STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255174	A. BUILDING _____ B. WING _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF MOSS POINT	3401 MAIN STREET MOSS POINT, MS 39563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and a Complaint Investigation (CI), MS #26776, at the facility, from 12/02/24 through 12/05/24. CI MS #26776 was investigated for resident abuse, resident safety, and quality of life and there were no deficiencies cited related to the complaint. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F623, F625, F640, F656, F699, F812, and F880. The facility was licensed for 160 beds and had a census of 103 at the time of survey.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (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. (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	F 623		1/6/25

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

Electronically Signed | 12/26/2024

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F 623	Continued From page 1	F 623		

(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, 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;

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F 623	Continued From page 2 (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 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). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to provide written notification of resident transfers to the	F 623	This Plan of Correction constitutes Diversicare of Moss Point□s credible allegations of compliance for the cited	

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F 623	Continued From page 3 resident or the resident representative (RR) for three (3) of (3) residents reviewed for hospitalizations. (Residents #47, #65, and #69). Findings included: A review of the facility's policy titled "Transfer & Discharge," revised November 1, 2016, revealed, "(Proper Name of Facility) shall permit each resident to remain at the center and not transfer or discharge the resident from the center except in accordance with federal and state laws and as directed in this policy ...Notice Requirements ...4 ...Before (Proper Name of Facility) transfers or discharges the Resident, it shall notify the Resident and the Resident's Representative of the basis for the transfer or discharge in a language and manner they understand ..." During an interview on 12/04/2024 at 10:30 AM, the Receptionist explained she was instructed by the Regional Business Office Consultant not to mail written notification of transfers to the RRs. She stated the company policy required calling the representatives instead. She confirmed she had stopped mailing written notification of transfer approximately six (6) months ago. During an interview on 12/05/2024 at 9:00 AM, with the Administrator, he explained he was unaware the receptionist had stopped mailing transfer letters. He acknowledged the regulation requiring written notification to representatives in a language they understand and stated the facility would resume mailing transfer notifications to representatives immediately. Resident #47	F 623	deficiencies. Nothing in this plan of correction should be construed as admission by the Center of any violation of State and Federal Statues, regulations, or standards of care. This Plan of Correction is to demonstrate compliance of the State and Federal requirements cited during the survey. 1. The receptionist mailed the written Notice of Transfer/Discharge to the residents' representatives for residents, on 12/19/2024 via certified mail, # 47 for transfer date 10/26/2024, #65 for transfer date 10/09/2024, and #69 for transfer date 08/15/2024. The Nursing Home Administrator (NHA) in-serviced the receptionist to ensure all residents and/or their resident representative must be informed in writing of the Facility's Notice of Transfer/Discharge on 12/6/2024. 2. The center identified that all residents in the Center that are transferred/discharged from the facility have the potential to be affected by the same deficient practice. 3. Review of transfers/discharges for the past 6 months/since last transfer/discharge identified to not have been mailed was mailed to resident/resident's representative by the receptionist on 12/23/24. 4, The NHA will review all resident transfers/discharges from the prior day, at the morning start-up meeting, to ensure the written notice of transfer/discharge has been mailed/emailed to the	

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F 623	Continued From page 4 A record review of the "Admission Record" revealed the facility initially admitted Resident #47 on 03/26/2020 and she had current diagnoses including Sepsis. A record review of Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/26/2024 revealed Resident #47 was discharged from the facility to an acute hospital. Resident #65 A record review of the "Admission Record" revealed the facility initially admitted Resident #65 on 05/04/2023 with diagnoses including Acute Respiratory Failure. A record review of Resident #65's Discharge MDS with an ARD of 10/09/2024 revealed Resident #65 was discharged to an acute hospital. Resident #69 A record review of the "Admission Record" revealed the facility admitted Resident #69 on 05/13/2024 with diagnoses including Paraplegia. A record review of the Discharge MDS with an ARD of 08/15/2024 revealed Resident #69 was discharged to an acute hospital.	F 623	resident/resident's representative beginning 12/6/2024 for 12 weeks. To monitor the performance of our corrective action and to assure sustainability, the NHA will review resident transfer/discharge notices 5 days per week x 12 weeks to ensure timely written notification to resident/resident's representative of transfer/discharge, beginning 12/6/2024--any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 1/2/2025, by the NHA for review and revision as necessary	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or	F 625		1/6/25

