STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255257	A. BUILDING _____ B. WING _____	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WINDSOR PLACE	81 WINDSOR BOULEVARD COLUMBUS, MS 39702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 10/7/24-10/9/24. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation related to F558, F655, F656, F677, F686, F689, F700, F755, F761, F812, and F880. The census at the time of the survey was 124 with a bed capacity of 140	F 000		
F 584 SS=D	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 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	F 584		11/6/24

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

Electronically Signed | 10/29/2024

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F 584	Continued From page 1 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 observation and staff interview, the facility failed to ensure a resident had a wheelchair in good repair for one (1) of 86 residents requiring a wheelchair for mobility. Resident #51 Findings include: The facility provided a statement on letter head that read, "The Proper Name of facility does not, currently, have a formal written policy regarding resident equipment being in good condition. Any issues of resident equipment not being in good condition or malfunctioning are to be reported to maintenance upon discovery." An observation on 10/7/24 at 12:05 PM, revealed Resident #51 sitting in his wheelchair with arm rests on the wheelchair that were torn and tattered with sharp plastic edges and the yellow foam visible.	F 584	October 8, 2024, Maintenance Director replaced wheelchair arms of Resident #51 immediately upon notification by State Agent. All residents requiring the use of a wheelchair have the potential to be affected by this practice. October 9, 2024, Staff Development Coordinator (Registered Nurse) initiated in-service for all staff regarding the importance of wheelchairs to be in good repair and working order, specifically wheelchair arms, and the process for reporting any negative findings to the maintenance department. October 16, 2024, In-service completed by all staff. October 17-18, 2024, Quality Assurance Nurse (Licensed Practical Nurse) performed an audit of wheelchairs in the facility. All negative findings were reported	

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F 584	Continued From page 2 An observation on 10/8/24 at 11:01 AM, revealed Resident #51 lying in bed. His wheelchair was in the room, with the arm rest in disrepair. The right arm rest had the yellow foam torn away, and the black hard plastic was exposed, which had jagged edges. The left arm rest had the black vinyl torn, and the yellow foam was exposed. An interview with Licensed Practical Nurse (LPN) #1 on 10/8/24 at 11:04 AM, confirmed Resident #51's arm rest needed to be repaired and revealed the resident could scratch the skin on his arms. She revealed the resident's equipment should be in good repair and explained that staff must let maintenance know by telling him or doing a work order for issues to be addressed. An interview with Maintenance #2 on 10/8/24 at 11:14 AM, revealed he would be responsible for any maintenance on the wheelchairs. He revealed the staff fill out a work order for anything that needs repairing. He revealed he had not received a work order for Resident #51's wheelchair and explained he was not aware it was in bad condition. Record review of the "Admission Record" revealed the facility admitted Resident #51 on 1/17/18 with a medical diagnosis of Hemiplegia and Hemiparesis following cerebral infarction affecting the left non-dominant side.	F 584	to the Maintenance Director and repaired by October 21, 2024. Beginning October 21, 2024, and going forward indefinitely, the Maintenance Director will perform monthly quality assurance audits of the condition of wheelchairs. Beginning October 21, 2024, the Quality Assurance Nurse and/or the Maintenance Director will conduct wheelchair audits to ensure wheelchairs are in good repair and working order with no rough edges or tearing for five (5) residents three (3) times per week for four (4) weeks, one (1) time per week for four (4) weeks, two (2) times per month for one (1) month and then one (1) time per month for one (1) month. Findings will be reported to the Quality Assurance Performance Improvement Committee beginning November 6, 2024, and continue for the next three (3) months and as needed for any recommendations, revisions, and/or resolutions.	
F 655 SS=G	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and	F 655		11/6/24

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F 655	Continued From page 3	F 655		

implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.

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F 655	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to develop a baseline care plan related to skin integrity concerns for a resident with excoriation to the buttocks. The resident developed a pressure ulcer within four days of admission to the facility. This was for one (1) of 28 care plans reviewed. Resident #39. Cross reference: F686 Findings include: A review of the facility policy titled, "Care Plan Policy," revealed, on admission a care plan must be completed. ... A review of the Baseline Care Plan dated 8/23/24 for Resident #39 revealed Skin risk: current skin integrity issues checked. ...Specific skin integrity issue: Excoriation to buttock ....Physician orders: see Medication Administration Record (MAR) and Treatment Administration Record (TAR). ... A record review of the Wound Assessment Report dated 8/23/24, the day of admission, revealed Resident #39 was assessed to have excoriation to the buttocks area, with a new treatment order for Calmoseptine for excoriation to the buttocks. On 10/8/24 at 2:05 PM, in a record review of the Order Summary Report for Resident #39 and interview with the Infection Control Nurse stated she was unable to find where the physician's order for the treatment of the excoriation to the buttocks was entered into the computer system	F 655	October 9, 2024, Resident #39□s baseline careplan was audited by Minimum Data Set Licensed Practical Nurse with no negative findings for the completion of all recommendations and orders to be entered into the baseline careplan, specifically skin integrity. All residents have the potential to be affected by this practice. October 16, 2024, Staff Development Coordinator (Registered Nurse) initiated in-service for nurse staff on the importance and requirement of the development of a baseline careplan, specifically skin integrity, and to ensure the completion of all recommendations and orders are entered into the baseline careplan. October 28, 2024, in-service was completed by nurse staff. Beginning October 21, 2024, and going forward indefinitely, Minimum Date Set (MDS) staff (Registered Nurse and Licensed Practical Nurse) will review all admitting resident□s baseline careplan for completion of all orders and accuracy. October 11, 2024, Minimum Date Set (MDS) staff (Registered Nurse and Licensed Practical Nurse) initiated a 100% audit of baseline careplans for completion of orders and accuracy. Audit was completed by October 18, 2024, with no negative findings. Beginning October 21, 2024, the Quality Assurance Nurse (Licensed Practical	

