STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255260	A. BUILDING _____ B. WING _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP MANOR HEALTH AND REHABILITATION CENTER	101 KIRKLAND STREET UNION, MS 39365

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey at the facility from 12/2/24 through 12/5/24. During the survey, the SA determined that the facility was not compliance with the requirements for participation in Medicare and Medicaid and cited F584, F641, F645, F679, F694, F761, and F880. The census at the time of the survey was 53 and the facility is licensed for 60 beds.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		1/6/25

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

Electronically Signed | 12/18/2024

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F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and facility policy review, the facility failed to provide a resident with a clean, comfortable, and homelike environment when the facility failed to change the dirty, stained linen for (1) one of 53 residents' bed linens observed. Resident # 20 Findings include: A review of the facility policy titled, "Making a bed," with no revision date revealed that all linens, including mattress pad, blanket, and bedspread should be replaced, if necessary... The pillowcase should also be checked for soiling and replaced as needed... Bed linens are regularly changed at least once a week. In an interview with Resident # 20 on 12/02/24 at 1:00 PM, she revealed she would like to have her bed linen changed, stating "I can't remember the last time they were changed." An observation of	F 584	Resident #20 linens were changed on 12/3/2024 by the staff Certified Nursing Assistant(CNA), on 12/3/2024 a 100% audit of bed linen was completed by the Director of Nurses(DON) and Assistant Director of Nurses(ADON) all stained or soiled linen was replaced at that time by the CNA. All residents of the facility have the potential to be affected by this issue. On 12/4/2024 the Assistant Director of Nurses(ADON) initiated education with CNAs and Nurses on routine linen changes for all beds of the facility and as needed linen changes for soiled or stained linens. Bed linens are to be changed at least once a week and as needed. Beginning on 12/9/2024 Quality Monitoring of 10% of residents bed linens	

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F 584	Continued From page 2 the linen with Resident #20 revealed the bottom sheet to be dingy white, the top sheet had a baseball size brown stain which the resident stated was from a bowel movement. The pillowcase was covered in small dark dried stains which the resident stated were dried blood stains. An observation of Resident # 20's bed linen on 12/03/24 at 11:34 AM, revealed the bed linen remained dingy in appearance with a brown stain on the top sheet, and numerous small dark stains on the pillowcase. An observation and interview with Registered Nurse (RN) # 1 on 12/03/24 at 11:37 AM, she confirmed the sheets on Resident # 20's bed were dirty in appearance and dingy white, the top sheet had a brown stain on it, and the pillow had numerous dark stains that she identified as dried blood spots. RN # 1 then confirmed that the linens did not appear to have been changed recently, and stated the linen should have already been changed. It is a sanitization concern. In an interview with the Director of Nursing (DON) on 12/03/24 at 11:45 AM, she revealed the resident's beds should be made daily and linen changed weekly and each time the linen is soiled. She then confirmed that it was a sanitization problem. Review of the "Admission Record" revealed Resident #20 was admitted by the facility on 2/27/24. Record review of Resident #20's Section C of the Minimum Data Set (MDS) revealed that on 9/17/24 the Brief Interview for Mental Status (BIMS) score was 15, indicating the resident was	F 584	will be conducted by DON or ADON 3 times a week for 4 weeks, 2 times a week for 4 weeks, weekly for 4 weeks. Findings will be reported by the DON monthly for 4 months to Quality Assurance Performance Improvement (QAPI) Committee Meeting. On 1/3/2025 QAPI Committee will conduct a QAPI to review of findings from Quality Monitoring to ensure our solution is sustained. Review all findings from our Quality Monitoring on the first Friday of each month during the QAPI meeting by the QAPI committee in the monthly meeting for 3 months to ensure our solutions are sustained.	