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F 625	Continued From page 5 the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to provide written notification of the facility's bed hold policies and information at the time of the transfer to the resident or the Resident Representative (RR) for three (3) of (3) residents reviewed for hospitalizations. (Residents #47, #65, and #69). Findings included: A review of the facility's "Bed Hold Policy", revised November 1, 2016, revealed, "(Proper Name of Facility) shall permit each resident to remain at	F 625	1. The receptionist mailed the written Bedhold Notices on 12/19/2024 via Certified Mail to the resident/Resident's representatives for residents # 47 for transfer date 10/26/2024, #65 for transfer date 10/09/2024, and #69 for transfer date 08/15/2024l. 2. The center identified that all residents in the Center that require a Bedhold Notice due to being transferred/discharged from the facility have the potential to be affected by the same deficient practice.	

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F 625	Continued From page 6 the center and not transfer or discharge the resident from the center except in accordance with federal and state laws and as directed in this policy ...Notice Requirements ...4 ...Before (Proper Name of Facility) transfers or discharges the Resident, it shall notify the Resident and the Resident's Representative of the basis for the transfer or discharge in a language and manner they understand ..." During an interview on 12/04/2024 at 10:30 AM, the Social Services Director explained she was told by the Regional Business Office Consultant not to mail or provide the RR's with written notification regarding the facility's bed hold policies and information. She stated she was told the company policy did not require written notification and that representatives could be contacted by phone. The Social Services Director reported she had stopped mailing bed hold notifications six (6) months ago. During an interview on 12/05/2024 at 9:00 AM, the Administrator revealed he was unaware the Social Services Director had stopped mailing bed hold notification information to RRs. He stated the facility would resume mailing bed hold notification to RR's immediately. Resident #47 A record review of the "Admission Record" revealed the facility initially admitted Resident #47 on 03/26/2020 and she had current diagnoses including Sepsis. A record review of Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/26/2024 revealed Resident #47 was	F 625	3. The Receptionist reviewed of Bedhold Notices for the past 6 months/since last transfer/discharge identified and for those that had not been mailed was mailed to resident/resident's representative by the receptionist on 12/23/24. The Nursing Home Administrator (NHA) in-serviced the receptionist to ensure all residents and/or their resident representative must be informed in writing of the Facility's Bedhold Notice on 12/6/2024. 4. The NHA will review, beginning 12/6/2024 5 times a week for 12 weeks, all resident transfers/discharges from the prior day, at the morning start-up meeting, to ensure the written notice of bedhold has been mailed to the resident/resident's representative. To monitor the performance of our corrective action and to assure sustainability, the NHA will review resident transfer/discharge notices 5 days per week x 12 weeks to ensure timely written notification to resident/resident's representative of the Facility's Bedhold Notice, beginning 12/6/2024--any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 1/2/2025, by the NHA for review and revision as necessary.	

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F 625	Continued From page 7 discharged from the facility to an acute hospital. Resident #65 A record review of the "Admission Record" revealed the facility initially admitted Resident #65 on 05/04/2023 with diagnoses including Acute Respiratory Failure. A record review of Resident #65's Discharge MDS with an ARD of 10/09/2024 revealed Resident #65 was discharged to an acute hospital. Resident #69 A record review of the "Admission Record" revealed the facility admitted Resident #69 on 05/13/2024 with diagnoses including Paraplegia. A record review of the Discharge MDS with an ARD of 08/15/2024 revealed Resident #69 was discharged to an acute hospital.	F 625		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death.	F 640		1/6/25

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F 640	Continued From page 8 (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to transmit	F 640	1. The Minimum Data Set (MDS) discharge assessment with Assessment	

