| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25A178 | A. BUILDING _____ B. WING _____ | 11/07/2024 |

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

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| F 000 | INITIAL COMMENTS<br><br>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 requirements of participation in Medicare and Medicaid and cited F550, F565, F584, F604, F623, F644, F880 and F919.<br><br>The facility had a census of 99 and was licensed for 110 beds. | F 000 | | |
| F 550 SS=E | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights. | F 550 | | 12/19/24 |

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

Electronically Signed | 11/26/2024

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| F 550 | Continued From page 1<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record reviews, interviews, and facility policy review, the facility failed to treat residents 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 two (2) of 21 sampled residents.<br><br>Findings Include:<br><br>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 property, knocking on doors and requesting permission to enter ..."<br><br>Resident #69 | F 550 | F 550<br><br>1. 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 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.<br><br>2. All residents have the potential to be | |

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| F 550 | Continued From page 2<br>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 the visit.<br><br>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 while 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.<br><br>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. | F 550 | affected by the deficient practice. All residents on the facility census have the potential to be affected by the deficient practice.<br><br>3. 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.<br><br>4. 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 | |

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| F 550 | Continued From page 3<br><br>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.<br><br>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 14, indicating that the resident was cognitively intact.<br><br>Resident #85<br><br>During an observation on 11/04/24 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.<br><br>During an interview on 11/06/24 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.<br><br>During an interview on 11/06/24 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).<br><br>During an interview on 11/07/24 at 10:18 AM, the DON stated that the information on the resident's | F 550 | 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 Assurance Committee monthly beginning 12/18/24 for three months or until compliance is met. | |

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| F 550 | Continued From page 4<br>board was intended to guide staff who may be unfamiliar with the resident's care needs. She acknowledged that the same information was accessible in the EMR.<br><br>A record review of the "Admission Record" revealed the facility admitted Resident #85 on 04/19/24 with diagnoses including Adult Failure to Thrive.<br><br>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 was severely impaired. | F 550 | | |
| F 565 SS=E | Resident/Family Group and Response<br>CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)<br><br>§483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.<br>(i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.<br>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.<br>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.<br>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.<br>(A) The facility must be able to demonstrate their | F 565 | | 12/19/24 |

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| F 565 | Continued From page 5<br>response and rationale for such response.<br>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.<br><br>§483.10(f)(6) The resident has a right to participate in family groups.<br><br>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews, record review, and facility policy review, the facility failed to ensure grievances raised by resident council members were consistently resolved for six (6) of (12) months.<br><br>Findings Include:<br><br>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 ..."<br><br>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 ..." | F 565 | F 565<br><br>1. 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. | |

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| F 565 | Continued From page 6<br><br>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.<br><br>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.<br><br>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 Resident #87. | F 565 | 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 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.<br>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 | |

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| F 565 | Continued From page 7<br>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.<br><br>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.<br><br>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.<br><br>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 instruct 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. | F 565 | 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 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.<br><br>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.<br><br>3. On 11/7/24, the grievance policy was reviewed by the Director of Nursing, | |

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| F 565 | Continued From page 8 | F 565 | 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. 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 | |

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| F 565 | Continued From page 9 | F 565 | 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. 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.<br><br>4. 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.<br>Timers have been ordered for each meal cart and are expected to be delivered the week of 12/2/24. Once the timers are | |

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| F 565 | Continued From page 10 | F 565 | 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.<br>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.<br>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 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.<br>On Monday, 11/11/24, the facility bus was taken to and left at a repair shop to install | |

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| F 565 | Continued From page 11 | F 565 | 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. | |
| F 584 SS=D | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>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.<br><br>The facility must provide-<br>§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.<br>(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.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance | F 584 | | 12/19/24 |

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| F 584 | Continued From page 12<br>services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§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<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>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 one (1) of twenty-six (26) resident rooms on Unit 2. This affected Resident #2.<br><br>Findings Include:<br><br>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 | F 584 | F 584<br><br>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 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 | |

