MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31JC	A. BUILDING: _____ B. WING _____	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JASPER COUNTY NH	15 A SOUTH SIXTH STREET BAY SPRINGS, MS 39422

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 11/04/2024 through 11/07/2024. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500 and M1570.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a	M 500		12/19/24

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M 500	Continued From page 1 pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;	M 500		

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M 500	Continued From page 2 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical	M 500		

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M 500	Continued From page 3 record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, interviews, record reviews, and facility policy review, the facility failed to maintain and provide a clean, sanitary, and home-like environment for a resident's room (Resident #2), facility failed to ensure a resident's right to be free from physical restraints by not identifying and documenting the use of a seatbelt	M 500	M 500 1. On 11/5/24, during the survey process resident #2 reported that her bathroom was not cleaned appropriately. A housekeeping representative immediately met with resident #2 regarding the status of her bathroom. On 11/5/24, the Environmental Policy was reviewed by the	

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M 500	Continued From page 4 as a restraint (Resident #44), failed to treat a resident in a dignified manner by posting clinical data in a resident room (Resident #85) and failing to knock before entering a resident's room (Resident #69) for four (4) of 21 sampled residents, and failed to ensure grievances raised by resident council members were consistently resolved for six (6) of (12) months. Findings Include: A review of the facility's "Environmental Policy" (undated) revealed, " ...It is the policy of this facility to provide a safe, clean, comfortable, and homelike environment ...Special Information - A determination of 'comfortable and homelike' should include whenever possible, the resident's or a representative of the resident's opinion of the living environment ...'Environment' refers to any environment in the facility that is frequented by residents, including resident rooms, bathrooms ..." A review of the facility's "Restraint Policy" dated 09/18/14 revealed, " ...It is the policy of this facility that restraints will be used as follows: Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body..." A review of the facility's "Dignity Policy", undated, revealed, " ...It is the policy of this facility to promote care for the residents ...in a manner and environment that maintains or enhances each resident's dignity, with respect in full recognition of his or her individuality ...Special Concerns ...Respecting the resident's private space and	M 500	Nursing Home Administrator and Director of Nursing, Quality Assurance Performance Improvement Nurse with no revisions necessary. On 11/6/24, resident #2□s room was thoroughly cleaned which included a wiping down of the ceramic tile in the bathroom and a wiping down of the recliner in her room by a housekeeping representative. On 11/7/24, the Housekeeping Supervisor conducted an inservice training with housekeeping staff regarding timely cleaning of resident's rooms. On 11/06/24, Licensed Practical Nurse Supervisor notified the purchasing department to order and deliver a chair pad alarm to the station to replace the seatbelt. On 11/07/24, Licensed Practical Nurse Supervisor received the chair pad alarm, and the seatbelt was removed from resident #44□s wheelchair and replaced with the new chair pad alarm. The Director of Nursing, Quality Assurance Performance Improvement Nurse assessed resident #44 and found no ill effects of deficient practice. On 11/7/24, an order to discontinue the seatbelt was put into place, and a new order for the chair pad alarm was initiated. On 11/7/24, the unit nurses and Certified Nursing Aides were notified of the new changes. On 11/5/24 during the survey process, Certified Nurse Aide #2 was observed entering the room of resident #69 without knocking on the door and waiting for response. Resident #85 was identified as having clinical data in room. The Dignity policy was immediately reviewed with Certified Nurse Aide #2 by Staff Development Nurse with	