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F 640	Continued From page 9 a discharge Minimum Data Set (MDS) assessment in a timely manner for one (1) of twenty-one (21) MDS assessments reviewed. (Resident #86) Findings included: A review of the facility's policy "MDS and Care Plan", effective August 2019, revealed, " ...Care plans and MDS will be developed and maintained per RAI (Resident Assessment Instrument) Guidelines." A record review of the "Admission Record" revealed the facility admitted Resident #86 on 7/2/24 with current diagnoses including Spastic Hemiplegia Affecting Left Non-Dominant Side. A record review of the Discharge Minimum Data Set (MDS) in the electronic medical record with an Assessment Reference Date (ARD) of 08/06/2024 revealed Resident #86 discharged home, however, it was not electronically submitted. During an interview on 12/05/2024 at 10:05 AM, Licensed Practical Nurse (LPN) #3 stated that the corporate nurse was responsible for submitting the discharge MDS. LPN #3 confirmed the corporate nurse completed the discharge MDS but failed to submit it to Centers for Medicare and Medicaid Services (CMS). During an interview on 12/05/2024 at 10:30 AM, Registered Nurse (RN) #2 confirmed she failed to submit the discharge MDS for Resident #86. RN #2 stated she did not know how she missed it. During an interview on 12/05/2024 at 10:45 AM,	F 640	Reference Data (ARD) 8/6/24 was submitted for resident #86 on 12/6/2024 by MDS Nurse. 2. The center identifies that all residents with completed Minimum Data Sets are at risk for the same deficient practice. 3. A review of all MDSs completed for the past 4 months to date (August-December 2024) to ensure all were submitted timely on 12/6/2024 by MDS Nurse. All MDSs completed for past 4 months were submitted timely. 1:1 education with Nurses, completing MDSs, regarding guidelines of timing of completion and submission by Director of Nursing Services on Friday, December 6, 2024. MDS Nurses will complete and submit MDSs at least weekly to ensure they are submitted timely within the guidelines. 4. To monitor the performance of our corrective action and to assure sustainability, the MDS Nurse will review all MDSs ARD and submission 3 days per week x 12 weeks to ensure timely submission beginning 12/6/2024. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 1/2/2025, by the MDS Nurse for review and revision as necessary.	

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F 640	Continued From page 10 the Director of Nursing (DON) stated she did not know the MDS was not submitted and expected MDS assessments to be submitted timely.	F 640		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		1/6/25

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F 656	Continued From page 11 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to develop care plan interventions related to triggers for a resident diagnosed with Post-Traumatic Stress Disorder (PTSD) (Resident #27) and failed to implement care plan interventions related to enhanced barrier precautions (EBP)(Resident #203) for two (2) of (21) sampled residents. Findings included: A review of a statement provided by the facility titled "MDS (Minimum Data Set) and Care Plans," effective August 2019, revealed, "Policy: Care plans and MDS will be developed and maintained per RAI (Residential Assessment Instrument) Guidelines." A review of the facility's Social Services Manual", undated, revealed, " ...Trauma-informed care is an approach to providing care to trauma survivors ...Incorporating their story into the care plan and daily care is key to successfully caring for patients and residents who have experienced trauma ..."	F 656	1. IDT (Interdisciplinary Team) developed care plan interventions related to Resident #27 Post Traumatic Stress Disorder (PTSD) triggers on 12/5/24. Enhanced Barrier Precautions (EHP) interventions were put into place 12/5/24 for resident #203 and Occupational Therapist (OT)was in-serviced on EBP when providing care for resident #203 by DNS on 12/6/2024. 2. All residents with PTSD has the potential to be affected by same deficient practice. All residents with Enhanced Barrier Precautions has the potential to be affected by deficient practice. 3. An audit of all residents with PTSD was conducted by Director of Nursing Services (DNS)and Social Service Director (SSD) on 12/5/24 and interview was conducted with each to determine triggers with care plans updated to reflect triggers by IDT. All residents with Enhanced Barrier Precautions has the potential to be affected by deficient practice. An audit by DNS was conducted	