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F 584	Continued From page 3 cognitively intact.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and Resident Assessment Instrument (RAI) review, the facility failed to ensure that Minimum Data Set (MDS) was coded accurately for one (1) of 18 sampled residents. Resident #5. Findings included: Record review of the facility policy, titled "MDS" with a revision date of 9/25/17 revealed "Policy...Each person completing a section or portion of the MDS signs the Attestation Statement indicating its accuracy..." A record review of the "Admission Record" revealed Resident # 5 was admitted by the facility on 12/24/20 with a diagnosis of Bipolar Disorder. Record review of Resident #5's Significant Change MDS with an Assessment Reference Date (ARD) of 7/30/24, revealed Section A 1500 coded as "No", Is the resident currently considered by the state level II PASRR (Preadmission Screening and Resident Review) process to have serious mental illness and/or intellectual disability or a related condition? Record review of Resident # 5's "Summary of Findings Report", from the PASRR Office, dated	F 641	On 12/9/2024 Minimum Data Set(MDS) nurse corrected Resident #5□s MDS to reflect accurate Level II Preadmission Screening and Resident Review(PASRR) determination. On date the MDS nurse conducted a review of current residents□ most recent MDS assessment to ensure accurate coding of the any Level II PASRR determinations. Residents of the facility that require a Level II Preadmission Screening and Resident Review determination have the potential to be affected by this issue. On 12/4/2024 education was conducted by the Administrator with MDS nurses of the facility on accurate coding of the MDS assessment with emphasis on Preadmission Screening and Resident Review (PASRR) level II determination. MDS nurses will verify Level II PASRR determination through electronic medical record of the resident prior to coding Section A 1500 of the MDS. Beginning on 12/9/2024 Quality Monitoring of 10% of residents MDS assessment for accurate coding of Section A 1500 will be conducted by MDS	1/6/25

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F 641	Continued From page 4 12/30/20 under "Mental Health" revealed "the individual meets criteria for having a diagnosis of mental illness as defined by PASRR. During an interview with the MDS Nurse on 12/4/24 at 9:30 AM, she verified that the MDS was coded incorrectly and agreed that the importance of correctly coding MDS was to ensure residents received care they needed. An interview with the Director of Nursing (DON) on 12/4/24 at 12:00 PM, she agreed that it was her expectation that the MDS would be coded correctly.	F 641	nurse weekly times(x) 4 weeks, then monthly x 2 months. Findings will be reported by the MDS nurse monthly x 3 months to Quality Assurance Performance Improvement (QAPI) Committee Meeting. On 1/3/2025 QAPI Committee will conduct a QAPI to review of findings from Quality Monitoring to ensure our solution is sustained. Review all findings from our Quality Monitoring on the first Friday of each month during the QAPI meeting by the QAPI committee in the monthly meeting for 3 months to ensure our solutions are sustained.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State	F 645		1/6/25

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F 645	Continued From page 5	F 645		

intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).

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F 645	Continued From page 6 (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately submit a resident's information for Preadmission Screening and Resident Review (PASRR) for a Level II evaluation for (1) one of (4) four residents reviewed for PASRR. Resident #54 Findings include: Review of the facility policy titled, "Preadmission Screening and Resident Review (PASRR)," with a revision date of 11/8/21 revealed, Policy: The center will assure that all Serious Mentally Ill (SMI) ... residents receive appropriate pre-admission screenings according to the Federal/State guidelines. The purpose is to ensure that the residents with SMI ...receive the care and services they need in the most appropriate settings. ... Record review of the "Admission Record" revealed Resident #54 was admitted by the facility on 5/24/24 with diagnoses of Brief Psychotic Disorder and Anxiety Disorder. A record review of Resident #54's May 2024 "Order Summary Report," revealed that Divalproex sodium delayed release tablet 500 mg (milligrams): give two tablets by mouth twice daily for behaviors and hydroxyzine pamoate 100 mg capsule: give one capsule three times daily for	F 645	On 12/3/2024 Preadmission Screening and Resident Review(PASRR) was submitted by the Social Worker for change in status on Resident #54, to add diagnosis of Anxiety and Brief Psychotic Disorder. On 12/3/2024 the Social Worker conducted an audit of current residents PASRR to ensure that residents of the facility were screened appropriately. Residents of the facility that require a Level II Preadmission Screening and Resident Review determination have the potential to be affected by this issue. On 12/3/2024 Education was conducted by the Administrator with the Social Worker and Medical Records Coordinator on Preadmission Screening and Resident Review(PASRR) process. The facility will ensure that all active diagnosis and medications are captured when submitting a resident□s PASRR. Beginning on 12/9/2024 Quality Monitoring of 10% of residents PASRR screening for accurate submission will be completed by the Social Worker or Medical Records Coordinator weekly times (x) 4 weeks, then monthly x 2 months. Findings will be reported by the Social Worker monthly x 3 months to	