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M 500	Continued From page 5 property, knocking on doors and requesting permission to enter ..." A review of the facility's "Grievance/Complaint Policy" (undated) revealed: "It is the policy of this facility that a resident/responsible party/legal representative has the right to voice a grievance ...All grievances should be directed/reported to Social Services ..." A review of the facility's "Resident Council Policy" (undated) revealed, "It is the policy of this facility that residents have the right to form a Resident Council group to elect a governing body made up of fellow residents who preside over the resident council, conduct regularly scheduled meetings ...Purpose ...to identify problems within the nursing home, to help resolve the problems that have been identified ..." Clean, Sanitary, and Home-like Environment (Resident #2): On 11/05/24 at 11:06 AM, during an observation and interview with Resident #2, the resident reported that her bathroom was not cleaned appropriately. A thick white substance (dust) was observed on the ceramic tile in the resident's bathroom and on the back of her recliner. During an interview on 11/07/24 at 11:00 AM, the housekeeper confirmed that she had failed to clean the ceramic tile in Resident #2's bathroom and to wipe down the resident's recliner. The housekeeper stated that she occasionally forgets to clean some residents' furniture and ceramic tiles but would ensure this was done daily going forward. During an interview on 11/07/24 at 11:10 AM, the	M 500	acknowledgement of deficient practice. On 11/5/24, the clinical data posted in resident #85□s room was immediately removed. The Nursing Home Administrator and Director of Nursing, Quality Assurance Performance Improvement Nurse confirmed with resident #69 and resident #85 no actual harm occurred. On 11/5/24, grievances were identified during the survey process with the residents expressing dissatisfaction with the resolutions process of grievances during a resident council meeting. On 11/6/24, the Nursing Home Administrator and Director of Nursing, Quality Assurance Performance Improvement Nurse met with the resident council members to discuss the resolution process for grievances. The process was reviewed with resident #1, resident #2, resident #10, resident #53, resident #57, resident #61, resident #66, resident # 74, resident #79, and resident #87 to include the reporting process and procedure to notify the Director of Nursing, Quality Assurance Performance Improvement Nurse, Nursing Home Administrator, or Social Worker if concerns or grievances are not addressed properly to resident's satisfaction. After a record review by state surveyors of the Resident Council Minutes from 5/22/24- 10/16/24, recurring complaints noted regarding issues of staff noise level. On 11/6/24, the Resident Council Members including resident number resident #1, resident #2, resident #10, resident #53, resident #57, resident #61, resident #66, resident #74, resident #79, and resident #87 met with the Dietician, Dietary Manager, Social Worker, Activity	

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M 500	Continued From page 6 Housekeeping Supervisor confirmed the facility failed to clean the dust on the ceramic tile in Resident #2's bathroom and on the back of her recliner. The supervisor stated that he conducted in-service training with staff, emphasizing that the ceramic tile in resident bathrooms and the residents' furniture should be cleaned daily to promote a home-like environment. During an interview on 11/07/24 at 11:20 AM, the Administrator stated that he expects the housekeeping staff to dust the residents' bathrooms and furniture to keep the environment clean and sanitized. A record review of the "Admission Record" for Resident #2 revealed an admission date of 06/05/17, with diagnoses including Type 2 Diabetes. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/9/24 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), indicating that the resident was cognitively intact. Restraints (Resident #44): On 11/04/24 at 12:07 PM, during an observation, Resident #44 was sitting in a wheelchair in the day room with a seatbelt attached across the waistline. When asked if she could remove the seatbelt, Resident #44 was unable to understand the request. At 01:20 PM on 11/05/24, during an interview with Certified Nurse Aide (CNA) #1, she reported that although Resident #44 understands some instructions, she is unable to remove the seatbelt	M 500	Director, Director of Nursing, and Administrator related to the issue of noise level on the unit in question. During this meeting, residents reiterated concerns about staff noise including talking loudly, yelling down the hall, and playing music. After a record review by state surveyors of the Resident Council Minutes from 5/22/24- 10/16/24, recurring complaints noted regarding issues of staff clearing meal trays before residents have finished eating were identified. On 11/6/24, the Resident Council Members including resident number resident #1, resident #2, resident #10, resident #53, resident #57, resident #61, resident #66, resident #74, resident #79, and resident #87 met with the Dietician, Dietary Manager, Social Worker, Activity Director, Director of Nursing, Quality Assurance and Performance Improvement Nurse, and Nursing Home Administrator. The residents complained that staff frequently removed the meal trays before residents could finish eating, leading some residents to hide food in napkins to ensure they had time to eat. On 11/8/24, the Director of Nursing, Quality Assurance Performance Improvement Nurse, Staff Development Nurse, and Unit Supervisor of resident #1, resident #2, resident #10, resident #53, resident #57, resident #61, resident#66, resident#74, resident#79, and resident#87 met and determined that the best way to ensure residents are allowed at least 30 minutes before asked if they are finished eating is to obtain a timer. The timer will be placed on top of the facility tray carts and will be set to 30 minutes upon the last meal tray being delivered. This will ensure	

