine. On 09/23/24 at 2:05 PM, during an interview, Certified Nursing Assistant (CNA) #1 stated that she had noticed the strong urine odor before 11:00 AM but had not located the source or notified housekeeping. The room continued to have a pungent urine smell throughout the day. On 09/23/24 at 2:35 PM, during an interview with the Assistant Housekeeping Supervisor, she confirmed that she smelled the strong odor of urine in the room of Resident #2. On 09/23/24 at 3:20 PM, an observation of Resident #3 and Resident #4 in their shared room revealed both residents seated on their beds with an extremely strong urine odor in the room. A urinal and a pool of spilled urine was noted under the bed of Resident #3.	F 584	Housekeeping Department Manager and to ensure all soiled wet incontinence briefs are discarded per proper infection control practices. On 9/23/24, Registered Nurse (RN) #2 emptied the urinal for Resident #3. On 9/23/24, the Housekeeping Manager stripped, waxed, and deep cleaned the floors of the room for Resident #3 and Resident #4. On 9/23/24, Resident #3 was provided incontinent care by Certified Nursing Assistant (CNA) #2, including Resident #3 clothing and bed linens changed. All residents have the potential to be affected.¿ On 9/25/24, the Licensed Pratical Nurse #1 and ¿Certified Nursing Assistant (CNA) #1 were educated by the Director of Nursing (DON) on proper urgent notification to the Housekeeping Department Manager for cleanliness of residents rooms with odors. The education on 9/25/24 also included for LPN#1 and CNA #1 to perform any incontinent care needed for residents including discarding soiled linen and replacing with clean linen on residents beds. On 9/25/24, The Housekeeping Supervisor was educated by the Administrator on ensuring cleanliness of resident rooms. The Housekeeping Department Manager in-serviced 10 out of 10 housekeeping staff on 9/23/24 ensuring cleanliness of resident's rooms daily. On 10/1/24, the Housekeeping Department Manager in-serviced all housekeeping staff related to always	

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F 584	Continued From page 3 On 09/23/24 at 4:10 PM, during an observation and interview, CNA #2 assisted Resident #3 to stand, revealing a non-disposable incontinence pad. The pad was white around three edges but yellowed on one side, with brown streaks and stains in the middle. The pad emitted a strong odor of urine and feces. CNA #2 stated, "It's soaking wet under there, the sheet is wet too. It looks like he's just been sitting there letting it go." She reported that she had not entered the room since 1:00 PM. On 09/24/24 at 2:50 PM, during an interview with the Housekeeping Supervisor, she stated that the floor in the room of Resident #3 and Resident #4 needed to be stripped, waxed, and possibly have the tiles replaced. She described the room as smelling like "hot pee." On 09/25/24 at 12:05 PM, during an interview with the Director of Nursing (DON), she confirmed that CNAs could summon housekeeping services at any time or provide cleaning of urine or bodily fluids themselves to maintain a clean and safe environment for residents. A record review of Resident #2's "Admission Record" revealed that the facility admitted the resident on 03/24/2020, The resident had diagnoses that included Cerebral Infarction (Stroke), Repeated Falls, and Malignant Neoplasm of the Bladder. A record review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/12/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated no	F 584	using the five (5) and (7) step cleaning method. On 9/25/24, the Director of nursing completed a one-to-one education with CNA #2 related to proper timely rounding every two hours of the residents. Beginning the week of 09/30/2024, the Housekeeping Department Manager will audit resident rooms to ensure cleanliness and home like environment on (5) five rooms weekly times (4) four weeks and monthly for (4) four months and quarterly thereafter. An immediate Quality Assurance Meeting was held with the Administrator, Medical Director, Director of Nursing, Assistant Administrator, Housekeeping Department Manager, Maintenance Director, Minimum Data Set Coordinator, Staff Development Coordinator, Registered Nurse, Regional Maintenance Director, and the Corporate Clinical Specialist on 9/26/24 related to requirements not met during the complaint survey. The Housekeeping Supervisor is responsible for bringing the results of the audit to the monthly Quality Assurance/Performance Improvement (QAPI) meeting for four months beginning on 10/24/2024. The administrator is responsible for monitoring and compliance.	