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F 655	Continued From page 5 on 8/23/24. On 10/8/24 at 2:10 PM, during a record review of the August 2024 TAR for Resident #39 and an interview with the Infection Control Nurse on she revealed she was unable to find where a treatment was initiated on 8/23/24 for the excoriation to the buttocks and she confirmed that the resident now has a Stage 2 pressure ulcer to the buttocks. An interview with the Minimum Data Set (MDS) Coordinator on 10/09/24 at 8:23 AM, she revealed that they failed to develop the baseline care plan for Resident #39 and failed to implement the new skin orders on the day of her admission for the excoriation to the buttocks. She revealed the purpose of the baseline care plan is to give staff a guide to the care the residents requires until the comprehensive care plan can be developed. Review of the "Admission Record" revealed the facility admitted Resident # 39 on 8/23/24 with a diagnosis of Encounter for orthopedic aftercare following surgical amputation.	F 655	Nurse) and/or Minimum Data Set (MDS) nurse (Registered Nurse and Licensed Practical Nurse) will complete an audit on admissions to ensure completion of all recommendations and orders are accurate and on the baseline careplan three (3) times per week for four (4) weeks, one (1) time per week for four (4) weeks, two (2) times per month for one (1) month, and then one (1) time per month for (1) month. Findings will be reported to the Quality Assurance Performance Improvement Committee beginning November 6, 2024, and continue for the next three (3) months and as needed for any recommendations, revisions, and/or resolutions.	
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 §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	F 656		11/6/24

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F 656	Continued From page 6	F 656		

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-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident and staff interview, record review, and facility policy review,

October 8, 2024, Resident #80 was shaved by the Director of Nursing.

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F 656	Continued From page 7 the facility failed to implement a care plan for shaving a dependent resident for one (1) of 25 resident care plans reviewed. Resident #80 Findings include: Record review of facility policy titled, "Care Plan Policy" dated 11/21, revealed, "It is the policy of this facility that an individualized, interdisciplinary care plan will be developed and maintained for each resident in the facility. ... If the resident has a working care plan, you may use this and update it as indicated". Record review of Resident #80's "Care Plan" date initiated 9/4/24 revealed, the resident has an ADL, self-care performance deficit related to congestive heart failure and diabetes mellitus which includes an intervention for bathing/showering. On 10/07/24 at 12:30 PM, during an observation and interview Resident #80 stated he wanted to be shaved and felt that the staff would do this today since it was shower day. He stated he was unsure when he was last shaved and told his family that if they would bring him a razor, he would shave himself. Observation revealed the resident had an approximate one-third inch long, scruffy stubble of facial hair on bearded areas of his cheeks, chin, and upper lip. On 10/8/24 at 8:40 AM, an observation and interview revealed Resident #80 was still unshaved. He stated he preferred to be clean shaven and was not used to being unshaven. On 10/8/24 at 2:30 PM Resident #80 was observed and interviewed in the hallway	F 656	October 8, 2024, Resident #80□s comprehensive careplan was audited by Minimum Data Set Licensed Practical Nurse with no negative findings. All residents requiring assistance with Activities of Daily Living as defined in the comprehensive careplan, specifically shaving, have the potential to be affected by this practice. October 16, 2024, Staff Development Coordinator (Registered Nurse) initiated in-service for nurse and certified nurse assistant regarding the importance of following Activities of Daily Living (ADL) for residents as defined in the comprehensive careplan. October 28, 2024, in-service completed by nurse staff and certified nurse assistants. October 11, 2024, Minimum Date Set (MDS) staff (Registered Nurse and Licensed Practical Nurse) initiated a 100% audit of comprehensive careplans for Activites of Daily Living (ADL) accuracy. Audit was completed by October 18, 2024, with no negative findings. Beginning October 21, 2024, and going forward indefinitely, Minimum Data Set (MDS) staff (Registered Nurse and Licensed Practical Nurse) will conduct quarterly quality assurance audit on comprehensive careplan for Activities of Daily Living (ADL) accuracy. Discrepancies will be corrected upon discovery. Beginning October 21, 2024, the Minimum Data Set (MDS) nurse (Licensed Practical Nurse) will complete audits of	

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F 656	Continued From page 8 propelling himself in the wheelchair and was still unshaved. He stated the staff had not shaved him and he wanted this to be done. During an interview on 10/8/24 at 2:40 PM, the Director of Nursing (DON) stated the resident was scheduled for bathing and showering on Monday, Wednesday, and Friday, and he did not typically refuse care, but the care record from yesterday revealed the resident refused his shower. She stated each resident has the right to refuse care, but the process to ensure care is done as desired included any refusal of care to be reported to the nurse and the nurse should followed up with the resident for options for care and document that in the resident's notes and that was not done. She also stated the staff are to follow up with the resident at a later time to see if care is wanted at that time and there was no documentation that was done. The DON acknowledged that grooming and shaving was part of the bathing activities of daily living (ADL) care. She confirmed the facility failed to shave the facial hair of a resident that preferred to be clean shaven. She confirmed the care plan was to give staff information on the care needed and preferences of each resident and the ADL care plan was developed but it was not followed since shaving and grooming was a part of the bathing care plan. An interview with the Minimum Data Set (MDS) Coordinator on 10/9/24 at 9:15 AM revealed she was the person responsible for the development of care plans and stated the care plan should be followed by the staff since it guides the staff in the care and preferences of each resident. She stated this resident had a care plan developed for ADL bathing care which included	F 656	grooming/shaving residents as defined in the comprehensive careplan for five (5) residents weekly for four (4) weeks, three (3) residents weekly for four (4) weeks, and three (3) residents monthly for two (2) months. Findings will be reported to the Quality Assurance Performance Improvement Committee beginning November 6, 2024, and continue for the next three (3) months and as needed for any recommendations, revisions, and/or resolutions.	