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M 500	Continued From page 7 independently, and staff have to remove it for her. She confirmed that the resident is dependent on staff for Activities of Daily Living (ADLs) and requires a full-body lift with transfers. On 11/06/24 at 09:30 AM, during an interview with Licensed Practical Nurse (LPN) #1, she stated that Resident #44 was a fall risk due to her diagnoses, but had not experienced recent falls. She added that Resident #44 is forgetful and sometimes displays behaviors in the evening with increased anxiety, attempting to get out of the chair to go home. At 02:10 PM on 11/06/24, during another interview with LPN #1, she explained that Resident #44 cannot always remove the seatbelt on demand, depending on her mood. She stated that in the evenings, the resident sometimes tries to release the seatbelt herself when she becomes intent on going home, which indicates her behavior changes. LPN #1 confirmed that if Resident #44 cannot remove the seatbelt on command, it should be considered a restraint, as it restricts her from getting out of the wheelchair. At 02:15 PM on 11/06/24, during an observation with LPN #1, Resident #44 was unable to remove the seatbelt when prompted by the nurse. Resident #44 attempted multiple times, saying, "I can't do it, you do it," indicating she could not remove it independently. LPN #1 confirmed that Resident #44 could not remove the seatbelt at that time. On 11/06/24 at 02:50 PM, during an interview with Registered Nurse (RN) #1, she confirmed that Resident #44 cannot remove the seatbelt on command consistently. She noted that although Resident #44 had experienced previous falls, no	M 500	ample time for all residents to eat in tranquility before staff offers to remove their meal tray. After a record review by state surveyors of the Resident Council Minutes from 5/22/24- 10/16/24, recurring complaints noted regarding issues of the bus not being available to use for outings. On 11/6/24, the Director of Nursing, Quality Assurance Performance Improvement Nurse, Staff Development Nurse, and Unit Supervisor of resident #1, resident #2, resident #10, resident #53, resident #57, resident #61, resident#66, resident#74, resident#79, and resident#87 met. During this meeting, residents reiterated concerns about not being able to go on outings due to the bus not working. 2. All residents have the potential to be affected by the deficient practice. All residents on the facility census have the potential to be affected by the deficient practice. One other resident was identified to have a seatbelt positioning device at time of survey. 3. On 11/6/24, the Environmental Policy was reviewed by the Nursing Home Administrator and Director of Nursing, Quality Assurance Performance Improvement Nurse with no revisions necessary. On 11/6/24 and 11/7/24, all housekeeping staff were in-serviced on the daily/weekly/monthly cleaning schedule and the expectations to maintain a safe, clean and homelike environment. On 11/6/24, the Housekeeping Supervisor developed a daily/weekly checklist with assigned duties for each housekeeping	

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M 500	Continued From page 8 falls had occurred in the past six (6) months, and she should have been reevaluated for seatbelt use. RN #1 confirmed that if the resident cannot remove the seatbelt on demand, it acts as a restraint, as it restricts her movement and ability to exit the wheelchair. She acknowledged that the facility had not considered the seatbelt a restraint, nor had an assessment or consent been completed for its use. At 04:00 PM on 11/06/24, during an interview with the Director of Nursing (DON), she explained that Resident #44 had been using the seatbelt for an extended period. The DON confirmed that the resident has a low BIMS score and dementia, with variable memory. She also stated that while the resident occasionally removes the seatbelt for her sister or some staff members, she has not had falls in the past six (6) months but remains a fall risk. The DON admitted that staff only check the seatbelt once a week to ensure Resident #44 can remove it independently, and she had not been informed that the resident was unable to remove the seatbelt consistently. The DON confirmed that the seatbelt was not identified as a restraint and stated the facility aims to avoid restraints. At 04:40 PM on 11/06/24, during an interview with the Administrator, he reported awareness that Resident #44 could not remove the seatbelt on command consistently. He explained that the resident's ability to remove it varies depending on the day and who is asking. The Administrator emphasized that the facility tries to avoid restraints and expects staff to assess properly for restraints. A record review of the "Admission Record" revealed the facility admitted Resident #44 on	M 500	employee to initial after having completed the tasks. On 11/7/24, all other residents who have an active order for a seatbelt were evaluated by the Unit Supervisors, Director of Nursing, Quality Assurance Performance Improvement Nurse, Minimum Data Set, and physical therapy for the need for the device and that the device did not act as a restraint for the resident. One other resident was identified with a seatbelt in place, which was immediately discontinued and removed from the wheelchair. On 11/7/24, Restraint Policy was reviewed with no revisions by the Director of Nursing, Quality Assurance Performance Improvement Nurse, and in-services with all staff regarding Restraint Policy was conducted by the Staff Development Nurse. On 11/14/24, a referral was made for resident #44 to specialized wheelchair company for a new, customized wheelchair to accommodate the resident #44□s comfort and safety. An evaluation will be completed on a resident prior to application of a positioning device. The evaluation will include what interventions were tried prior to applying the device, and ensure that the least restrictive approach is attempted first. The evaluation will be completed by Physical Therapy and reviewed by the Director of Nursing, Quality Assurance Performance Improvement Nurse. All positioners and devices require a physician's order. On 11/7/24, the Director of Nursing, Quality Assurance Performance Improvement Nurse reviewed the record of one other resident identified as having a seatbelt. The seatbelt was immediately	