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F 645	Continued From page 7 anxiety with an order date of 5/24/24. Record review of Resident #54's intake information for PASRR dated 5/24/24 revealed, Section J: Disease Diagnoses: the admitting diagnoses of Anxiety and Brief Psychotic Disorder were not listed as an active diagnosis... Section L: Referral Questions: 31.) Does Resident # 54 have any history of mental illness? answered No...32.) Does Resident #54 take, or have a history of taking, psychotropic medications? answered No. In an interview with the Social Service staff #1 on 12/3/24 at 2:45 PM, she revealed after reviewing Resident #54's intake information for Level II PASRR evaluation she confirmed that Resident #54's active admission diagnoses for mental illness and use of psychotropic medications were not listed. She stated the inaccurate completion resulted in an inaccurate depiction of the resident's mental health status. This resulted in Resident #54 not being referred for a level II PASRR evaluation. She stated that the concern from not completing the initial PASRR correctly is that a resident with mental illness may not be appropriate for nursing home stay and may need specialized mental health services.	F 645	Quality Assurance Performance Improvement (QAPI) Committee Meeting. On 1/3/2025 QAPI Committee will conduct a QAPI to review of findings from Quality Monitoring to ensure our solution is sustained. Review all findings from our Quality Monitoring on the first Friday of each month during the QAPI meeting by the QAPI committee in the monthly meeting for 3 months to ensure our solutions are sustained.	
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities,	F 679		1/6/25

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F 679	Continued From page 8 designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, record review and facility policy review, the facility failed to provide an activities program seven (7) days a week as evidenced by a lack of structured activities on weekends for five (5) of six (6) residents at the Resident Council meeting, with the potential to affect all residents. Resident #8, #13, #36, #37 and #40. Findings Included: A record review of a facility policy, titled "Group Activities" with no revision date revealed "Group activities are scheduled to enhance the resident's well-being and self-esteem ..." During a Resident Council meeting on 12/4/24 at 9:45 AM, Residents #8, #13, #36, #37, and #40 stated that church services are provided on Sundays, but no other activities occur on the weekends. The residents explained that the Activity Director leaves activity/coloring pages and puzzles for them, and occasionally Resident #40 plays the piano. Residents #36 and #37 noted that there are no scheduled weekend activities because no activity staff are present, and other staff do not assist with any activities. They expressed a desire for structured activities on weekends. A review of the September, October, and November 2024 activity schedules revealed that Saturday activities included providing coloring,	F 679	On 12/4/2024 the Administrator and Activities Director met to discuss concerns from residents on not having consistent weekend activities. Administrator and Activities Director planned weekend activities to begin on 12/7/2024 and ongoing to be conducted by Restorative Certified Nursing Assistants(RCNA) as part of daily duties on Saturdays and Sundays. Residents of the facility that wish to participate in weekend activities have the potential to be affected by this issue. On 12/4/2024 Education was conducted by the Administrator with the Activities Director, and RCNAs that consistent scheduled activities will be scheduled and conducted on weekend days consistently and would be added to the duties of the RCNAs going forward on weekend days beginning on 12/7/2024. On 12/11/2024 the Activities discussed revised weekend activity plan with the Resident Council. Beginning on 12/9/2024 Quality Monitoring of Weekend Activity Schedule and Participation will be conducted by the Administrator or Activities Direct weekly times (x) 4 weeks, every other week x 4 weeks, then monthly for 1 month. Findings will be reported by the	