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| F 584 | Continued From page 13<br>residents, including resident rooms, bathrooms ..."<br><br>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.<br><br>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.<br><br>During an interview on 11/07/24 at 11:10 AM, the 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.<br><br>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.<br><br>A record review of the "Admission Record" for Resident #2 revealed an admission date of 06/05/17, with diagnoses including Type 2 Diabetes. | F 584 | Housekeeping Supervisor conducted an inservice training with housekeeping staff regarding timely cleaning of resident□s rooms.<br><br>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.<br><br>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 employee to initial after having completed the tasks.<br><br>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 | |

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| F 584 | Continued From page 14<br><br>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 15, indicating that the resident was cognitively intact. | F 584 | 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. | |
| F 604 SS=D | Right to be Free from Physical Restraints<br>CFR(s): 483.10(e)(1), 483.12(a)(2)<br><br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must- | F 604 | | 12/19/24 |

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| F 604 | Continued From page 15<br>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right to be free from physical restraints by not identifying and documenting the use of a seatbelt as a restraint for one (1) of 21 sampled residents. Resident #44.<br><br>Findings Include:<br><br>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..."<br><br>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.<br><br>At 1:20 PM on 11/05/24, during an interview with Certified Nurse Aide (CNA) #1, she reported that | F 604 | F 604<br><br>1. 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.<br><br>2. All residents with positioning devices have the potential to be affected by cited deficient practice. One other resident was identified to have a seatbelt positioning device at time of survey. There were no residents with physician-ordered restraint devices at the time of survey. | |

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| F 604 | Continued From page 16<br>although Resident #44 understands some instructions, she is unable to remove the seatbelt 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.<br><br>On 11/06/24 at 9:30 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.<br><br>During an additional interview at 2:10 PM on 11/06/24, LPN #1, 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.<br><br>At 2:15 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.<br><br>On 11/06/24 at 2:50 PM, during an interview with Registered Nurse (RN) #1, she confirmed that | F 604 | 3. 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. | |

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| F 604 | Continued From page 17<br>Resident #44 cannot remove the seatbelt on command consistently. She noted that although Resident #44 had experienced previous falls, no falls had occurred in the past six (6) months, and she should have been re-evaluated for seatbelt use. RN #1 confirmed that if the resident cannot remove the seatbelt on command, 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.<br><br>At 4:00 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 Brief Interview for Mental Status (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.<br><br>At 4:40 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 | F 604 | The seatbelt was immediately discontinued. The seatbelt on resident #44 was discontinued on 11/7/24.<br><br>4. 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 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. | |

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| F 604 | Continued From page 18<br>restraints.<br><br>A record review of the "Order Summary Report" revealed Resident #44 had a physician order, dated 8/1/24 to "Ensure Resident Can Remove Self-Release Alarming Seatbelt On Que ..."<br><br>A record review of the "Admission Record" revealed the facility admitted Resident #44 on 07/17/20 with diagnoses including Parkinson's Disease.<br><br>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 BIMS score of (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.<br><br>A record review of Resident #44's medical record revealed there were no assessments for a restraint or a consent for the seatbelt use. | F 604 | | |
| F 623 SS=D | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. | F 623 | | 12/19/24 |

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(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights,

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including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the

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| F 623 | Continued From page 21<br>State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff, Resident Representative (RR) interview and record review, the facility failed to provide written notification to the resident or RR of a transfer to an acute care hospital for one (1) of (21) residents sampled. (Resident #7)<br><br>Findings Include:<br><br>A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/06/24 indicated Resident #7 was discharged to an acute hospital and it was anticipated she would return to the facility.<br><br>On 11/06/24 at 8:38 AM, during an interview with the Director of Nursing (DON), she acknowledged that the facility did not provide written documentation to Resident #7's Representative (RR) to inform them of the resident's transfer to the hospital or the reason for the transfer. The DON confirmed that the facility calls the resident's RR by phone to inform them that the resident has been sent to the hospital.<br><br>On 11/06/24 at 8:45 AM, during an interview with the RR, she stated that facility staff spoke with her in person regarding the resident being sent to the hospital and the reason for the hospitalization. The RR confirmed she did not receive written documentation related to the hospitalization.<br><br>On 11/06/24 at 9:02 AM, during an interview with | F 623 | F 623<br><br>1. On 11/6/24, during the survey process resident #7 was identified as not having a written notification of transfer given to the resident or resident representative. The facility did call the resident representative for resident #7 and informed the resident representative of transfer. On 11/7/24, a new form has been developed, Discharge/Transfer Tracking Form, which will be completed on any resident who requires transfer to another facility. This form will be given to the resident at the time of transfer and a copy of the form will be mailed to the resident representative by the Social Worker.<br><br>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.<br><br>3. On 11/26/24, the facility implemented a Notification of Hospital Transfer policy that states residents being transferred to another facility for possible admission, will be given written notice informing them of the reason for the transfer. The policy also requires the Social Worker or Nursing Home Administrator to mail a copy of the | |