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M 500	Continued From page 9 07/17/20 with diagnoses including Parkinson's Disease Without Dyskinesia. A record review of the "Order Summary Report" revealed Resident #44 had a Physician's Order, dated 8/1/24 to "Ensure Resident Can Remove Self-Release Alarming Seatbelt On Que ..." A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/10/24 revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of four (4), indicating severely impaired cognition. Section GG indicated no range of motion limitations for upper or lower extremities, and the resident used a wheelchair. Section J showed no recent falls, and Section P indicated no trunk restraint was used in or out of bed. A record review of Resident #44's medical record showed no assessment or consent for the seatbelt's use. Dignity (Resident #69 and #85) Resident #69 On 11/5/23 at 12:10 PM, during an observation and interview with Licensed Practical Nurse (LPN) #2, Certified Nurse Aide (CNA) #2 entered Resident #69's room without knocking on the door, addressing the resident, or introducing herself and did not explain the purpose for her visit.. CNA #2 placed the resident's meal tray on the bedside table, set it up for eating, and left the room. LPN #2 remarked that CNA #2's behavior did not align with proper protocol, noting that she should have knocked on the resident's door, waited for a response, entered the room, introduced herself, and explained the purpose for	M 500	discontinued. The seatbelt on resident #44 was discontinued on 11/7/24. On 11/5/24, the Unit Supervisor and Staff Development Nurse inspected all resident□s rooms to ensure no other clinical data was posted. No other resident□s rooms were identified as having this deficient practice present. On 11/5/24, the Dignity Policy was reviewed by the Director of Nursing, Quality Assurance Performance Improvement Nurse with no revisions. All staff will be in-serviced regarding facility dignity policy to include proper procedure for knocking and entering any resident□s room by Staff Development Nurse beginning on 11/7/24 and will be completed by 12/13/24. The Unit Supervisors and charge nurses will monitor all staff randomly three times per week for one month and then monthly for three months or until compliance is met to ensure utilization of proper procedure before entering any resident□s room and to ensure no posting of clinical data or any other postings that does not comply with the facility dignity policy beginning on 11/26/24. On 11/7/24, the grievance policy was reviewed by the Director of Nursing, Quality Assurance Performance Improvement Nurse with no revisions necessary. On 11/7/24, an inservice on the grievance policy was completed by the Staff Development Nurse to include the Director of Nursing, Quality Assurance Performance Improvement Nurse, Assistant Director of Nursing, and all Unit Supervisors regarding grievance reporting/handling, procedure policy, and review of Grievance Complaint/Concern Form and the Grievance Resolution Form.	