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F 679	Continued From page 9 puzzles, movies, arts, and dominoes for the residents to do on their own and Sunday activities were limited to a church service. During an interview with the Activity Director (AD) on 12/4/24 at 10:00 AM, she confirmed there are no scheduled activities on the weekends. She stated that she is scheduled to work Monday through Friday, with no activity staff assigned on weekends. She confirmed that she leaves puzzles and activity/coloring pages for residents to use during the weekend and encouraged staff to put on movies. She mentioned that some residents play the piano on weekends but verified that no structured activities occur beyond the Sunday church service. She acknowledged that residents have expressed interest in additional weekend activities and stated she reported this to the Administrator. The AD emphasized that having activities seven (7) days a week is important for preventing boredom, encouraging socialization, and promoting residents' well-being. In an interview with the Administrator on 12/4/24 at 10:25 AM, he stated that the Restorative Certified Nursing Assistant (RCNA) is responsible for facilitating activities on weekends if residents request them. He agreed that the lack of weekend activities could negatively impact residents' well-being and quality of life. An interview with the RCNA on 12/4/24 at 11:00 AM revealed that she works Saturdays conducting restorative exercises. She explained that if time permits, she may organize an activity such as singing while a resident plays the piano. However, she noted that her responsibilities also include transportation and covering staff shortages, leaving her unavailable to consistently	F 679	Administrator monthly x 3 months to Quality Assurance Performance Improvement (QAPI) Committee Meeting. On 1/3/2025 QAPI Committee will conduct a QAPI to review of findings from Quality Monitoring to ensure our solution is sustained. Review all findings from our Quality Monitoring on the first Friday of each month during the QAPI meeting by the QAPI committee in the monthly meeting for 3 months to ensure our solutions are sustained.	

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F 679	Continued From page 10	F 679		

provide activities. She confirmed that she does not work on Sundays.

Record review of the "Admission Record" revealed that the facility admitted Resident #8 on 12/25/17 with a diagnosis of Borderline Intellectual Functioning.

Record review of Resident #8's Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 9/20/24 revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating that the resident is cognitively intact.

Record review of the "Admission Record" revealed that the facility admitted Resident #13 on 1/27/23 with a diagnosis of Major Depressive Disorder.

Record review of the MDS with an ARD of 10/28/24 revealed Resident #13 had a BIMS score of 15 indicating that the resident is cognitively intact.

Record review of the "Admission Record" revealed that the facility admitted Resident #36 on 7/29/24 with a diagnosis of Major Depressive Disorder.

Record review of Resident #36's MDS with an ARD of 8/29/24 revealed a BIMS score of 15 indicating that the resident is cognitively intact.

Record review of the "Admission Record" revealed that the facility admitted Resident #37 on 11/29/19 with a diagnosis of Major Depressive Disorder.

Record review of Resident #37's MDS with an

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F 679	Continued From page 11 ARD of 9/25/24 revealed a BIMS score of 15 indicating that the resident is cognitively intact. Record review of the "Admission Record" revealed that the facility admitted Resident #40 on 10/7/20 with a diagnosis of Blindness Right Eye. Record review of Resident #40's MDS with an ARD of 10/21/24 revealed a BIMS score of 15 indicating that the resident is cognitively intact.	F 679		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, record reviews, professional standards of practice, and facility policy review the facility failed to provide Peripherally Inserted Central Catheter (PICC) care for one (1) of four (4) residents with intravenous access. Resident #10. Findings include: Record review of the facility policy titled "Central Vascular Access Device (CVAD) Dressing Change," effective date 6/1/24 revealed the guidance: "Perform sterile dressing changes using Standard-Aseptic Non-Touch Technique (ANTT) at least weekly."	F 694	On 12/2/2024 the Director of Nurses (DON)/Assistant Director of Nurses (ADON)/Unit Manager obtained an order for Resident #10□s dressing change to Peripherally Inserted Central Catheter(PICC), the dressing was changed on 12/2/2024 by the Unit Manager. On 12/2/2024 the DON conducted a review of current residents with intravenous catheters to ensure that orders for dressing changes were present and that the dressing was within 7 days. Residents of the facility with intravenous catheters have the potential to be affected by this issue.	1/6/25