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F 656	Continued From page 9 grooming/shaving, but confirmed this was not followed. Record review of Resident #80's "Admission Record" revealed the facility admitted the resident on 6/22/22. Diagnoses included Type 2 Diabetes Mellitus and Osteoarthritis. Record review of Resident #80's quarterly "Minimum Data Set" (MDS) with Assessment Reference Date (ARD) of 8/28/24, revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate cognitive impairment.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to shave a resident that was dependent on staff for care for one (1) of three (3) residents reviewed for Activities of Daily Living (ADL). Resident #80 Findings include: Record review of facility policy titled, "Activities of Daily Living Policy", undated, revealed, "It is the policy of the facility to encourage resident choice and participation in activities of daily living (ADL) and provide oversight cuing and assistance as necessary. ADL's included bathing, dressing,	F 677	October 8, 2024, Resident #80 was shaved by the Director of Nursing. All residents requiring assistance with Activity of Daily Living, shaving, have the potential to be affected by this practice. October 16, 2024, Staff Development Coordinator (Registered Nurse) initiated in-service for nurse and certified nurse assistant staff regarding the importance of providing Activities of Daily Living (ADL), specifically grooming/shaving, to residents. October 28, 2024, in-serviced completed by nurse and certified nurse	11/6/24

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F 677	Continued From page 10 grooming, hygiene, toileting, and eating. CNA (Certified Nursing Assistant) will review the resident care card for information on individual care needs and preferences. CNA will provide needed oversight, cuing or assistance to resident. CNA will report any changes in ability or refusals to the nurse". During an observation and interview on 10/07/24 at 12:30 PM, Resident #80 stated he wanted to be shaved and felt that the staff would do this today since it was shower day. He stated he was unsure when he was last shaved and he told his family that if they would bring him a razor, he would shave himself. Observation revealed the resident had an approximate one-third inch scruffy stubble of facial hair on bearded areas of his cheeks, chin, and upper lip. An observation and interview on 10/8/24 at 8:40 AM, revealed Resident #80 was still unshaved and stated he preferred to be clean shaven and was not used to being unshaven. Resident #80 was observed on 10/8/24 at 2:30 PM and was still unshaved. He stated the staff had not shaved him and he wanted this to be done. The Director of Nursing (DON) came to the resident and Resident #80 informed her that he wanted to be shaved and had asked staff for this, but it had not been done. The DON informed him that it was the responsibility of the Certified Nursing Assistants (CNAs) to shave him and she assured him she would get this done for him. The DON acknowledged that grooming and shaving was part of the bathing activity of daily living (ADL) care and confirmed the facility failed to shave the facial hair of a resident that preferred to be clean shaven.	F 677	assistant staff. October 11, 2024, Director of Nursing (Registered Nurse) initiated and completed audit of all residents requiring assistance with grooming/shaving with no negative findings. Beginning October 21, 2024, and going forward indefinitely, certified nurse assistants will report any resident refusing Activities of Daily Living (ADL) care, specifically grooming/shaving, to the resident□s nurse for documentation. Beginning October 21, 2024, the Quality Assurance Nurse (Licensed Practical Nurse) or the Director of Nursing (Registered Nurse) will complete audits of Activities of Daily Living (ADL), specifically grooming/shaving, to residents for five (5) residents weekly for four (4) weeks, three (3) residents weekly for four (4) weeks, and three (3) residents weekly for two (2) months. Findings will be reported to the Quality Assurance Performance Improvement Committee beginning November 6, 2024, and continue for the next three (3) months and as needed for any recommendations, revisions, and/or resolutions.	

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	255257	A. BUILDING _____ B. WING _____	10/09/2024

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F 677	Continued From page 11 Record review of an ADL care summary revealed Resident #80 was scheduled for baths on Monday, Wednesday, and Friday. Record review of Resident #80's "Admission Record" revealed the facility admitted the resident on 6/22/22. Diagnoses included Type 2 Diabetes Mellitus and Osteoarthritis. Record review of Resident #80's quarterly "Minimum Data Set" (MDS) with Assessment Reference Date (ARD) of 8/28/24, revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate cognitive impairment.	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review and facility policy review, the facility failed to provide necessary treatment	F 686	October 10, 2024, Infection Control Preventionist (Registered Nurse) reviewed Resident #39□s wound assessment	11/6/24

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F 686	Continued From page 12 and services to promote healing and prevent new ulcers from developing for (1) one of five (5) residents with wounds reviewed. Resident #39 Findings include: A review of the facility policy titled, "Overview of Skin and Wound Care Management," revealed, the facility staff strives to prevent/patient skin impairment. ... The Interdisciplinary team works with the resident and family to identify and implement interventions to prevent and treat potential skin integrity issues. ...Components of the skin care and wound management program include, but are not limited to, the following: 2.) Implementation of prevention strategies to minimize the potential for developing pressure ulcers and skin integrity issues. ... An interview with Resident # 39 on 10/07/24 at 11:24 AM, revealed she had a pressure sore on her lower buttocks that she got while in the facility. A record review of the Wound Assessment Report dated 8/23/24 revealed Resident #39 was assessed to have excoriation to the buttocks area with a new treatment order for Calmoseptine treatment to the buttocks. A record review of the Order Summary Report for Resident #39 and interview with the Infection Control Nurse on 10/8/24 at 2:05 PM, she stated she was unable to find the physician's order for the Calmoseptine treatment to the excoriation on the buttocks was even entered into the computer system on 8/23/24 and confirmed that the facility failed to implement the physician's order.	F 686	report, specifically skin integrity, to ensure all treatment orders are current and being followed through to help prevent and/or heal pressure ulcers with no negative findings. All residents with excoriation or pressure ulcers have the potential to be affected by this practice. October 9, 2024, Staff Development Coordinator (Registered Nurse) initiated in-service for nurse staff regarding skin integrity and ensuring that all treatment orders are being followed through to help prevent and/or heal pressure ulcers. October 28, 2024, in-service completed by nurse staff. October 17, 2024, Infection Control Preventionist (ICP, Registered Nurse) and treatment nurses (Licensed Practical Nurses) initiated and then completed on October 18, 2024, audits to ensure treatments have been implemented for admissions between October 9, 2024, and October 18, 2024, that were identified with excoriation(s) and/or pressure ulcer(s). No negative findings. Beginning, October 18, 2024, and going forward indefinitely, the Infection Control Preventionist (Registered Nurse) will review new admissions for treatment orders being implemented for residents identified with excoriation(s) and/or pressure ulcer(s). Beginning October 23, 2024, the Infection Control Preventionist (Registered Nurse) and/or Treatments Nurse (Licensed Practical Nurse) will complete audits of	