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M 500	Continued From page 10 the visit. On 11/5/24 at 12:25 PM, in an interview with CNA #2, she admitted that she failed to knock on Resident #69's door before entering the room wile the resident was receiving medication. She explained that her familiarity with the resident made her feel comfortable enough to skip this step, believing it would not offend the resident. However, she acknowledged her awareness of the facility's policy, which requires knocking, waiting for a response, and then entering the room with an introduction. CNA #2 confirmed that this protocol was included in her training program as well as during her orientation at the facility. On 11/6/24 at 9:00 AM, the Director of Nursing (DON) confirmed that CNA #2 should have knocked on Resident #6's door before entering the room. The DON emphasized that the facility's policy supports residents' rights to a home-like environment and personal dignity. She explained that knocking and acknowledging residents before entering their room is essential for maintaining privacy and dignity, as well as demonstrating common courtesy. A record review of the "Admission Record" revealed the facility admitted Resident #69 on 03/29/22 with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction. A record review of the "Significant Change Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/27/24 revealed Resident #69 had a Brief Interview for Mental Status (BIMS) score of fourteen (14), indicating that the resident was cognitively intact. Resident #85	M 500	A new form Compliance Rounds Form has been developed and implemented on 11/26/24 to address grievances and present concerns identified during the survey process regarding noise level, talking loudly, yelling down hall, playing music at night, removing meal trays before completion of meal, and facility outings due to broken lift on bus. The Nursing Home Administrator and Director of Nursing, Quality Assurance Performance Improvement Nurse met on 11/7/24 with resident council members to communicate that the facility will work to resolve grievances in a timely manner. On 11/11/24, the Employee Conduct Policy was revised as follows: Keep noise level at a minimum on the unit, especially at night. This is the residents□ home and they have the right to restful sleep. Unit Nurse and Supervisor should ensure that this policy is followed. Failure to adhere to this policy may result in disciplinary action. Beginning 11/11/24, an in-service regarding the updated Employee Conduct Policy was conducted with all staff. Beginning 11/21/24, an in-service was initiated with nursing staff stating that each Unit Supervisor, as well as cart nurses, will be responsible for ensuring that staff follow the Meal Tray Pick-up policy as it is written. This will ensure that all residents have ample time to eat without feeling rushed. Unit Supervisors will utilize the Compliance Rounds Form to interview residents regarding this issue and document their responses three times a week for one month and then monthly for three months to obtain status of progress in correction of this deficiency.	

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M 500	Continued From page 11 During an observation on 10/04/24 at 11:17 AM, there was clinical documentation (Resident Baseline Care Plan) containing Resident #85's name and care details posted on a wall at the head of the bed. This documentation remained publicly visible during subsequent observations on 10/04/24, 10/05/24, and 10/06/24. During an interview on 10/06/24 at 10:18 AM, Resident #85's family member explained that the documentation was meant to assist CNAs and staff in providing specific care for his grandfather, such as showing the direction and timing for turning the resident to prevent pressure sores. During an interview on 10/02/24 at 3:45 PM (LPN) #2 stated that information on the resident's board was intended to make staff aware of specific care needs. LPN #2 acknowledged that the documents included the resident's name, which could be considered a dignity issue, and confirmed that this information was also available in the Electronic Medical Record (EMR). During an interview on 10/02/24 at 10:18 AM, the DON stated that the information on the resident's board was intended to guide staff unfamiliar with the resident's care needs. She acknowledged that the same information was accessible in the EMR. A record review of the "Admission Record" revealed the facility admitted Resident #85 on 04/19/24 with diagnoses including Adult Failure to Thrive. A record review of the Quarterly MDS with an ARD of 10/14/24 revealed Resident #85 had a BIMS score of 3, which indicated his cognition	M 500	The condition of the facility bus will be communicated to the Resident Council members during their monthly resident council meetings beginning on 11/20/24, then monthly, and ongoing thereafter. 4. On 11/6/24, resident #2□s room was thoroughly cleaned which included a wiping down of the ceramic tile in the bathroom and a wiping down of the recliner in her room by a housekeeping representative. On 11/6/24, the Housekeeping Supervisor implemented a Daily Room Checklist that he or the Assistant Housekeeping Supervisor will complete after thoroughly inspecting rooms. Beginning 11/6/24, the Housekeeping Supervisor/Assistant Housekeeping Supervisor will inspect at least fifteen rooms per unit weekly and ongoing to ensure rooms are being thoroughly cleaned and are free of dust buildup. After rooms have been inspected the completed Daily Room Checklists will be submitted to the Quality Assurance Committee beginning 12/18/24 and then monthly for three months until compliance is met and maintained. The results of these inspections will be reported to the Quality Assurance Committee until the committee determines compliance is met and maintained. On 11/7/24, the new changes were communicated with the Director of Nursing, Quality Assurance Performance Improvement Nurse, Minimum Data Set, and unit staff. On 11/12/24, an order was initiated for Nurses and Certified Nursing Aides who are assigned to resident #44 to monitor placement and function of the new chair	