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F 656	Continued From page 12 Resident #27 A record review of Resident #27's Comprehensive Care Plan with a date initiated of 7/5/2017 revealed the care plan included forgetfulness, memory loss, and short-term memory impairment related to PTSD, but no triggers were identified in the interventions. During an observation and interview on 12/02/2024 at 12:11 PM, Resident #27 was lying in bed and reported he had PTSD due to his service in the Vietnam War. He explained that his triggers included gunfire and hearing people grunting or moaning as if being hurt. During an interview on 12/03/2024 at 11:55 AM, Licensed Practical Nurse (LPN) #1 stated Resident #27 had always been pleasant and cooperative with medications. She reported being unaware of the resident's PTSD triggers and noted that the care plan only mentioned a history of PTSD but did not include specific triggers. A record review of the "Admission Record" revealed the facility admitted Resident #27 on 07/01/2016 with current diagnoses including Post-Traumatic Stress Disorder (PTSD), chronic, with an onset date of 08/09/2016. A record review of the "Order Summary Report" with active orders as of 12/5/2024 revealed Resident #27 had a Physician's Order, dated 5/31/2023 for Ritalin (5) milligrams (mg) twice daily for PTSD. A record review of a "Behavioral Health Progress Note", dated 6/29/2023, revealed Resident #27 had "Subjective Interim History" completed that	F 656	for residents with need for EBP and education to staff was provided by DNS/Assistant Director of Nursing Services (ADNS) on 12/6/24. DNS/ADNS in-serviced IDT on PTSD triggers and EBP care plan development and implementation for residents on 12/6/24. DNS/ADNS in-serviced staff on implementation of care plan for PTSD triggers and EBP on 12/6/24. Occupational Therapist (OT)was in-serviced on EBP when providing care for resident #203 by DNS on 12/6/2024. 4. To monitor the performance of our corrective action and to assure sustainability, the DNS/ADNS/Director of Clinical Education (DCE) will review 5 residents 3 days per week x 12 weeks ensure PTSD triggers and EBP care plan development and implementation for residents beginning 12/9/2024. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 1/2/2025, by the DNS for review and revision as necessary.	

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F 656	Continued From page 13	F 656		

indicated he had " ...PTSD that stemmed from serving in Vietnam war in the Marine Corp ...

Resident #203

A record review of Resident #203's Comprehensive Care Plan with a review start date of 11/26/2024, included enhanced barrier precautions related to tracheostomy status, with interventions requiring staff to wear gowns and gloves when rendering care.

During an observation on 12/02/2024 at 10:55 AM, an Occupational Therapist (OT) was in Resident #203's room and was providing hand therapy and applying moisturizer to the resident's lips. The resident, who was non-verbal, had a tracheostomy in place and a feeding pump infusing. A sign on the resident's door indicated "Enhanced Barrier Precautions," with a picture of the required Personal Protective Equipement (PPE) to wear during care. PPE, including gowns and gloves, was available on the hall and at other residents' doors. The OT was observed wearing gloves and a surgical mask but no gown.

During an interview on 12/03/2024 at 12:15 PM, the OT confirmed providing therapy for Resident #203 on 12/02/2024, including hand exercises and oral care. She admitted she did not wear a gown while providing care.

On 12/03/2024 at 3:00 PM, during an interview with LPN #3/Care Plan nurse, she confirmed that Resident #27's care plan did not identify any PTSD triggers. She was unaware of the need to list or identify triggers on the care plan. She stated that care plans are the guide for providing care and staff are expected to follow the care

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F 656	Continued From page 14 plan to provide the highest functional care for residents. She also confirmed Resident #203 had a care plan intervention for EBP to include wearing a gown while providing care. During an interview on 12/03/2024 at 3:20 PM, the Director of Nursing (DON) stated social services was responsible for evaluating PTSD and identifying triggers. She was unaware that Resident #27's care plan did not include PTSD triggers. She acknowledged that triggers must be identified to provide quality care and prevent re-traumatization of the resident. The DON also confirmed the OT did not implement the care plan intervention to wear a gown as EBP when providing care to Resident #203. A record review of the "Admission Record" revealed the facility admitted Resident #203 on 08/26/2024 with diagnoses including Gastrostomy Status and Encounter for Attention to Tracheostomy. A record review of the "Order Summary Report" revealed Resident #203 had a Physician's Order, dated 11/20/24 for OT and a Physician's Order dated 12/3/24 for enteral feedings.	F 656		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.	F 699		1/6/25