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F 686	Continued From page 13 A record review of the August 2024 Treatment Administration Record (TAR) for Resident #39 and interview with the Infection Control Nurse on 10/8/24 at 2:10 PM she revealed she was unable to find where a treatment was initiated on 8/23/24 for the excoriation to the buttocks and confirmed that not performing the treatment as ordered may have contributed to the acquired pressure ulcer. Record review of the Wound Assessment Report dated 8/27/24 for Resident #39 completed by Registered Nurse (RN) #1 revealed a new stage (2) two pressure ulcer to the right buttock measuring 1 centimeter (CM) in length, 1.5 CM in width, and 0.1 CM in depth. Review of the Order Summary Report for Resident # 39 revealed an order dated 8/27/24 "Cleanse stage 2 to the right buttock with (NS) normal saline, pat dry, apply collagen, and cover with dry dressing every day (QD) and as needed (PRN). Monitor dressing to the right buttock for soilage/dislodgement as needed." Review of the August 2024 TAR for Resident # 39 revealed cleanse stage 2 to the right buttock with NS, pat dry, apply collagen, and cover with dry dressing QD and PRN. Monitor dressing to the right buttock for soilage/dislodgement as needed dated 8/27/24. An interview with Registered Nurse (RN) #1 on 10/8/24 at 3:15 PM, he revealed on 8/27/24 Resident #39 was assessed to have a stage 2 pressure ulcer to the right buttock/ischial area. He revealed that he and the treatment nurse obtained an order for Collagen treatment from the provider and treated the wound.	F 686	skin integrity for five (5) residents one (1) time per week for four (4) weeks, three (3) residents one (1) time per week for four (4) weeks, then three (3) residents one (1) time per month for two (2) months. Findings will be reported to the Quality Assurance Performance Improvement Committee beginning November 6, 2024, and continue for the next three (3) months and as needed for any recommendations, revisions, and/or resolutions.	

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F 686	Continued From page 14 An interview with the Director of Nursing (DON) on 10/08/24 at 3:30 PM, she revealed after reviewing the August 2024 TAR for Resident #39 she was unable to find where the treatment for the excoriation to the buttocks was ever started. An interview with the Assistant Director of Nursing (ADON) on 10/09/24 8:45 at AM she revealed the physician's order for the Calmoseptine treatment on 8/23/24 for Resident #39 was accidentally missed and it could have contributed to the deterioration of the area to the buttocks. Review of the "Admission Record" revealed the facility admitted Resident # 39 on 8/23/24 with a diagnosis of Encounter for orthopedic aftercare following surgical amputation. Record review of Resident # 39's "Section C" of the Admission Minimum Data Set (MDS) revealed on 8/29/24 a Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was cognitively intact.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review the facility failed to	F 689	October 8, 2024, Maintenance Director replaced both locks on janitor closets	11/6/24

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F 689	Continued From page 15 ensure the residents had a environment free of potential hazards as evidenced by cleaning chemicals not being securely locked in a janitors storage closet for two (2) of five (5) units in the building. 400 Hall and Dementia Unit. Findings include: Review of a document provided by the facility,on facility letterhead revealed the facility does not currently have a formal written policy specific to resident accident prevention or monitoring. An observation on 10/7/24 at 11:20 AM on the Dementia Unit revealed a door with a sign that read "Janitor's Closet" was unlocked and held three full bottles of disinfectant. An interview and observation on 10/7/24 at 11:25 AM with Certified Nurse Assistant (CNA) #1 confirmed the "Janitors Closet" has a coded lock that was broke and the room was unlocked. She confirmed there were three full bottles of liquid disinfectant in the closet. She stated that she had not told maintenance and is not sure if they know. She revealed that the closet with the cleaning supplies should always be locked. This observation revealed this unit was an open unit with all resident rooms, day room and janitors closet within view from all areas and the nurses station is directly across from the janitors closet. She confirmed that the janitors closet could always be seen by the staff because it is a small open unit with three (3) CNA's and one nurse in the unit at all times. An observation on 10/7/24 at 11:45 AM of the 400-hall revealed there was a door labeled "Janitors Closet" that had a coded lock that was	F 689	determined to not be working properly. All residents have the potential to be affected by this practice. October 9, 2024, Housekeeping Supervisor initiated in-service for all staff on the importance of janitor closets being always locked and how to report any lock not working properly to the maintenance department. In-service completed by October 16, 2024. October 9, 2024, Housekeeping Supervisor audited all janitor closet□s locks for accurate operation, specifically being lockable, with no negative findings. Beginning October 18, 2024, and going forward indefinitely, housekeepers and janitors will notify Maintenance Director through text and written work orders immediately upon identifying any janitor closet lock not working properly. Beginning October 21, 2024, the Administrator or the Housekeeping Supervisor will audit all janitor closets to ensure they are locked for safety three (3) times per week for four (4) weeks, then two (2) times per week for four (4) weeks, two (2) times per month for one (1) month and one (1) time per month for one (1) month. Findings will be reported to the Quality Assurance Performance Improvement Committee beginning November 6, 2024, and continue for the next three (3) months and as needed for any recommendations, revisions, and/or resolutions.	