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M 500	Continued From page 12 was severely impaired. Resident Group Response: A record review of the resident council minutes revealed from 5/22/24 through 10/16/24, residents had recurring complaints regarding issues such as staff noise on the unit, staff clearing meal trays before residents finished eating, and the malfunctioning lift on the facility bus, which prevented outings. The minutes documented unresolved concerns regarding these issues over six (6) consecutive months. On 11/05/24 at 9:30 AM, during the resident council meeting, members expressed dissatisfaction with the facility's failure to resolve grievances, leading to the resignation of the council's president and vice president. The council decided to reconvene the meeting on 11/06/24 to invite department heads to discuss these unresolved issues. On 11/06/24 at 1:00 PM, the resident council met with the Dietitian, Dietary Manager, Social Worker, Activity Director, Director of Nursing (DON), and Administrator. During this meeting, residents reiterated concerns about staff noise, including talking loudly, yelling down the hall, and playing music at night. They also complained that staff frequently removed meal trays before residents could finish eating, leading some residents to hide food in napkins to ensure they had time to eat. Additionally, the residents reported that the lift on the facility bus had been broken for an extended period, preventing outings. The resident council members included Resident #1, Resident #2, Resident #10, Resident #53, Resident #57, Resident #61, Resident #66, Resident #74, Resident #79, and	M 500	pad alarm every shift. As of 11/7/24 and ongoing, any resident who may require a seatbelt alarm will be evaluated by the unit supervisor, therapy, and Minimum Data Set nurse using the Restraint/Alarm Evaluation form to determine if use is appropriate. If seatbelt alarm is deemed appropriate for any resident, the cart nurses will chart per treatment administration record (TAR) weekly that resident can remove alarming seatbelt on que. If it is noted that resident is no longer capable of removing seatbelt on que, the seatbelt will be removed, and the resident will be evaluated for other safety measures. The Unit Supervisors will utilize the Compliance Rounds Form report which includes device monitoring beginning 11/26/24 and give a report to the Quality Assurance Committee monthly beginning on 12/18/24 and ongoing to be reviewed for any recommendations deemed necessary. Beginning 11/26/24, the Unit Supervisors will randomly monitor certified nurse aides, compliance with knocking before entering a resident's room and clinical data postings and document findings three times weekly for one month and then monthly for three months or until compliance is met using the Compliance Rounds Form. The Compliance Rounds Form includes the following measures to be monitored: Staff knock on doors and wait for permission to enter and monitor room for clinical data. Any staff found to be noncompliant with facility Dignity Policy will be counseled and disciplined by the Director of Nursing and Nursing Home Administrator. The Unit Supervisor will report to the Quality	