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F 699	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility Social Services Manual review, the facility failed to ensure triggers and resident-specific interventions were identified and initiated for a resident with Post-Traumatic Stress Disorder (PTSD) for one (1) of 21 sampled residents, Resident #27. Findings included: A review of the facility's Social Services Manual", undated, revealed, " ...Trauma-informed care is an approach to providing care to trauma survivors. Trauma-informed care recognizes the experiences endured by survivors, responds to their needs, and helps them on their path ... Safety ...Survivors of trauma need to feel safe and have a low-stress environment ... Care for the Traumatized Patient ...Recognizing the many experiences of a trauma survivor is essential to their care ...Incorporating their story into the care plan and daily care is key to successfully caring for patients and residents who have experienced trauma ..." A record review of the "Admission Record" revealed the facility admitted Resident #27 on 07/01/2016 with current diagnoses including Post-Traumatic Stress Disorder (PTSD), chronic, with an onset date of 08/09/2016. A record review of the "Order Summary Report" revealed Resident #27 had a Physician's Order, dated 5/31/2023 Ritalin 5 milligrams (mg) twice daily for PTSD. A record review of the Quarterly Minimum Data	F 699	1. IDT (Interdisciplinary Team) developed care plan interventions related to Resident #27 Post Traumatic Stress Disorder (PTSD) triggers on 12/5/24. 2. The center identifies that all new or current residents with PTSD has the potential to be affected by same deficient practice. 3. An audit of all residents with PTSD was conducted by Director of Nursing Services (DNS)and Social Service Director (SSD) on 12/5/24 and interview was conducted with each to determine triggers with care plans updated to reflect triggers by IDT. DNS/ADNS (Assistant Director of Nursing Services) in-serviced IDT on PTSD triggers identification and implementation for residents on 12/6/24. DNS/ADNS in-serviced staff on implementation of care plan for PTSD triggers on 12/6/24. 4. To monitor the performance of our corrective action and to assure sustainability, the DNS/ADNS will review 5 residents 3 days per week x 12 weeks to ensure PTSD triggers are identified, care planned and communicated to staff for residents beginning 12/9/2024. The DNS/ADNS will review all new admissions daily x 12 weeks to ensure PTSD triggers are identified, care planned and communicated to staff for residents beginning 12/9/2024. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 1/2/2025, by the DNS	

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F 699	Continued From page 16 Set (MDS) with an Assessment Reference Date (ARD) of 11/20/2024 revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of eleven (11), which indicated moderate cognitive impairment. Section I-Active Diagnoses listed PTSD as an active diagnosis. A record review of Resident #27's Certified Nurse Aide (CNA) Kardex revealed there were no triggers listed for PTSD. A record review of Resident #27's medical record revealed no documentation indicating the resident was evaluated to identify triggers and resident-specific interventions related to PTSD. A record review of a "Behavioral Health Progress Note", dated 6/29/2023, revealed Resident #27 had "Subjective Interim History" completed that indicated he had " ...PTSD that stemmed from serving in Vietnam war in the Marine Corp ..." On 12/02/2024 at 12:11 PM, during an observation and interview, Resident #27 was lying in bed and reported he had PTSD due to his service in the Vietnam War. He explained that his triggers included gunfire and hearing people grunting or moaning as if being hurt. On 12/03/2024 at 11:20 AM, during an interview with CNA #1, she stated Resident #27 did not have problems receiving care and was always cooperative. She reported being unaware of any PTSD triggers for the resident and confirmed that no triggers were listed on the Kardex or care plan in his electronic medical record. At 11:55 AM on 12/03/2024, during an interview with Licensed Practical Nurse (LPN) #1, she	F 699	for review and revision as necessary.	

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F 699	Continued From page 17 stated Resident #27 had always been pleasant and cooperative with medications. She reported being unaware of the resident's PTSD triggers and noted that the care plan only mentioned a history of PTSD but did not include specific triggers. On 12/03/2024 at 2:45 PM, during an interview with the Social Services Director (SSD), she explained that when a resident is diagnosed with PTSD, assessments regarding PTSD are the responsibility of nursing. She stated she refers residents with PTSD for one-on-one consultations and to the psychiatrist if needed. She acknowledged the importance of identifying PTSD triggers to prevent re-traumatization. On 12/03/2024 at 3:20 PM, during an interview with the Director of Nursing (DON), she stated social services was responsible for evaluating PTSD and identifying triggers. She was unaware that Resident #27's care plan did not include PTSD triggers. She acknowledged that triggers must be identified to provide quality care and prevent re-traumatization of the resident. On 12/05/2024 at 2:00 PM, during an interview with the Administrator, he stated residents diagnosed with PTSD are expected to receive trauma-informed care to prevent re-traumatization.	F 699		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		1/6/25