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F 694	Continued From page 12 Review of the professional standard of practice "Checklist for Prevention of Central Line Associated Blood Stream Infections" published by the Centers for Disease Control (CDC) revealed change semipermeable dressings at least every seven days. During an observation on 12/2/24 at 12:00 PM, Resident #10 was noted to have a PICC line inserted to the right arm with a transparent dressing dated 11/21/24. The resident stated that she had been on intravenous (IV) antibiotics, which were completed on 11/29/24, and was unsure why the PICC line had not been removed. She also stated that the dressing had not been changed. In an observation, interview and record review with Registered Nurse (RN) #2 on 12/2/24 at 12:20 PM, she verified that the PICC line dressing for Resident #10 was dated 11/21/24. She revealed after reviewing Resident #10's "Order Summary Report" that there were no orders for dressing changes to the PICC line, but there should have been. In an interview with the Director of Nursing (DON) on 12/2/24 at 1:00 PM, she confirmed that there should have been an order for Resident #10's PICC line dressing to be changed. The DON confirmed that Resident #10's PICC line dressing had not been changed and acknowledged that dressings should be changed every seven days. She stated that failure to do so could result in adverse effects, such as infection. Record review of the "Admission Record" revealed that the facility admitted Resident #10	F 694	On 12/2/2024 the Director of Nurses (DON) and Assistant Director of Nurses (ADON) initiated in-service with Registered Nurses on ensuring that orders were obtained for dressing changes on intravenous catheters and dressing changes occurred as ordered for residents with intravenous catheters. Beginning on 12/9/2024 Quality Monitoring of residents with Intravenous catheters will be conducted by DON or ADON to ensure orders for dressing change are present and carried out 3 times (x) a week for 4 weeks, 2 x a week for 4 weeks, weekly for 4 weeks. Findings will be reported by the DON monthly x 3 months to Quality Assurance Performance Improvement (QAPI) Committee Meeting. On 1/3/2025 QAPI Committee will conduct a QAPI to review of findings from Quality Monitoring to ensure our solution is sustained. Review all findings from our Quality Monitoring on the first Friday of each month during the QAPI meeting by the QAPI committee in the monthly meeting for 3 months to ensure our solutions are sustained.	

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F 694	Continued From page 13 on 8/30/24 with a diagnosis of Diabetes Mellitus. Record review of the Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 11/28/24 revealed a Brief Interview of Mental Status (BIMS) score of 15 indicating that the resident is cognitively intact.	F 694		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff	F 761	On 12/3/24 the Director of Nurses (DON)	1/6/25