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M 500	Continued From page 13 Resident #87. During an interview on 11/06/24 at 2:30 PM, the Social Services Director confirmed that all department heads receive copies of the resident council minutes. She explained that it is the responsibility of each department head to address and resolve complaints documented in these minutes. During an interview on 11/07/24 at 11:45 AM, the Activity Director stated that residents had not been to local shops since she began working at the facility in December. She was unaware that the facility had a van for resident transportation and stated she would discuss this with the Administrator. During an interview on 11/07/24 at 11:50 AM, the Administrator confirmed that the bus had been out of commission for approximately six (6) months due to a malfunctioning lift and door. He indicated plans to take the bus to a repair shop and acknowledged that residents could be transported in smaller groups using a facility van, which accommodates two (2) wheelchairs at a time. During an interview on 11/07/24 at 12:12 PM, the DON stated that she expects staff to allow residents ample time to finish their meals. She reported that staff had previously been in-serviced regarding noise reduction and the timing of tray removal but acknowledged that the issues had resurfaced. She noted that she would reinstruct staff to wait at least thirty (30) minutes after serving meals before entering resident rooms to collect trays and indicated plans to make unannounced visits to monitor compliance.	M 500	Assurance Committee monthly beginning 12/18/24 for three months or until compliance is met. Beginning 11/26/24, Unit Supervisors and cart nurses will ensure that all staff follow the new policy on employee conduct/noise level. Unit Supervisors will utilize the Compliance Rounds Form to interview residents regarding this issue and document their responses three times a week for one month and monthly for three months to obtain status of progress in correction of this deficiency. The Compliance Rounds Forms will be reviewed during the monthly Quality Assurance Performance Improvement Committee meetings beginning 12/18/24 for three months or until compliance is achieved and maintained. Timers have been ordered for each meal cart and are expected to be delivered the week of 12/2/24. Once the timers are delivered, the timer will be placed on top of the facility tray carts and will be set to 30 minutes upon the last meal tray being delivered. This will ensure ample time for all residents to eat in tranquility before staff offers to remove their meal tray. Beginning 11/21/24, an in-service was initiated with nursing staff stating that each Unit Supervisor, as well as cart nurses, will be responsible for ensuring that staff follow this policy as it is written. This will ensure that all residents have ample time to eat without feeling rushed. Unit Supervisors will utilize the Compliance Rounds Form to interview residents regarding this issue and document their responses three times a week to obtain status of progress in correction of this	

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M 500	Continued From page 14	M 500	deficiency. Unit Supervisors and staff nurses are directly monitoring meal times to ensure residents are allowed ample time for meals until timers arrive. The Compliance Rounds Forms will be reviewed during the monthly Quality Assurance Committee meetings beginning 12/18/24 for three months or until compliance is achieved and maintained. The Director of Nursing, Quality Assurance Performance Improvement Nurse will report to the Quality Assurance Committee monthly of monitoring and any negative findings reported until compliance is achieved. The nursing home administrator will be notified of all grievances. Negative findings will be reported to and handled by the Nursing Home Administrator. On Monday, 11/11/24, the facility bus was taken to and left at a repair shop to install a new lift (the old lift is obsolete and can not get parts to repair) and repair the back doors. The expected date of return for the bus is on or before December 13, 2024. Upon the return of the bus from the repair shop, the Maintenance Department will check and log the working status of the bus, including the hydraulic lift, monthly to ensure that everything is operating as intended and it is available for safe use. A Maintenance Department representative will submit a written report to the Quality Assurance Committee monthly and ongoing regarding the status and working condition of the bus.	
M1570	48.58.1 Infection Control	M1570		12/19/24

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M1570	Continued From page 15 The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observation, staff interview, record review and facility draft policy review, the facility failed to implement Enhanced Barrier Precautions (EBP) for one (1) of three (3) residents reviewed as high risk for acquiring multi-drug-resistant organisms (MDROs) Resident #69 and had the potential to affect six (6) residents identified as high risk for MDROs. Findings Include:	M1570	M 1570 1. On 11/7/24, an Enhanced Barrier Precaution sign was placed on Resident #69□s door. On 11/7/24, Nurse #1 was immediately in-serviced on Enhanced Barriers Precautions guidelines. Resident # 69 was assessed by the Director of Nursing, Quality Assurance Performance Improvement Nurse and Nursing Home Administrator on 11/7/24 and was found to have no adverse condition related to the	