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F 812	Continued From page 18 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to store food in accordance with professional standards for food safety related to foods not labeled, food with no identified date, exposed foods, a scoop left in the flour bin, and an unclean ice machine for one (1) of two (2) kitchen observations. Findings included: A record review of the facility's policy, "Refrigerated Storage," effective June 1, 2013, revealed, "It is the policy of this facility to store, prepare, and serve foods in accordance with federal, state, and local sanitary codes... 7. All foods will be properly wrapped and/or stored in sealed containers and dated and labeled." A record review of the facility's policy, "Dry Storage," effective August 1, 2012, revealed, " ...8. Scoops will not be stored in bulk containers."	F 812	1. The Dietary Manager (DM) took the ice machine in the kitchen out of service on 12/2/2024. The six (6) trays containing portioned glasses of various liquids were labeled and dated by the DM on 12/2/2024. The open bag of breaded chicken strips was discarded by the DM on 12/2/2024. The open bag of hamburger buns was discarded by the DM on 12/2/2024. The scoop in the flour bins was removed by the DM on 12/2/2024. The open bag of dehydrated onions and the 3 open spice jars were discarded by the DM on 12/2/204. The bottle of lemon juice that was not refrigerated was discarded by the DM on 12/2/2024 2. The center identified that all residents in the center, who receive meals from the dietary department, have the potential to be affected by the same deficient practice.	

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F 812	Continued From page 19 On 12/02/2024 at 10:22 AM, during an observation and interview of the kitchen with the Dietary Director (DD), the ice machine revealed dirt-like stains along the interior, in contact with the ice. When the DD wiped the soiled areas with a white towel, the smudge transferred onto the towel. An observation of Refrigerator #2 revealed six (6) trays containing portioned glasses of various liquids with no label or date. Freezer #1 was observed to contain one (1) opened bag of breaded chicken strips, leaving the food exposed, with no date. An observation of the pantry revealed one (1) opened bag containing six (6) hamburger buns, left exposed, and a scoop left in the flour bin, touching the flour. Additionally, one (1) opened bag of dehydrated onions was left exposed. On the spice rack, three (3) spice jars were noted with the lids open, leaving the spices exposed. A bottle of lemon juice was noted with manufacturer's instructions to refrigerate after opening, but it was left unrefrigerated. The DD confirmed the dirt-like stains inside the ice machine, undated food, exposed foods, and the scoop left in the flour bin. She stated she was responsible for monitoring food safety but admitted she had tried to clean the ice machine unsuccessfully. The DD reported she did not know the nature of the stains and had not tested the machine for bio-growth, as the Maintenance Director was responsible for such checks. On 12/02/2024 at 10:52 AM, during an interview, Cook #1 stated that cooks are responsible for monitoring food safety and labeling. The cook confirmed that staff are in-serviced monthly on food safety. On 12/05/2024 at 9:08 AM, during an interview, the Administrator he had been told of the issues	F 812	3. The DM was in-serviced by the District Manager of dietary services on the proper labeling, dating, storage, and cleaning of the kitchen areas on 12/5/24. DM in-serviced dietary staff on the proper labeling, dating, storage, and cleaning of the kitchen areas on 12/5/24. 4. To monitor the performance of our corrective action and to assure sustainability, the DM will review all storage areas, freezers, cooler, and the ice machine 5 x per week x 12 weeks to ensure all items within the kitchen are properly stored in a sanitary manner. The DM or the Dietary Manager in Training will monitor 5 x per week for 12 weeks sanitations rounds for 12 weeks to ensure proper storage, dating, labeling, and the ice machine are correct and maintained in a sanitary condition, beginning 12/6/2024. Any negative findings will be brought by the DM to the QAPI (Quality Assurance Performance Improvement) meeting monthly beginning 1/2/2025 for a minimum of three months or until substantial compliance noted.	