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| F 623 | Continued From page 22<br>the Administrator, he acknowledged that the facility failed to notify Resident #7's RR in writing regarding the reason for her hospitalization.<br><br>A record review of the "Admission Record" revealed the facility admitted Resident #7 on 03/16/10 with diagnoses including Anoxic Brain Damage. | F 623 | notice to the Resident Representative of record as soon as possible. In-service training began on 11/26/24, for all Licensed Practical and Registered Nurses to ensure they know the policy and know their responsibilities when a resident from their assigned unit is transferred to another facility for possible admission.<br><br>4. Effective 11/26/24, the Unit Supervisor will review the medical record of each resident transferred from their unit to another facility to ensure the Notification of Hospital Transfer Form was sent with the transferring resident. The Unit Supervisors will complete a Discharge/Transfer Tracking Form for any resident that is transferred to another facility and provide a copy to the Director of Nursing, Quality Assurance Performance Improvement Nurse. Also, in the morning Resident Care Meeting, the Social Worker or Nursing Home Administrator will be made aware of any resident transferred out the previous day, (On Monday if over a weekend or the next working day if on a Holiday), so the Social Worker or Nursing Home Administrator can send a copy to the Resident Representative. The Quality Assurance Performance Improvement Committee will review the Discharge/Transfer Tracking Forms for every resident transferred beginning 11/26/24 to ensure that the notifications as described above are being sent and the deficient practice is corrected. Beginning on 12/18/24, Medical Records Department will submit the Discharge/Transfer Tracking Forms to the | |

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| F 623 | Continued From page 23 | F 623 | Quality Assurance Committee. The Quality Assurance Committee will review monthly for three months or until compliance is met and maintained. | |
| F 644 SS=D | Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews, record review, and facility policy review, the facility failed to obtain a Level II Preadmission Screening and Resident Review (PASARR) for a resident receiving psychotropic medications and diagnosed with a new mental health diagnosis for one (1) of one (1) resident reviewed for PASARR. (Resident #69)<br><br>Findings Include: | F 644 | F 644<br><br>1. On 11/6/24, resident #69 was identified during the survey process as not having a Level II screening completed after a significant change in behavior. On 11/7/24, a review of resident # 69□s records were reviewed by the Director of Nursing, Quality Assurance Performance Improvement Nurse, Nursing Home | 12/19/24 |

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| F 644 | Continued From page 24<br>Record review of the "Resident Assessment-Coordination with PASARR Program", undated, revealed "Policy: This facility coordinates assessment with the preadmission screening and resident review (PASARR) under Medicaid to ensure that individual with a mental disorder, intellectual disability or related condition receives care and services in the most integrated setting appropriate to their needs ...9.Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review ..."<br><br>A record review of Resident #69's "Pre-Admission Screening (PAS)", dated 03/25/22 revealed the Level II Referral Criteria had negative responses to all questions regarding the need for a Level II evaluation, indicating there was no history of mental illness or the use of psychotropic medications.<br><br>A record review of Resident #69's "Physician Orders List" revealed Resident #69 started Seroquel on 08/07/23 for increased psychotic behaviors and hallucinations.<br><br>A record review of the "Admission Record" revealed the facility admitted Resident #69 on 03/29/22 with diagnoses including Unspecified Psychosis Not Due to a Substance or Known Physiological Condition and Unspecified Hallucinations, both with an onset date of 08/07/23.<br><br>A record review of the "Significant Change Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/27/24 revealed | F 644 | Administrator, and Social Worker regarding the need for submission of Level II Screening. On 11/14/24, a Level II Preadmission Screening and Resident Review Status Change Request Form was completed and submitted in the appropriate state authority for resident #69 who was identified during the inspection for not having a Level II Screening completed after a significant change in behavior. The facility received a Status Change Request Outcome letter from the appropriate state authority that stated no further Level II Preadmission Screening and Resident Review screening is required at this time.<br><br>2. All residents have the potential to be affected by the deficient practice. All residents on the facility census who exhibit a newly evident or possible serious mental disorder, intellectual disability, or a related condition have the potential to be affected by the deficient practice.<br><br>3. Any resident who experiences a significant change exhibiting a newly evident or possible serious mental health disorder, intellectual disability, or a related condition will be reviewed and evaluated for potential need of a Level II Preadmission Screening and Resident Review, as deemed necessary. On 11/14/24, the facility implemented the Resident Assessment-Coordination with Preadmission Screening and Resident Review Program policy. On 11/14/24, the Staff Development nurse conducted an in-service regarding the policy with the | |