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F 689	Continued From page 16 not locked with four bottles of liquid disinfectant. An interview and observation on 10/7/24 at 11:50 AM with Licensed Practical Nurse (LPN) #1 confirmed that the "Janitors Closet" on the 400 hall was unlocked but should always be locked, because there were chemicals that they would not want the residents to have access to. This observation revealed the janitors closet was directly across from the nurses station and was in view from the 300 and 400 hall. She confirmed that there was a staff member that sat at the nurses desk at all times, answering phone calls and call lights and also the dining area was open and within view of the closet. An interview on 10/7/24 at 11:55 AM with Housekeeping #1 confirmed that the "Janitors Closet" on the 400 hall had a coded lock that had been broken for a few days, but she is not sure if maintenance knows about it. An interview on 10/8/24 at 9:15 AM with Maintenance #2 confirmed that the locks on the "Janitors Closets" on the 400 hall and the "Dementia Unit" were both broken. He stated he put batteries in the lock on the 400-hall last week and thought it was fixed, but he had not been told about the one on the "Dementia Unit". An interview on 10/8/24 at 9:30 AM with the Administrator confirmed the "Janitors Closets" should always be locked.	F 689		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate	F 700		11/6/24

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F 700	Continued From page 17 alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure an informed consent was obtained for the application of bed rails for one (1) of 25 sampled residents. Resident #30 Findings Include: Review of the facility policy titled "Side Rails Policy" with a revision date of 10/19 revealed under, "Policy: it is the policy of this facility to keep residents as safe as possible while they are in the bed, as well as enable them to be as active in their care physically as they are able." An observation of Resident #30 on 10/7/24 at 4:05 PM revealed he was lying in bed. The left	F 700	October 9, 2024, Resident #30□s Responsible Party was contacted by Licensed Social Worker and gave verbal consent for the bedrail. October 14, 2024, Licensed Social Worker acquired a signed bedrail consent form from Resident #30□s Responsible Party. This was earliest date that the Responsible Party was able to return the signed bedrail consent form. All residents requiring a bedrail have the potential to be affected by this practice. October 16, 2024, Staff Development Coordinator (Registered Nurse) initiated in-service for the Interdisciplinary Team	

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F 700	Continued From page 18 side of the bed was against the wall, and one-half (1/2) side rails were raised on both sides of the bed. Record review of the "Physician's Orders" for Resident #30 revealed an order dated, 10/27/20, "1/2 (one half) siderails up x (times) 2 (two) when in bed for increased bed mobility & (and) independence". An interview with the Minimum Data Set (MDS) Nurse on 10/9/24 at 8:20 AM revealed bed rail assessments were completed on admission and quarterly. She revealed the benefits, and the risk of the bed rails were explained to the family and a consent was signed as part of the admission paperwork. Record review of the "Bed Rail Assessment" dated 8/12/24 for Resident #30 revealed, "Bilateral Side Rails/Assist Bar are indicated and serve as an enabler to promote independence". Record review of the "Resident Dashboard" revealed, Resident #30 required one-person extensive assist with bed mobility. An interview with the Assistant Director of Nursing (ADON) on 10/9/24 at 10:20 AM, confirmed a consent was not signed for bed rails for Resident #30 and revealed this should have been done before applying the bed rails to ensure the family was notified of the risk. Record review of the "Resident Dashboard" revealed the facility admitted Resident #30 on 10/26/20 with a medical diagnosis of Hemiplegia following cerebral infarction affecting the left non-dominant side.	F 700	staff regarding the importance and requirement of acquiring a signed bedrail consent form from a resident or the resident□s Responsible Party. October 28, 2024, in-service completed by Interdisciplinary Team staff. October 16, 2024, Medical Records department initiated and then completed on October 18, 2024, an audit to ensure all residents requiring a bedrail have signed consent forms with no negative findings. Beginning October 21, 2024, and going forward indefinitely, Quality Assurance Nurse (Licensed Practical Nurse) will audit new admits for signed bedrail consent if applicable. Beginning October 21, 2024, Medical Records Director and/or Quality Assurance Nurse (Licensed Practical Nurse) will complete audits of new admissions for completion of a signed bedrail consent form, if indicated, three (3) times per week for four (4) weeks, one (1) time per week for four (4) weeks, two (2) times per month for two (2) months. Findings will be reported to the Quality Assurance Performance Improvement Committee beginning November 6, 2024, and continue for the next three (3) months and as needed for any recommendations, revisions, and/or resolutions.	

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F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to maintain an account of all controlled medications and provide evidence of periodic reconciliation for	F 755	October 9, 2024, Resident #80□s narcotic was discontinued and removed from the medication chart to be destroyed by the Director of Nursing (Registered	11/6/24