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F 812	Continued From page 20 observed in the kitchen. He stated he would ensure, through self-monitoring, that the DD maintains food quality and sanitation in the kitchen. He also stated he would implement a strong plan of correction to address unsafe food storage.	F 812		
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 21 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 interviews, record reviews, and facility policy reviews, the facility failed to follow infection control practices by not	F 880	1. Enhanced Barrier Precautions (EBP) interventions were put into place 12/5/24 for resident #203, at high risk for Multidrug	

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F 880	Continued From page 22 implementing Enhanced Barrier Precautions (EBP) for a resident at high risk for Multidrug-resistant Organisms (MDRO) for one (1) of 21 sampled residents. (Resident #203) Findings included: A review of the facility's policy "Transmission Based Precaution", dated 2022, revealed, " ...Enhanced Barrier Precautions recommendation is to consider expanding the use of PPE (Personal Protective Equipment) and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk ..." A record review of the "Admission Record" revealed the facility admitted Resident #203 on 08/26/2024 with diagnoses including Gastrostomy Status and Encounter for Attention to Tracheostomy. A record review of the "Order Summary Report"with active orders as of 12/4/24 revealed Resident #203 had a Physician's Order, dated 11/20/24 for Occupational Therapy (OT) and a Physician's Order dated 12/3/24 for enteral feedings. On 12/02/2024 at 10:55 AM, observed an Occupational Therapist in Resident #203's room. The Occupational Therapist was providing hand therapy and applying moisturizer to the resident's lips. The resident, who was non-verbal, had a	F 880	Resistant Organisms (MDRO), and Occupational Therapist (OT)was in-serviced on EBP when providing care for resident #203 by Director of Nursing Services (DNS) on 12/6/2024. 2. All residents at high risk for Multidrug Resistant Organisms (MDRO) with Enhanced Barrier Precautions has the potential to be affected by deficient practice. 3. An audit by DNS was conducted for residents with need for EBP and education to staff was provided by DNS/Assistant Director of Nursing Services (ADNS) on 12/6/24. DNS/ADNS in-serviced staff on following EBP on residents identified at high risk for MDRO and EBP needs on 12/6/24. Occupational Therapist (OT)was in-serviced on EBP when providing care for resident #203 by DNS on 12/6/2024. 4. To monitor the performance of our corrective action and to assure sustainability, the DNS/ADNS/Director of Clinical Education (DCE) will review 5 residents 3 days per week x 12 weeks to ensure EBP implementation for residents beginning 12/9/2024. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 1/2/2025, by the DNS for review and revision as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255174	A. BUILDING _____ B. WING _____	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 23	F 880		

tracheostomy in place and a feeding pump infusing. A sign on the resident's door indicated "Enhanced Barrier Precautions," with a picture of the required PPE to wear during care. PPE, including gowns and gloves, was available on the hall and at other residents' doors. The OT was observed wearing gloves and a surgical mask but no gown.

On 12/02/2024 at 2:30 PM, during an interview with Registered Nurse (RN) #1, she explained all residents with wounds, gastrostomy tubes, tracheostomies, or catheters were on EBP, which are designed to protect residents from infections brought in by staff. She confirmed all staff, including therapy staff, had been in-serviced on enhanced barrier precautions and stated the OT should have worn a gown while providing care for Resident #203.

On 12/03/2024 at 12:15 PM, during an interview with the OT, she confirmed providing therapy for Resident #203 on 12/02/2024, including hand exercises and oral care. She admitted she did not wear a gown while providing care. She stated she was aware of the enhanced barrier signage and had been educated on the purpose of enhanced barrier precautions, which is to prevent residents from contracting infections from staff. She explained she only wears PPE when the PPE is located on the resident's door itself, but confirmed PPE was readily available on the hall.

On 12/03/2024 at 3:20 PM, during an interview with the Director of Nursing (DON), she confirmed that staff are expected to follow proper infection precautions while providing care. She stated the OT should have worn a gown while providing therapy at the bedside for a resident

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F 880	Continued From page 24 with a gastrostomy tube and tracheostomy. She reported that PPE was readily available on the hall, noting that the absence of PPE hanging on the door was not a valid reason to omit proper precautions.	F 880		