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| F 644 | Continued From page 25<br>Resident #69 had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. Section I noted diagnoses of Anxiety Disorder, Depression, and a Psychotic Disorder (other than Schizophrenia). Section N indicated the resident had taken antipsychotic, antianxiety, and antidepressant medications during the look-back period.<br><br>On 11/06/24 at 4:15 PM, during an interview with the Director of Nursing (DON), she explained the staff member who completed Resident #69's initial PAS was no longer employed at the facility, and the completion date was prior to her tenure as the DON. After reviewing the resident's medical record, she confirmed that only the PAS screening from the resident's admission was available, which did not indicate the need for a Level II evaluation. The DON acknowledged that Resident #69 experienced a change in mental health status with a new diagnosis after her admission to the facility and was prescribed a psychotropic medication, including Seroquel. She was unaware that a new diagnosis or initiation of psychotropic medication would necessitate another screening to determine if a Level II evaluation was indicated.<br><br>At 4:40 PM on 11/06/24, during an interview with the Administrator, he confirmed his awareness that a Level II PASARR is required if a resident undergoes a significant change, including a new diagnosis or medication. He stated he expects his staff to adhere to these regulations. | F 644 | Director of Nursing, Quality Assurance Performance Improvement Nurse, Assistant Director of Nursing, Unit Supervisors, Minimum Data Set nurse, Social Worker, Nursing Home Administrator, and Pharmacist.<br><br>4. On 11/14/24, the Resident Care Committee, which consists of the Director of Nursing, Quality Assurance Performance Improvement Nurse, Assistant Director of Nursing, Unit Supervisors, Social Worker, Nursing Home Administrator, Pharmacist, will meet at least three times per week and ongoing to review any new medications orders, acute charting documentation and the twenty four (24) hour report in electronic health record to identify residents that qualify for a Status Request Form to be submitted to determine if a Level II Screening is required. The facility Social Worker will be responsible for completing the Status Change Request Form, with the Unit Supervisors input, and submitting to the appropriate authority. On 11/14/24, the Director of Nursing, Quality Assurance Performance Improvement Nurse and Nursing Home Administrator created a Preadmission Screening and Resident Review Status Change Request Referral Tracking Form, which will be provided to the Quality Assurance Committee by the Social Worker beginning 12/18/24 and ongoing. | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f) | F 880 | | 12/19/24 |

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| F 880 | Continued From page 26<br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, | F 880 | | |

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| F 880 | Continued From page 27<br>depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>Findings Include:<br><br>Record review of the facility policy "Draft | F 880 | F 880<br><br>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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| F 880 | Continued From page 28<br>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 ..."<br><br>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.<br><br>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.<br><br>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 in September 2024. She indicated that the | F 880 | 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.<br><br>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.<br><br>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 | |

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| F 880 | Continued From page 29<br>facility's policies were being revised to enhance compliance with EBP guidelines.<br><br>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.<br><br>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.<br><br>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. | F 880 | Resident who receives the Diagnosis for an indwelling device, chronic wound, or a 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.<br><br>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. | |
| F 919 SS=D | Resident Call System | F 919 | | 12/19/24 |