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F 755	Continued From page 20 two (2) of five (5) medication carts reviewed during medication pass. 100 hall and 200 hall. Findings include: Record Review of the facility policy titled, "Pharmacy Delivery", Revised 9/4/15, revealed the policy read, "The dispensing pharmacy will transport medication to the facility in a manner that prevents contamination, degradation, and diversion of medications." Review of Resident #80's Physician orders dated 08/01/2024 revealed Hydrocodone/APAP(acetaminophen) 10-325 MG(milligrams), "Give 1/2 TABLET by mouth every 4 hours as needed for pain". The label on the medication card was not changed to reflect the new order. Observation of Resident #80's Controlled Substance Record during medication pass on 10/09/24 at 8:10 AM revealed instructions for Hydrocodone/APAP 10-325 MG, "Give 1 TABLET by mouth every 4 hours as needed for pain". On 09/25/2024, 09/26/2024, 09/28/2024, 09/29/2024, and 10/07/2024 the record revealed (1) tablet signed out by Licensed Practical Nurse (LPN) #7 but 1/2 tablet was not recorded as wasted or witnessed. Review of the medication card for Resident #80's Hydrocodone/APAP 10-325 MG, revealed dose #41 was missing from the card and was not accounted for on the Controlled Substance Record. Interview on 10/09/2024 at 8:10 AM with LPN #4 on 100 Hall revealed LPN #4 confirmed	F 755	Nurse) and Pharmacy Consultant. October 9, 2024, a direction change sticker was placed on medication pill card to alert nurse staff that there has been a change in the order and to verify the correct order prior to administering the next dosage. All residents have the potential to be affected by this practice. October 16, 2024, Staff Development Coordinator (Registered Nurse) initiated an in-service for nurse staff regarding signature requirement when receiving narcotics form pharmacy and correct procedures for reconciliation of medication pill card/box compliance to include procedures when discrepancies are noted. October 28, 2024, in-service completed by nurse staff. October 18, 2024, audit initiated and completed October 23, 2024, by Licensed Practical Nurses/Medication Nurses on medication pill cards/boxes matching physician orders. Discrepancies were corrected during audit by placement of a direction change sticker on medication pill card/box. Beginning October 23, 2024, and going forward indefinitely, upon receipt of medications from pharmacy, the following will be completed by nurse on duty: verify receipt of medications ordered; reconcile medication orders to the labels on the medication pill card/box and if any discrepancies noted a direction change sticker will be applied to the medication pill card/box and pharmacy notified; narcotic sheet will be updated	

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F 755	Continued From page 21 09/25/2024, 09/26/2024, 09/28/2024, 09/29/2024, and 10/07/2024 (1) tablet signed out by LPN #7 but 1/2 tablet was not recorded as wasted for Resident #80. LPN #4 also confirmed a missing tablet and stated the card was received from the pharmacy with dose #41 missing. Review of the pharmacy delivery "Packing Receipt" dated 5/4/24 revealed LPN #6 and LPN #4 signed as receiving the 60 Hydrocodone/APAP 10-325 MG pills medication card with no notation of a missing dose. Review of the "Controlled Substance Record" narcotic count record revealed 60 Hydrocodone/APAP 10-325 MG pills received by LPN #6 with no notation of pill missing for dose #41. Review of the shift count signature records revealed no notations of a missing dose or waste of Hydrocodone/APAP 10-325 MG dose #41. Record review of the facility's narcotic sheets "Controlled Substance Record" revealed no "Received By (Sign): Date" nurse signature or date received for 18 Controlled Substance Records. In an interview on 10/09/24 at 9:15 AM, the facility's Consultant Pharmacist stated he performs random audits of the narcotic sign in sheets and narcotic counts but has not noted any issues during the audits. The facility's Consultant Pharmacist stated he did not have evidence of audits, but the facility keeps a record of medication deliveries. Interview by phone on 10/09/24 at 11:45 AM with	F 755	and signed; appropriately store all medications received. Beginning October 21, 2024, The Director of Nursing (Registered Nurse) and/or Assistant Director of Nursing (Registered Nurse) will audit ten (10) medication orders and medication cards/boxes for matching physician orders to ensure compliance with medication administration practice three (3) times per week for four (4) weeks, one (1) time per week for four (4) weeks, two (2) times per month for two (2) months. Findings will be reported to the Quality Assurance Performance Improvement Committee beginning November 6, 2024, and continue for the next three (3) months and as needed for any recommendations, revisions, and/or resolutions.	

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F 755	Continued From page 22 the Pharmacy Technician from (proper name of pharmacy) revealed that the pharmacy delivers resident medications as needed and facility keeps the original receipt sheet then faxes a copy signed by a facility nurse back to the pharmacy. Interview on 10/09/24 at 12:50 PM with the Director of Nurses (DON) and Assistant Director of Nurses (ADON) revealed the facility keeps the pharmacy medication delivery receipts in the business office. DON stated that discontinued narcotics are removed from the carts and placed in a locked box in the medication room which is also locked. She stated that when the pharmacist makes monthly rounds, the DON and Pharmacist remove the narcotics and destroy the medications with a liquid designed for this purpose and then disposed. DON provided the logbook with evidence of destruction with signatures of Pharmacist and DON noted. An interview on 10/09/24 at 1:50 PM with the Business Office Representative confirmed the pharmacy medication delivery receipts were kept by the business office. Record review of the pharmacy medication delivery receipts "Packing Slip" revealed receiving nurse's signature on each delivery form.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		11/6/24

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F 761	Continued From page 23 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed 1) to ensure a medication order, medication administration record, and narcotic record label were all labeled correctly for one (1) of five (5) medication carts reviewed during medication pass, (100 hall medication cart) and; 2) the facility failed to securely store medications when two medication capsules were found sitting in a clear medication cup in a resident's room for 1 of 124 residents observed on initial tour. (Resident #28). Findings include: 100 Hall Medication Cart Review of the facility policy, "Narcotic Medication	F 761	October 7, 2024, Resident #28, medication discovered in resident□s room was immediately removed by Registered Nurse #1 upon notification by State Agent. October 9, 2024, a direction change sticker was placed on Resident #80□s medication pill card by Licensed Practical Nurse/Medication Nurse to alert nurse staff that there has been a change in the order and to verify the correct order prior to administering the next dose. October 9, 2024, Resident #80□s narcotic was discontinued and removed from the medication chart to be destroyed by the Director of Nursing (Registered Nurse) and Pharmacy Consultant. All residents have the potential to be	