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F 584	Continued From page 4 cognitive impairment. Section GG indicated Resident #2 required moderate assistance for toileting hygiene. Section H indicated Resident #2 was frequently incontinent of bowel and bladder. A record review of Resident #3's "Admission Record" revealed that the facility admitted the resident on 11/29/21. The resident had diagnoses that included Stage 3 Chronic Kidney Disease, Psychotic Disorder, and Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms. A record review of Resident #3's Quarterly MDS with an ARD of 08/17/24, in Section C revealed a BIMS score of thirteen (13), which indicated Resident #3 was cognitively intact. Section GG indicated revealed the resident required substantial assistance for personal hygiene and supervision for toileting. A record review of Resident #4's "Admission Record" revealed that the facility admitted the resident on 10/30/23 with diagnoses of Cerebral Infarction (Stroke) and Cognitive, Social or Emotional Deficit following Cerebral Infarction. A record review of Resident #4's Quarterly MDS with an ARD of 07/26/24 revealed a BIMS score of 99, indicating the resident was unable to participate in the interview.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		10/25/24

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F 656	Continued From page 5 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 656		

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F 656	Continued From page 6 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure the Comprehensive Care Plan interventions were implemented for two (2) of five (5) sampled residents. Residents #2, and #3 Findings Include: A review of the facility policy titled "Care Plans Comprehensive Person-Centered," reviewed January 2023, revealed "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident ... The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment ..." Resident #2 A record review of the comprehensive care plan for Resident #2 with a date initiated of 3/25/2020 revealed "Focus: The resident has an ADL (activities of daily living) self-care performance deficit ...Interventions/Task ...Personal Hygiene: The resident requires ext (extensive) assistance x 1 staff with personal hygiene and oral care." Record review of the comprehensive care plan for Resident #2 with a date initiated of 3/7/2022	F 656	On 09/25/2024, a one-on-one in-service was conducted by the Staff Development Coordinator (SDC) with Certified Nursing Assistant (CNA) #1 and Certified Nursing Assistant (CNA)#2 regarding the implementation of comprehensive resident specific plan of care interventions. The in-service on 9/25/2024 also included education on where CNA's can locate a residents ADL care plan information. On 9/27/2024, an ADL care plan audit was conducted by the facility Minimum Data Set Coordinator (MDS) to identify any residents that required assistance with incontinence care that could have been affected by the deficient practice. At the time of the audit,117 residents required some degree of assistance with incontinence care and were identified with having the potential to be affected. On 9/30/2024, all Certified Nursing Assistants (CNA) were in-serviced by the Staff Development Coordinator (SDC) regarding the implementation of comprehensive resident specific plan of care interventions The in-service on 9/30/2024 also included education on where both Licensed Nursing Staff and Certified Nursing Assistants (CNA) can locate a residents ADL care plan information. Beginning 9/30/2024, the Director of	