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M1570	Continued From page 16 Record review of the facility policy "Draft Enhanced Barrier Precautions Policy" dated reviewed 9/28/24 revealed "This policy aims to mitigate the risk of transmission of Multidrug-Resistant Organisms (MDROs) within our facility by implementing Enhanced Barrier Precautions (EBP). This policy seeks to prevent the spread of MDRO's among residents and staff members by expanding the use of personal protective equipment (PPE) during high contact resident care activities for certain residents ...Policy Explanation and Compliance Guidelines ...4. Examples of indwelling medical devices for EBP should include but are not limited to ...feeding tube ..." On 11/05/24 at 12:10 PM, during an observation, Licensed Practical Nurse (LPN #1) entered Resident # 69's room to administer medication via the residents Percutaneous Endoscopic Gastrostomy (PEG) tube. LPN #1 did not put on a gown while accessing the PEG tube and administering the medication. During an interview with LPN #1 on 11/05/24 at 12:25 PM, she admitted that she had forgotten to wear a gown and noted that there was no signage or other indicators to alert the staff that Resident #69 resident required EBP, nor was PPE readily accessible. She acknowledged the importance of EBP in preventing the transmission of MDROs, particularly during high-contact activities with residents who have PEG tubes, catheters, or central lines. During an interview with the Director of Nursing (DON) on 11/06/24 at 9:00 AM, she confirmed that the facility had developed a Performance Improvement Plan (PIP) for EBP training, initiated	M1570	deficient practice. On 11/20/24, Maintenance installed a gown holder on the inside of Resident #69□s door. Glove holder and gloves already in place. A wall hanger for sanitizer was also applied to the wall for quick point of care access. 2. All residents have the potential to be affected by this deficient practice. 6 residents on the facility resident census were identified as having an indwelling device at the time of survey. 3. On 11/7/24, the Enhanced Barriers Precautions Policy was reviewed and updated by the Director of Nursing, Quality Assurance Performance Improvement Nurse and Nursing Home Administrator. On 11/7/24, an indepth evaluation was conducted for other residents that could potentially be affected by this deficiency practice. 6 Residents identified were assessed by the Registered Nurse Charge Nurse to ensure all supplies for Enhanced Barriers Precautions were in place. On 11/7/24 the Director of Nursing, Quality Assurance Performance Improvement Nurse evaluated the 6 residents identified on the facility census with indwelling devices to ensure no ill effects were identified related to this deficient practice. All staff on duty were immediately In-serviced beginning on 11/7/24 on the Enhanced Barriers Precautions policy. On 11/7/24, Unit Supervisors were notified by the Director of Nursing, Quality Assurance Performance Improvement Nurse to include the same protocol for any Resident who receives the Diagnosis for an indwelling device, chronic wound, or a	

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M1570	Continued From page 17 in September 2024. She indicated that the facility's policies were being revised to enhance compliance with EBP guidelines. On 11/06/24 at 9:25 AM, an interview with Registered Nurse (RN) #1 revealed that the facility follows standard precautions and uses transmission-based precautions for contact, droplet, and airborne pathogens. RN #1 confirmed that EBP protocols require the use of gowns and gloves during high-contact care activities involving residents with PEG tubes, catheters, and central lines. She noted that the facility currently had no policies in place to incorporate enhanced barrier precautions but was updating their infection control policies to include EBP guidelines. During an interview on 11/7/24 at 10:45 AM, the Licensed Nursing Home Administrator (LNHA) disclosed that the facility was currently under a PIP for EBP training, which began in September 2024. He indicated that facility policies were being revised to improve compliance with EBP guidelines. The revised policy aims to reduce the transmission of MDROs within the facility by implementing enhanced barrier precautions, specifically through expanded use of PPE during high-contact care activities. The LNHA expressed that his expectation for nursing staff was to follow universal precautions consistently, along with any additional protective measures necessary to prevent resident exposure to potential pathogens. A record review of the "Admission Record" revealed the facility admitted Resident #69 on 03/29/22 with diagnoses including Benign Neoplasm of the Brain.	M1570	multidrug resistant organism. On 11/20/24, Housekeeping and Laundry were in-serviced on the changes that this policy would affect in their department, such as placement of isolation gowns in the closet, how used gowns will be handled, how the bed sanitizing will be conducted, how residents on Enhanced Barriers Precautions linen are handled, etc. Beginning 11/17/24, all other departments were in-serviced on the effects of the Enhanced Barriers Precautions on their daily activities. 4. Beginning on 11/26/24, the Unit Supervisors or Charge Nurse will monitor the use of Enhanced Barriers Precaution compliance and supplies three times weekly for one month and then monthly for three months using the Compliance Rounds Form. Beginning 12/18/24, the completed Compliance Rounds Forms will be submitted to the Quality Assurance Committee to be reviewed for any recommendations deemed necessary monthly for three months or until compliance is met and maintained.	