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F 761	Continued From page 24 Accountability" updated 1/02, revealed 3. As narcotic medication is used/wasted, the nurse responsible should document the usage and any wastage on the accountability record. Observation of Resident #80's Controlled Substance Record revealed instructions for Hydrocodone/APAP(acetaminophen) 10-325 MG (milligrams), "Give 1 TABLET by mouth every 4 (four) hours as needed for pain". Review of Resident #80's Physician orders dated 08/01/2024 revealed Hydrocodone/APAP 10-325 MG, "Give 1/2 TABLET by mouth every 4 hours as needed for pain". The label on the medication card was not changed to reflect the new order. Interview on 10/09/2024 at 8:10 AM with Licensed Practical Nurse (LPN) #4 on 100 Hall revealed LPN #4 confirmed 09/25/2024, 09/26/2024, 09/28/2024, 09/29/2024, and 10/07/2024 (1) tablet signed out by LPN #7 but 1/2 tablet was not recorded as wasted for Resident #80. LPN #4 also confirmed a missing tablet and stated the card was received from the pharmacy with dose #41 missing. Resident #28 During the initial tour rounds on 10/07/24 at 11:00 AM, an observation of Resident # 28's room from the hallway doorway revealed a clear medication cup with what appeared to medication in the cup sitting next to the television. Upon entrance to the room, the clear medication cup sitting next to the television on the dresser contained two bright yellow and white capsules. An observation of the two yellow and white	F 761	affected by these practices. October 16, 2024, Staff Development Coordinator (Registered Nurse) initiated in-service for nurse staff regarding the importance of medications being labeled appropriately in accordance with medication order and ensuring all medications are taken by residents at time of medication pass. October 28, 2024, in-service completed by nurse staff. October 10, 2024, a 100% audit was conducted by Director of Nursing (Registered Nurse) and Assistant Director of Nursing (Registered Nurse) to ensure no medications are left in resident rooms with no negative findings. October 18, 2024, audit initiated and completed October 23, 2024, by Licensed Practical Nurses/Medication Nurses on medication pill cards matching physician orders. Discrepancies were corrected during audit by placement of a direction change sticker on medication pill card. Beginning October 23, 2024, and going forward indefinitely, upon medication pass Medication Nurse (Licensed Practical Nurse/Registered Nurse) will verify that the resident has taken medications. If resident refuses a medication(s), the medication(s) will be removed from resident□s room by Medication Nurse (Licensed Practical Nurse/Registered Nurse). Also beginning October 23, 2024, and going forward indefinitely, upon receipt of medications from pharmacy, the following will be completed by nurse on duty: verify receipt of medications ordered; reconcile medication orders to	

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F 761	Continued From page 25 capsules in Resident # 28 room with Registered Nurse (RN) # 1 on 10/07/24 at 11:05 AM, he confirmed the capsules were on the dresser and should not be in the room and removed the capsules from the room. In a continued observation with RN #1 of Resident#28's medications, he revealed the yellow and white capsules that were found in Resident #28's room were identified as Gabapentin 300 milligrams (mg) and confirmed Resident #28 receives one 300 mg tablet every night at bedtime. He also confirmed the resident did not have an order to self-administer medications and revealed that staff should always ensure each resident has taken their medications before leaving the resident. RN #1 then stated concerns about medications being left in the room is that the resident could have taken the extra pills and had a reaction. Review of the Active Orders for Resident #28 revealed and order for Gabapentin 300 mg capsule give one capsule by mouth at bedtime. In an interview with Resident # 28 on 10/07/24 at 11:10 AM, he revealed that the pills in his room were for his bowels and stated the nurse last night left him an extra pill, and he was saving them until he needed them. He then stated, "I will take them both when I get back to the room." In an interview with LPN # 3 on 10/07/24 at 11:22, she confirmed that Resident #28 cannot self-administer medications and revealed that staff should always watch residents take their medications. She then revealed that with the medications being left in the room, it placed residents at risk for accidentally ingesting the medications, causing possible adverse reactions.	F 761	the labels on the medication pill card/box and if any discrepancies noted a direction change sticker will be applied to the medication pill card/box and pharmacy notified; narcotic sheet will be updated and signed; appropriately store all medications received. Beginning October 21, 2024, The Director of Nursing (Registered Nurse) and Assistant Director of Nursing (Registered Nurse) will audit ten (10) controlled substance records and pill count cards to ensure compliance with medication administration three (3) times per week for four (4) weeks, one (1) time per week for four (4) weeks, two (2) times per month for two (2) months. Beginning October 21, 2024, The Director of Nursing (Registered Nurse) and/or Registered Nurse supervisor will perform medication pass audits three (3) times per week for four (4) weeks, one (1) time per week for four (4) weeks, and two (2) per month for two (2) months. Findings will be reported to the Quality Assurance Performance Improvement Committee beginning November 6, 2024, and continue for the next three (3) months and as needed for any recommendations, revisions, and/or resolutions.	

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F 761	Continued From page 26 In an interview with the Director of Nursing (DON) on 10/08/24 at 11:38 AM, she revealed no medications should ever be left in a resident's room. She stated the resident could have accidentally ingested extra doses, or a wandering resident could have gotten the medication. The DON stated she spoke with Resident #28 on 10/7/24 and stated he was saving the medication to give it back to the nurse, and he stated he paid for it and was not going to waste it. The DON revealed in her professional opinion that the nursing staff could not have observed Resident #28 take his medications because if they did, he would not have been able to save the medications that were found in his room. Review of the "Admission Record" revealed the facility admitted Resident # 28 on 8/20/24 with a diagnosis of Unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and Anxiety. Record review of Resident # 28's Section C of the Admission Minimum Data Set (MDS) revealed on 8/26/24 a Brief Interview for Mental Status (BIMS) score was 11, indicating the resident was moderately cognitively impaired.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		11/6/24