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F 656	Continued From page 7 revealed "Focus: The resident has a communication problem ...Interventions/Task...Anticipate and meet needs. Record review of the comprehensive care plan with a date initiated of 3/25/2020 revealed "Focus: The resident is at risk for falls ...Interventions/Task ...Anticipate and meet the resident's needs ..." Record review of the comprehensive care plan revealed with a date initiated of 3/25/2020 revealed " The resident has ...impairment to skin integrity...Interventions/Task ...Provide peri care with each incontinent episode ...anticipate and meet the resident's needs and ensure the resident's call light was within reach." On 9/23/24 at 1:25 PM, an observation of Resident #2 revealed the resident was kneeling at his bedside wearing a saturated incontinence brief that had sagged down to his lower thighs. On 9/23/24 at 2:05 PM, during an interview, Certified Nursing Assistant (CNA) #1 stated that she last checked Resident #2 for incontinence care before 11:00 AM. CNA #1 confirmed that Resident #2's care plan required incontinence with every incontinent episode, to prevent skin breakdown. CNA #1 stated that she returned from lunch at 1:29 PM but had not checked on Resident #2 until 1:50 PM. A record review of Resident #2's "Admission Record" revealed that the facility admitted the resident on 3/24/2020, The resident had diagnoses that included Cerebral Infarction (Stroke), Repeated Falls, and Malignant Neoplasm of the Bladder.	F 656	Nursing (DON) and/or Registered Nurse (RN) will perform unannounced ADL observation audits to ensure licensed nurses and CNA's are utilizing the person center care plan with observations on the implementation of the ADL care for required assistance on two residents three times a week for four weeks, then weekly times four weeks then monthly times four (4) months. An immediate Quality Assurance Meeting was held with the Administrator, Medical Director, Director of Nursing, Assistant Administrator, Housekeeping Department Manager, Maintenance Director, Minimum Data Set Coordinator, Staff Development Coordinator, Registered Nurse, Regional Maintenance Director, and the Corporate Clinical Specialist on 9/26/24 related to requirements not met during the complaint survey. The Director of Nursing (DON) or Assistant Director of Nursing (ADON) is responsible for bringing the results of the audit to the monthly Quality Assurance Performance Improvement (QAPI) meeting for four months beginning on 10/24/2024. The administrator is responsible for monitoring and compliance.	

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F 656	Continued From page 8	F 656		

A record review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/12/24 revealed in Section C, a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated Resident #2 was cognitively intact. Section GG indicated Resident #2 required moderate assistance for toileting hygiene. Section H indicated Resident #2 was frequently incontinent of bowel and bladder.

Resident #3

A record review of the comprehensive care plan, undated, revealed "Focus: ...Prefers to have his urinal on his bedside table ...Interventions: Assist with emptying urinal as needed ..."

A record review of the comprehensive care plan, undated, revealed "Focus: The resident is at risk for falls r/t (related to) weakness ...Interventions ...Anticipate and meet the resident's needs ..."

A record review of the comprehensive care plan, undated revealed "Focus: The resident has potential/actual impairment to skin integrity... Interventions ...Provide peri-care every 2 hrs (hours) and prn (as needed).

On 9/23/24 at 3:20 PM, an observation of Residents #3 revealed his room had a strong urine odor. Resident #3 was sitting up in bed on a saturated incontinence pad. There was a urinal and a pool of urine under the resident's bed.

On 09/23/24 at 4:10 PM, as CNA #2 provided incontinence care to Resident #3, an observation revealed the incontinence pad was soaked with

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F 656	Continued From page 9 urine and feces. CNA #2 confirmed that she had last checked Resident #3's urinal and incontinence pad around 1:00 PM and had not provided care since then. A record review of Resident #3's "Admission Record" revealed that the facility admitted the resident on 11/29/21. The resident had diagnoses that included Stage 3 Chronic Kidney Disease, Psychotic Disorder, and Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms. A record review of Resident #3's Quarterly MDS with an ARD of 08/17/24, in Section C revealed a BIMS score of thirteen (13), which indicated Resident #3 was cognitively intact. Section GG indicated revealed the resident required substantial assistance for personal hygiene and supervision for toileting. On 9/25/24 at 12:05 PM, during an interview, the Director of Nursing (DON) confirmed that it was crucial for staff to follow each resident's care plan interventions and care instructions. The DON explained that all care plans were accessible via the "facility's documentation software," generating care instructions available to CNAs through the Kardex. On 9/25/24 at 1:50 PM, the Minimum Data Set (MDS) Coordinator emphasized that following the care plan was essential, as it detailed the instructions for providing individualized care to each resident. She stated that if staff did not follow care-planned instructions for an incontinent resident, it could result in falls or skin damage.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		10/25/24