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F 761	Continued From page 14 interview, record review and facility policy review, the facility failed to ensure that medications were securely stored as evidenced by medications observed on the bedside table for two (2) of 53 residents reviewed. Resident #13 and #22. Findings Include: Review of the facility policy titled, "Medication and Medication Supply Storage and Disposal," with no revision date revealed, "Central storage of medications is required for prescription, prescribed over-the-counter medications ...Will be kept in a locked area ...Procedure :1.) Storage is required for the following situations and will be locked with limited access: If the facility administers or assists with self-administration of medication ..." Resident # 13 An observation on 12/2/24 at 2:30 PM revealed a bottle of Travoprost 0.004% eye drops sitting on Resident #13's overbed table. The resident stated that she puts the drops in her eyes herself at night and had been using the medication for 10 years. A record review of assessments revealed that Resident #13 did not have a "Self-Administration of Medication" assessment. A record review of the "Order Review Report" dated 12/3/24 for Resident #13 revealed that there was no physician's order for Travoprost 0.004%, nor an order to self-administer medications. An interview with Registered Nurse (RN) #3 on	F 761	removed a bottle of Travoprost 0.004% eye drops from Resident #13□s room, on 12/3/2024 Resident #13□s physician ordered Visine Dry Eye Relief 1 drop both eyes every 24 hours as needed for dry eyes and Latanoprost 0.005% 1 drop both eyes every evening for Glaucoma. On 12/3/24 the DON removed a box of Hydrocortisone cream from Resident #22□s room, on 12/3/2024 the DON assessed Resident #22 for any skin issues, Hydrocortisone Cream 1% to left upper arm as needed every shift for itching was ordered by the physician on 12/3/2024. An audit of all residents□ rooms was conducted by the DON and Assistant Director of Nurses (ADON) on 12/3/24 to ensure no other drugs were in other resident rooms. Residents of the facility that receive medications have the potential to be affected by this issue. On 12/3/24 the Director of Nurses (DON) and Assistant Director of Nurses (ADON) initiated education with nursing staff of the facility on the Policy Medication and Medication Supply Storage and Disposal to ensure that nursing staff were aware that medications are not to be left unattended and unsecured in any residents□ room. Beginning on 12/9/2024 Quality Monitoring of 5 residents rooms will be conducted by DON or ADON to ensure no medications are unsecured in residents rooms 3 times (x) a week for 4 weeks, 2 x	

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F 761	Continued From page 15 12/3/24 at 1:25 PM, she stated that she was not aware of any medication that Resident #13 was self-administering. She verified that the resident did not have an order for Travoprost 0.004%. An observation and interview with RN #3 on 12/3/24 at 1:28 PM, she verified that there was a bottle of Travoprost 0.004% eye drops still sitting on residents over bed table. An interview with the Director of Nursing (DON) on 12/3/24 at 1:31 PM, she verified that Resident #13 did not have an assessment or a physician's order to self- administer any medications and did not have an order for the eye drops. She stated that the resident had been on the eye drops prior to her last hospitalization and felt they may not have been reordered upon her return. She agreed that the resident should be assessed for self-administration of mediation for safety. She agreed the resident could have adverse effects, such as drug interactions, from using a medication that was not ordered and agreed the medication should not be on the bedside table. Record review of the "Admission Record" revealed that the facility admitted Resident #13 to the facility on 11/25/19 with a diagnosis of Unspecified Glaucoma. Record review of the Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 10/28/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident is cognitively intact. Resident #22 An observation of Resident #22's room on 12/02/24 at 11:10 AM revealed a box sitting on	F 761	a week for 4 weeks, weekly for 4 weeks. Findings will be reported by the DON monthly x 3 months to Quality Assurance Performance Improvement (QAPI) Committee Meeting. On 1/3/2025 QAPI Committee will conduct a QAPI to review of findings from Quality Monitoring to ensure our solution is sustained. Review all findings from our Quality Monitoring on the first Friday of each month during the QAPI meeting by the QAPI committee in the monthly meeting for 3 months to ensure our solutions are sustained.	

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F 761	Continued From page 16	F 761		

the bedside table titled Hydrocortisone 1% cream. Resident #22 stated that he uses that cream for a rash on his arm. He stated that the treatment nurse gave him a full box of hydrocortisone and told him to apply it every day.

In an observation of Resident #22's room with Registered Nurse (RN) #1 on 12/03/24 at 11:00 AM, she confirmed the box on Resident #22's bedside table was Hydrocortisone cream. A continued record review of Resident #22's Order Summary Report dated 12/3/24 revealed that the resident had no orders for the Hydrocortisone cream. RN #2 confirmed Resident #22 did not administer his medications and the cream should not have been in the room.

In an interview with the Treatment Nurse on 12/03/24 at 11:10 AM, she revealed the box of Hydrocortisone in Resident # 22's room was facility stock medication. She stated she did not give the resident the box of hydrocortisone and confirmed he did not have an order for it. She then revealed the medication should not be in the resident's room because he could apply too much of the hydrocortisone and have a potential adverse reaction.

