STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255324	A. BUILDING _____ B. WING _____	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRUCE COMMUNITY LIVING CENTER	176 HIGHWAY 9 SOUTH BOX 1280 BRUCE, MS 38915

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification and a complaint investigation (CI MS #26616) survey at the facility from October 28, 2024 to October 30, 2024. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies F578, F623, F656, and F677. CI MS #26616 was investigated, the SA determined the facility was in compliance, and there were no deficiencies cited related to the complaint. The facility's census at the time of the survey was 27 with a bed capacity of 35 beds.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578		11/21/24

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

Electronically Signed | 11/15/2024

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F 578	Continued From page 1 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, record review, and facility policy review, the facility failed to consult with a cognitively intact resident about his Advance Directives, which resulted in a conflict between his documented preferences and his actual wishes for one (1) of sixteen (16) residents reviewed. Resident #6. Findings Included: Record review of the facility policy with reviewed date of 11/2022 and titled, "Advance Directives" revealed "The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment....1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her	F 578	On 10/29/24 Resident #6 was identified that the facility failed to consult with him on his Advances Directives. Resident #6, being of sound mind and cognitively intact with a Brief Interview for Mental Status score of 13 has the right and must be given the ability to formulate an advance directive of his choice. Social Service Director and Administrator met with Resident #6 to update his advanced directives to his personal choice. The alleged deficient practice has the potential to affect all residents. Social Service Director and Administrator performed an audit of all advanced Directive forms on 10/29/24.	

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F 578	Continued From page 2 legal representative, about the existence of any written advance directives.....2. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so.....5. If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative...." An interview on 10/28/24 at 10:50 AM, with Resident #6 revealed that his brother signed the admission paperwork. He revealed that he didn't remember anyone discussing Cardiopulmonary Resuscitation (CPR) with him or asking him what his wishes were regarding resuscitation if he stopped breathing. Resident #6 confirmed that he did not know that his brother signed for him to be a DNR (Do Not Resuscitate). He confirmed that if he quit breathing, he wanted them to do CPR and everything they could to save him. An interview on 10/29/24 at 8:40 AM, with the Social Services Director (SSD) stated that Resident #6's representative signed the "Code Status" form marked DNR at the time of admission and confirmed that she did not discuss CPR options with Resident #6. The SSD revealed that Resident #6 was cognitively intact and should have been asked about his wishes. He should have made the choice and signed his own Advanced Directive. An interview on 10/29/24 at 8:45 AM, with the Administrator (ADM) confirmed that they were supposed to ask the residents about their code status choice and get them to sign if they were	F 578	On 10/29/24 the Administrator in-serviced Social Service Director on policy for Advanced Directives and Code Status during Admission Process. On 10/29/24 Administrator did an in-service to the Social Service Director on Residents Rights Policy and Procedure. On 10/29/24 Administrator and Social Service Director audited all current medical records to ensure correct code status was implemented by the facility, issues were corrected immediately. Starting 10/29/24 all current resident medical records were audited to ensure a copy of the Advanced Directives was placed on the medical record for all current residents, issues identified, and Responsible Representatives and/or Power of Attorney were notified of chances made by cognitive intact residents. The Medical Director was also made aware of all the findings. On 10/29/24 Administrator to review all new admissions and change in status weekly for 4 weeks, bi-weekly for 2 weeks, monthly for 3 months to ensure the correct code status and advanced directive are accurately reflected in the resident charts and orders. And that all cognitively intact residents were active participants in making decisions regarding their care, treatment and advanced directives. The administrator will report results of the audit to the Quality Assurance Performance Improvement Committee (QAPI) monthly for 3 months starting on 11/21/24 (November QAPI meeting date with MD)	

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F 578	Continued From page 3 cognitively intact. She confirmed that Resident #6 was cognitively intact and capable of making his own decisions. ADM revealed that Resident #6 should have been asked about this choice and should have signed his own advanced directive on admission. Record review of Resident #6's "Code Status" form revealed that his representative initialed the "Do Not Attempt Resuscitation "choice and signed it on 08/19/24. Record review of Resident #6's "Physician Orders" revealed an order effective 08/19/24 which revealed, "Do Not Resuscitate in case of Arrest...." Record review of Resident #6's "Admission Record" revealed an admission date of 08/19/24 with diagnoses that included Syncope and Collapse, End Stage Renal Disease, and Anemia. Record review of Resident #6's "Care Plan" revealed "I am a DNR (Do Not Resuscitate)" Record review of Resident #6's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 08/23/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated that he was cognitively intact.	F 578		
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	F 623		11/21/24

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F 623	Continued From page 4	F 623		

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 (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:

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F 623	Continued From page 5 (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; (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.	F 623		