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F 677	Continued From page 10 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure that timely incontinent care was provided two (2) of five (5) sampled residents. Residents #2 and #3 Findings Include: Resident #2 On 09/23/24 at 1:25 PM, during an observation and interview, Resident #2 was found kneeling on a bedside mat with his upper torso resting on the mattress. He was wearing a saturated incontinence brief that had sagged down to his lower thighs. On 09/23/24 at 2:05 PM, during an interview, Certified Nursing Assistant (CNA) #1 stated that she last checked Resident #2 for incontinence care before 11:00 AM on 09/23/24. CNA #1 confirmed that Resident #2's care instructions included incontinence care every two (2) hours and as needed. CNA #1 returned from lunch at 1:29 PM and found the resident on the floor but had not provided care between 11:00 AM and 1:29 PM. A record review of Resident #2's "Admission Record" revealed that the facility admitted the resident on 03/24/2020, The resident had diagnoses that included Cerebral Infarction (Stroke), Repeated Falls, and Malignant	F 677	On 9/23/24, Certified Nursing Assistant (CNA) #1 immediately performed incontinence care for resident #2. On 9/23/24 CNA #2 immediately performed incontinence care for resident #3. On 9/23/24 RN #1 assessed resident #2 for any adverse reactions related to failure to provide timely incontinence care. No negative findings occurred for resident#1. On 9/23/24 RN #2 assessed resident #3 for any adverse reactions related to failure to provide timely incontinence care. No negative findings occurred for resident#2 On 9/27/2024, an ADL care plan audit was conducted by the facility Minimum Data Set Coordinator (MDS) to identify any residents that required assistance with incontinence care that could have been affected by the deficient practice. At the time of the audit,117 residents required some degree of assistance with incontinence care and were identified with having the potential to be affected. On 9/30/2024, all CNA's were in-serviced by the Staff Development Coordinator (SDC) regarding the timely implementation of the comprehensive resident specific care plan interventions. On 9/27/24, the Minimum Data Set Coordinator (MDS) audited all current	

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	255148	A. BUILDING _____ B. WING _____	C 09/25/2024

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WOODLANDS REHABILITATION AND HEALTHCARE CENTER	102 WOODCHASE PARK DRIVE CLINTON, MS 39056

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F 677	Continued From page 11 Neoplasm of the Bladder. A record review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/12/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated no cognitive impairment. Section GG indicated Resident #2 required moderate assistance for toileting hygiene. Section H indicated Resident #2 was frequently incontinent of bowel and bladder. Resident #3 During an observation of incontinence care and interview on 09/23/24 at 4:10 PM, revealed CNA #2 began providing incontinence care to Resident #3. The incontinence pad was soaked with urine and feces. CNA #2 confirmed that she had last checked Resident #3's urinal and incontinence pad around 1:00 PM and had not provided care between 1:00 PM and 3:47 PM. A record review of Resident #3's "Admission Record" revealed that the facility admitted the resident on 11/29/21. The resident had diagnoses that included Stage 3 Chronic Kidney Disease, Psychotic Disorder, and Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms. A record review of Resident #3's Quarterly MDS with an ARD of 08/17/24, in Section C revealed a BIMS score of thirteen (13), which indicated Resident #3 was cognitively intact. Section GG indicated revealed the resident required substantial assistance for personal hygiene and supervision for toileting. During an interview on 09/23/24 at 4:35 PM,	F 677	residents' care plans ensuring accuracy and resident specific needs are being met timely. Five (5) Care plans that did not reflect accurate needs were immediately corrected.¿ Beginning 9/30/2024, the Director of Nursing and/or Registered Nurse (RN) will perform unannounced ADL care observations to ensure nurses and CNA are providing timely ADL care according to the resident specific care plans for dependent residents on two residents three times a week for four weeks, then weekly times four weeks then monthly times four (4)months. An immediate Quality Assurance Meeting was held with the Administrator, Medical Director, Director of Nursing, Assistant Administrator, Housekeeping Department Manager, Maintenance Director, Minimum Data Set Coordinator, Staff Development Coordinator, Registered Nurse, Regional Maintenance Director, and the Corporate Clinical Specialist on 9/26/24 related to requirements not met during the complaint survey. The Director of Nursing (DON) or Assistant Director of Nursing (ADON) is responsible for bringing the results of the audit to the monthly Quality Assurance/Performance Improvement (QAPI) meeting for four months beginning on 10/24/2024. The administrator is responsible for monitoring and compliance.	