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F 812	Continued From page 27 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to label and date open items in the pantry, refrigerator, and freezer for one (1) of two (2) kitchen tours during the survey. Findings Include: Review of the facility policy titled "Food Storage" undated, revealed under, "Policy... Foods will be stored, at appropriate temperatures and by methods designed to prevent contamination or cross contamination... 14. Refrigerated food storage... f. All foods should be covered, labeled and dated." Also revealed under, "15. Frozen Foods: c. All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded." During initial tour of the kitchen on 10/7/24 at 11:20 AM, with the Dietary Manager (DM) #1, an observation of the walk-in refrigerator revealed, a 5-pound (lb.) clear bag of shredded mozzarella	F 812	October 7, 2024, Certified Dietary Manager (CDM) removed and discarded all five (5) items identified as open but not dated. All residents have the potential to be affected by this practice. October 7, 2024, Certified Dietary Manager and Kitchen Supervisor audited all items in dry storage and in the cooler for being dated once opened with no negative findings. October 8, 2024, Certified Dietary Manager (CDM) initiated and completed in-service for all dietary staff on the importance of dating items when opened. Beginning October 14, 2024, and going forward indefinitely, dietary aides will monitor two (2) times per week for items being dated once opened as dietary aide stocks grocery delivery. Kitchen Supervisor will be notified immediately upon identifying any items not dated	

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F 812	Continued From page 28 cheese that had been opened and had one-fourth (1/4) of the bag remaining, which was unlabeled and undated. Also revealed a 5 lb. container of low-fat cottage cheese that was opened and was undated. An observation of the walk-in pantry revealed a 32-ounce (oz) box of chicken broth, which was open and undated. DM #1 confirmed the box read "refrigerate after opening" and revealed it was not stored properly after opening and must be trashed. An observation of the walk-in freezer revealed a blue bag of six meat-like patties, which the DM confirmed were pork fritters and had not been labeled and dated after opening. Also revealed a blue bag that contained a round breaded food that the DM #1 confirmed was breaded squash and was opened and was also not labeled and dated. An interview with the Dietary Manager #1 on 10/7/24 at 11:55 AM, revealed the kitchen staff had been educated on making sure foods were labeled and dated when they were opened to ensure they use the oldest foods first. She confirmed, if the food was not dated when opened or stored appropriately, it could make someone sick. An interview with the Administrator (ADM) on 10/9/24 at 9:34 AM revealed his expectations were for the kitchen staff to label and date things that were opened and to ensure the foods were not out of date and stored appropriately. He confirmed this should be done so it did not make anybody sick.	F 812	correctly. Beginning October 14, 2024, the Certified Dietary Manager and/or Kitchen Supervisor will complete audits of food items for being dated once opened two (2) times per week for four (4) weeks, one (1) time per week for four (4) weeks, two (2) times per month for one (1) month and one (1) time per month for one (1) month. Findings will be reported to the Quality Assurance Performance Improvement Committee beginning November 6, 2024, and continue for the next three (3) months and as needed for any recommendations, revisions, and/or resolutions.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		11/6/24

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F 880	Continued From page 29	F 880		

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 880	Continued From page 30 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were initiated for one (1) of five (5) residents reviewed for EBP. Resident #370 Findings include: Review of the facility's "Enhanced Barrier Precautions Policy", dated 04/2024, revealed, "Purpose: "Enhanced Barrier Precautions (EBP) refer to infection control interventions designed to reduce transmission of multidrug-resistant	F 880	October 8, 2024, Director of Nursing (Registered Nurse) in-serviced Registered Nurse #1 immediately upon notification of Registered Nurse #1 not properly donning enhanced barrier precaution personal protective equipment while performing a direct care task, assessing the Peripheral Inserted Central Catheter (PICC) line on Resident #370. All residents requiring the use of enhanced barrier precautions have the potential to be affected by this practice.	

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F 880	Continued From page 31 organisms (MDRO) by wearing gown and gloves during high contact resident care activities. The use of EBP does not restrict room placement or out of room activities. 4. High-contact resident care activities include: g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes" On 10/08/24 at 10:40 AM, observation revealed Registered Nurse (RN) #1 performed hand hygiene and used a barrier on overbed table for supplies. Resident #370's RN #1 accessed the Peripheral Inserted Central Catheter (PICC) line using standard precautions. EBP was not done during the administration of the medication. Observation also revealed no EBP sign posted on the room door for Resident #370. On 10/08/24 at 11:40 AM, an interview with RN #1 revealed she was unaware of the need to implement EBP for a resident with a PICC line. On 10/08/24 at 11:55 AM, an interview with the facility's Training Coordinator and Director of Nurses (DON) revealed the facility policy is for EBP to be used with central lines which would include Resident #370. Record review of Resident #370's Admission Record revealed the facility admitted the resident on 10/07/24.	F 880	October 16, 2024, Staff Development Coordinator (Registered Nurse) initiated in-service for all direct care staff regarding the importance of properly using the correct personal protective equipment when enhanced barrier precautions are required for providing residents direct care tasks. October 28, 2024, in-service completed by all direct care staff. October 10, 2024, Infection Control Preventionist (Registered Nurse) performed audit of orders for enhanced barrier precautions along with personal protective equipment and signage being in proper placement for all residents requiring these precautions throughout the facility. No negative findings. Beginning October 21, 2024, and going forward indefinitely, Infection Control Preventionist (Registered Nurse) will audit orders weekly to ensure enhanced barrier precautions have been implemented for residents that meet enhanced barrier precaution criteria. Beginning October 21, 2024, The Infection Control Preventionist (ICP/Registered Nurse) and/or the Assistant Director of Nursing (Registered Nurse) will perform audits for appropriate usage of enhanced barrier precautions personal protective equipment for five (5) residents one (1) time per week for four (4) weeks, three (3) residents one (1) time per week for four (4) weeks, three (3) residents two (2) times per month for one (1) month and three (3) residents one (1) time per month for one (1) month. Findings will be reported to the Quality	

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F 880	Continued From page 32	F 880	Assurance Performance Improvement Committee beginning November 6, 2024, and continue for the next three (3) months and as needed for any recommendations, revisions, and/or resolutions.	