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| F 919 | Continued From page 30<br>CFR(s): 483.90(g)(1)(2)<br><br>§483.90(g) Resident Call System<br>The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-<br><br>§483.90(g)(1) Each resident's bedside; and<br>§483.90(g)(2) Toilet and bathing facilities.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interviews, the facility failed to maintain an audible call light system for one (1) of (16) rooms observed on Unit 4 hall. Room 235<br><br>Findings Include:<br><br>On 11/04/24 at 11:12 AM, during an observation, the call light in Room 235 was noted to be hanging from the outlet. The resident in the room activated the call light, but it did not illuminate above the door or sound.<br><br>During an interview and observation on 11/04/24 at 11:15 AM, Housekeeper #3 attempted to activate the call light unsuccessfully and stated this was the first time she noticed the light not working, despite Resident #76 frequently using the call light for assistance.<br><br>During an interview and observation on 11/04/24 at 11:20 AM, Licensed Practical Nurse (LPN) #3 also attempted to activate the call light in Room 235 and confirmed it was not working properly. She stated she was unaware that the call light was not functioning. She explained that both | F 919 | F 919<br><br>1. On 11/4/24, during the survey process the call light in room 235 on station 4 hall was noted to be hanging from the outlet, causing no alarm or light illumination when activated by the resident. Immediately when identified, housekeeper #3 attempted to activate the call light, unsuccessfully. Licensed Practical Nurse #3 then attempted to activate the call light, unsuccessfully. On 11/4/24, facility maintenance personnel were then notified and the call light box was replaced within 30 minutes of initial finding. On 11/4/24 the Director of Nursing, Quality Assurance Performance Improvement Nurse and Nursing Home Administrator confirmed with resident who resides in room 235 no ill effects were identified from this deficient practice.<br><br>2. All residents have the potential to be affected by this cited deficient practice. All residents on the facility census have the potential to be affected by this cited | |

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

| (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 919 | Continued From page 31<br>residents in the room typically used the call light when assistance was needed. She noted that, had she known the light was out, she would have notified maintenance, as they maintain a log at the nurse's station to record broken items.<br><br>During an interview on 11/04/24 at 11:25 AM with both residents in Room 235, both reported being unaware of how long the call light had been nonfunctional. They stated that if staff did not respond when they pressed the button, they would yell for assistance, and staff would come into the room.<br><br>During an interview on 11/04/24 at 11:30 AM, the Maintenance Director confirmed the call light was not working and explained that the call light box needed replacement. He stated that he planned to obtain a new box and complete the replacement as soon as possible, adding that he had been unaware of the malfunction prior to this incident. | F 919 | deficient practice.<br><br>3. On 11/20/24, a new order was added to each resident□s Treatment Administration Record (TAR) in the electronic health record that alerts Nurses and requires that they check the call light functionality every shift. In-service training on the new order in each resident□s Treatment Administration Record (TAR) began on 11/20/24. On 11/25/24, monthly preventative maintenance rounds, including a written log, will be performed by the Maintenance Department. This will include resident call light functionality. On 11/20/24, an Alternative Call Light Policy was reviewed and implemented by the Director of Nursing, Quality Assurance Performance Improvement Nurse. In the event a resident□s call light malfunctions, the Charge Nurse will be notified immediately, and the Alternate Call Light Policy will be initiated until the primary call light can be repaired. Beginning on 11/20/24, nursing staff was in-serviced by the Staff Development Nurse on the alternate call light policy. In-services will be complete by 12/13/24.<br><br>4. Beginning 11/21/24, Unit Supervisors will review previous day charting at daily Resident Care Committee meetings to ensure Nurses are checking and documenting call light functionality every shift and will be ongoing. This will be tracked by the Unit Supervisor (and/or Charge Nurse in their absence) beginning 11/26/24, using the Compliance Rounds Form three times weekly for one month | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25A178 | A. BUILDING _____ B. WING _____ | 11/07/2024 |

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|---|---|---|---|---|
| F 919 | Continued From page 32 | F 919 | and then monthly for three months. The Unit Supervisor will give the Compliance Rounds Form of findings and monitoring to the Quality Assurance Committee monthly beginning on 12/18/24 and will continue to be monitored for three months or until compliance for this deficient practice is achieved and maintained. Any negative findings will be reported and handled by the Nursing Home Administrator. | |