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F 677	Continued From page 12 Registered Nurse (RN) #1 stated that CNAs were expected to make rounds every two (2) hours and provide incontinence care as needed. During an interview on 09/24/24 at 12:41 PM, the Risk Management Nurse confirmed that CNAs were expected to make rounds every two (2) hours to ensure residents' needs were met and call lights were within reach. During an interview on 09/25/24 at 12:05 PM, the Director of Nursing (DON) confirmed that CNAs were responsible for making rounds every two (2) hours and as needed. She stated that all residents' care instructions were documented in the Kardex within the "facility's documentation software,' and CNAs had access to these instructions.	F 677		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, record review, and staff interviews, the facility failed to ensure mechanical patient care equipment was maintained in a safe operational condition for one (1) of six (6) mechanical lifts. Findings Include: A review of the facility policy titled "Safe Patient Handling and Moving Protocol," with a review date of 06/10/24, revealed, "The QA (Quality Assurance) Committee will ensure	F 908	The sit to stand life was removed off the floor on 9/25/24 and removed from use using the tag-out/lock-out procedure. Registered Nurse (RN) #2, Licensed Practical Nurse (LPN) #1, Licensed Practical Nurse (LPN)#6, Certified Nursing Assistant (CNA) #3, Risk Manager, and Licensed Practical Nurse (LPN) #4 were educated on 9/25/24 in regard to the tag-out/lock-out procedure and documentation being placed in the TELS work order system. On 9/26/24, the	10/25/24

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F 908	Continued From page 13 implementation of this policy to identify, assess, and develop strategies to control risk of injury to residents and nursing staff associated with the lifting, transferring, repositioning or movement of a resident ... Mechanical or Electric Lift ... All staff shall adhere to each lift's specific manufacturer guidelines for safe handling and operation ...The facility should develop and assign routine maintenance schedules to ensure equipment is in good working order ..." A record review of the "User Manual Stand Up Patient Lift," with copyright 2013, revealed ... "Detecting wear and damage ... It is important to inspect all stressed parts... for signs of cracking, fraying, deformation, or deterioration. Replace any defective parts IMMEDIATELY and ensure that the lift is not used until repairs are made ..." On 09/23/24 at 1:25 PM, during an observation revealed Registered Nurse (RN) #2 and Licensed Practical Nurse (LPN) #1 attempting to use a mechanical lift to move Resident #2 to his bed. The 100 Hall stand-up lift did not work when the hand control buttons were pressed. LPN #6 retrieved two (2) additional batteries, however, that did not resolve the issue with the lift. She then retrieved a third battery from another lift, and the transfer was completed at 1:45 PM. On 09/23/24 at 2:00 PM, during an interview, LPN #6 stated that the lift "wouldn't work," so she retrieved a battery from the charger at the 100 Hall nurse's station, but it did not fix the problem. She ultimately retrieved a third battery from another lift on a different hall, leaving that lift inoperable due to the lack of a battery. On 09/24/24 at 5:00 PM, during an observation	F 908	maintenance director and maintenance assistant received a written personnel action by the Regional Maintenance Director, Administrator, and Assistant Administrator concerning the importance of all equipment in the facility to be in a safe operating condition and utilization of the tag-out/lock-out procedures to take any equipment off the floor when under repair. All residents have the potential to be affected.¿¿¿ On 9/24/24, all nursing and certified nursing staff were in serviced by the Staff Development Coordinator on how to enter a TELS work order in Point Click Care, charging of lift batteries procedure, notification immediately of any equipment not working correctly, and the tag-out/lock-out procedures regarding safety equipment used in the facility. On 9/25/24, the administrator placed an order for (3) three new lift batteries and (4) battery wall chargers. On 9/25/24, a complete audit of all mechanical lifts used in the facility was completed, resulting in one sit-to-stand lift to be tagged out as not in use by removing off the floor. On 10/3/24, The Regional Maintenance Director completed a one to one education with the Maintenance Director and Maintenance Assistant related to proper inspections of maintenance equipment including required weekly, monthly, yearly inspections, provided a demonstration of each mechanical lift, tag out/lock out system requirements, and tels	