In an interview with the Director of Nursing (DON) on 12/03/24 at 11:15 AM, she confirmed Resident #22 did not have an assessment to self-administer medications and confirmed the medication should not have been left in the room. The DON stated the cream should have been stored in a locked medication/treatment cart.

Record review of the "Admission Record" revealed Resident #22 was admitted by the facility on 3/21/24 with diagnosis of End-stage

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F 761	Continued From page 17 Renal Disease. Record review of Resident #22's Section C of the quarterly MDS with an ARD of 11/26/24 revealed a BIMS score of 15, indicating the resident was cognitively intact.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		1/6/25

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F 880	Continued From page 18 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to prevent the possible transmission of infections	F 880	On 12/3/2024 the Infection Control Nurse conducted education with Certified Nurses Assistant(CNA)#1 and Restorative	

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F 880	Continued From page 19 when staff failed to use enhanced barrier precautions (EBP) during catheter care for one (1) one of (4) four direct care areas observed. (Resident #12) Findings include: Review of the facility policy titled, "Enhanced Barrier Precautions," with a revision date of August 2022 revealed, "Policy Statement: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents... Policy Interpretation and Implementation: EBP's employ targeted gown and glove use during high contact resident care activities ... Examples of high contact resident care activities.... g. device care ...urinary catheter..." An observation of catheter care for Resident #12 on 12/03/24 at 2:10 PM, revealed Certified Nurse Assistant (CNA) #1 and the Restorative CNA provided catheter care for Resident #12 and both CNAs failed to apply a gown before performing catheter care. In an interview with CNA #1 on 12/03/24 at 2:20 PM, she revealed she did not realize she had not used EBP. She then revealed that all residents with indwelling devices are on enhanced barrier precautions. In an interview with the Restorative CNA on 12/03/24 at 2:25 PM, she revealed that she had forgotten EBP and confirmed she knew she was supposed to. She then revealed the purpose of EBP is to reduce the risk of spread of infections for residents at increased risk of infection.	F 880	Certified Nurses Assistant (RCNA) on Enhanced Barrier Precautions(EBP), that provided catheter care to Resident #12 on 12/3/24. On 12/3/24 the Infection Control Nurse reviewed other residents of the facility on EBP to ensure staff were following the facility policy on EBP. Residents of the facility on Enhanced Barrier Precautions have the potential to be affected by this issue. On 12/3/2024 the Infection Control Nurse began education with CNAs and Nurses on the facility policy Enhanced Barrier Precautions (EBP) to ensure CNAs and Nurses providing care appropriately to residents that are on EBP. Beginning on 12/9/2024 Quality Monitoring of 20% of residents with catheter care will be conducted by Director of Nurses (DON) or Infection Control Nurse to ensure Enhanced Barrier Precautions are followed 3 times (x) a week for 4 weeks, 2 x a week for 4 weeks, weekly for 4 weeks. Findings will be reported by the DON or Infection Control Nurse monthly x 3 months to Quality Assurance Performance Improvement (QAPI) Committee Meeting. On 1/3/2025 QAPI Committee will conduct a QAPI to review of findings from Quality Monitoring to ensure our solution is sustained. Review all findings from our Quality Monitoring on the first Friday of each month during the QAPI meeting by the QAPI committee in the monthly meeting for 3 months to ensure our	

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F 880	Continued From page 20 Record review of the "Order Summary Report" for Resident #12 revealed an active order for "Catheter care every shift and as needed", dated 11/18/24. In an interview with the Infection Control Nurse on 12/03/24 at 2:35 PM, she confirmed that the CNAs should have implemented EBP to provide a layer of protection to prevent the spread of infection for residents at increased risk. Review of the "Admission Record" revealed Resident #12 was admitted by the facility on 8/20/20 with Encounter for Surgical Aftercare Following Surgery On The Genitourinary System. Record review of Resident #12's Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/25/24 revealed in Section: H-Bladder and Bowel: H0100 was coded Indwelling catheter.	F 880	solutions are sustained.	