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F 908	Continued From page 14 and interview with CNA #3 and the Risk Management Nurse, it was demonstrated that the stand-up lift on the 100 Hall did not operate unless the battery was squeezed into place with one hand while pressing the control buttons with the other hand. The Risk Management Nurse stated that the lift presented a risk to residents and should be removed from service until repaired by the Maintenance Director. On 09/25/24 at 12:05 PM, during an interview, the Director of Nursing (DON) stated that the facility had seven (7) lifts, but one (1) was out of service, leaving six (6) in operation. She confirmed that CNAs were supposed to place the batteries on chargers at the nursing stations at the end of each shift and when charging was necessary to power lifts for resident care. She further explained that any equipment in need of repair should be removed from use using the tag-out/lock-out procedure and documented in TELS (maintenance management software). On 09/25/24 at 2:17 PM, during an interview, CNA #4 stated that CNAs were responsible for charging lift batteries as needed and reporting equipment in need of repair. She confirmed that any staff member could tag equipment that was not functioning properly to notify others. On 09/25/24 at 2:35 PM, during an interview, LPN #4, Staff Coordinator, stated that she was aware of the issues with lift batteries and that nurses were supposed to monitor to ensure that batteries were charged. She was surprised to learn that any staff had used lifts that were malfunctioning. On 09/25/24 at 2:45 PM, during an interview, CNA #5 confirmed that she had received	F 908	system work order completion requirements. Beginning the week of 10/21/24, the Regional Maintenance Director will complete monthly audits for (4) four weeks of all mechanical lifts used in the facility and provide all results to the Administrator. Beginning 9/30/2024, an audit will be conducted weekly on all mechanical lifts used in the facility by the Maintenance Director for (4) four weeks and monthly for (4) four months and quarterly thereafter. An immediate Quality Assurance Meeting was held with the Administrator, Medical Director, Director of Nursing, Assistant Administrator, Housekeeping Department Manager, Maintenance Director, Minimum Data Set Coordinator, Staff Development Coordinator, Registered Nurse, Regional Maintenance Director, and the Corporate Clinical Specialist on 9/26/24 related to requirements not met during the complaint survey. The Maintenance Director is responsible for bringing the results of the audit to the monthly Quality Assurance/Performance Improvement (QAPI) meeting for four (4) months beginning on10/24/2024. The administrator is responsible for monitoring and compliance.	

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F 908	Continued From page 15	F 908		

in-service training on the use of mechanical lifts, including instructions not to use lifts that were broken or in disrepair.

On 09/25/24 at 4:08 PM, during an observation and interview, the Maintenance Director explained that the facility staff used TELS to report any maintenance issues. He had not received any work orders for lifts as of the interview. The Maintenance Director demonstrated that the prong on the lift where the battery snapped into place was bent forward, causing a gap between the battery and the lift, explaining why it only worked when the CNA squeezed the battery. He emphasized that using malfunctioning equipment could lead to resident injury.

A record review of Resident #2's "Admission Record" revealed that the facility admitted the resident on 03/24/20. Resident #2's diagnoses included Cerebrovascular Disease, Repeated Falls, and Malignant Neoplasm of the Bladder.

A record review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/12/24 revealed in Section C a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated the resident was cognitively intact.