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F 623	Continued From page 6 §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 interviews, record review, and facility policy review, the facility failed to provide written notification of discharge/transfer to the resident and/or resident representative (RR) upon transfer to the hospital for two (2) of two (2) residents reviewed for hospitalization. Resident #15 and Resident #30. Findings include: Review of the facility policy titled "Notice of a Transfer and/or Discharge" dated February 26, 2003, revealed " ...3. The resident, and/or representative (sponsor) will be provided with the following information: a. The reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The location to which the resident is being transferred or discharged". Resident #15 Record review of Resident #15's Progress Notes dated 8/2/24 revealed the resident was transported to the Emergency Room accompanied by two facility staff members. Record review revealed there was no	F 623	On 10/29/24 it was identified that the facility failed to provide proper discharge/transfer notice to Resident # 15 and Resident # 30. Both residents were transferred to the emergency room for decline in medical conditions. Residents # 15 and # 30 were provided the correct documentation on the day the deficient practice was found. The alleged deficient practice has the potential to affect all residents. The Social Service Director and Administrator performed an audit of all Residents that transferred out of facility to ensure correct transfer/discharge notices were given 10/29/24. On 10/29/24 the Administrator in-serviced Social Service Director on Policy and Procedure for Discharge/Transferring of Residents and Bed Hold when transferred outside of Facility. On 10/29/24 Administrator did an in-service to the Social Service Director on Residents Rights Policy and Procedure. On 10/29/24 Administrator and Social Service Director	

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F 623	Continued From page 7 transfer/discharge notification for Resident #15's transfer to the Emergency Room on 8/2/24. Record review of Resident #15's "Admission Record" revealed that he was admitted to the facility on 06/03/2024 with diagnoses that included a Personal History of Traumatic Brain Injury, and Hydrocephalus. Resident #30 Record review of the "Progress Notes" for Resident #30 revealed on 8/6/24 that the resident was transferred to the Emergency Room. Record review revealed there was no transfer/discharge notification for Resident #30's transfer to the Emergency Room on 8/6/24. On 10/29/24 at 11:37 AM, an interview with the Administrator (ADM) revealed that the facility failed to mail a written transfer/discharge notification to the Resident Representative (RR) for both Resident #15 and Resident #30 when they were transferred to the hospital. An interview on 10/29/24 at 3:00 PM, the Social Services Director (SSD) confirmed she was unaware that a copy of the transfer/discharge notification was supposed to be mailed to the Resident's RRs, but she would make sure to get them sent out from now on. Record review of the "Admission Record" revealed the facility admitted Resident #30 on 07/25/24 with medical diagnoses that included Aphasia and Metabolic Encephalopathy.	F 623	audited all current medical records to ensure Discharge/Transfer forms and bed hold forms were implemented by the facility, issues were corrected immediately. Starting 10/29/24 all current resident medical records were audited to ensure a copy of the Transfer/Discharge Notice were placed on the medical record chart for all current residents, issues identified, Residents, Responsible Representatives and/or Power of Attorney were notified of Residents Rights to be informed of Transfer/Discharge Notice. The Medical Director was also made aware of all the findings. On 10/29/24 Administrator to review all Discharges and Transfers weekly for 4 weeks, bi-weekly for 2 weeks, monthly for 3 months to ensure the correct Discharge/transfer and bed hold forms are provided to Resident/Responsible Representatives. The Administrator will report results of the audits to the Quality Assurance Performance Improvement Committee (QAPI) monthly for 3 months starting on 11/21/24 (November QAPI meeting date with MD)	
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		11/21/24

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F 656	Continued From page 8 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 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.	F 656		

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F 656	Continued From page 9 (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, staff interviews, record review, and facility policy review the facility failed to implement a comprehensive care plan for residents who required assistance with Activities of Daily Living (ADL) for two (2) of thirteen sampled residents. Resident #3 and Resident #4. Findings include: Review of the facility policy titled "Care Plan - Comprehensive" undated, revealed, "Policy Statement: It is the policy of this facility to develop comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs...Procedure: 1. An interdisciplinary team, in coordination with the resident and his/her family or representative, develops and maintains a comprehensive care plan for each resident". Resident #3 A record review of Resident #3's care plan revealed, "I have an ADL self-care performance deficit ...Interventions/Tasks ... Please shave when needed per my request ... Check nail length and trim and clean on bath day and as necessary".	F 656	The identified residents #3 and #4 were provided a bed bath to include cleansing of their hair, trimming and cleaning her fingernails and the removal of facial hair on 10/30/24 by a certified nursing assistant. On 10/30/24 a complete audit was completed on all residents in the facility who have care plans that require assistance with Activities of Daily Living by the Minimum Data Set (MDS) Coordinator and the Administrator. All residents have the potential to be affected by the deficient practice. The administrator completed an in-service on 11/01/24 to educate staff on following residents Care Plans. The Assistant Director of Nursing included focuses on ensuring that any resident who requires assistance with Activities of Daily Living should receive nail care, facial grooming, and hair washed. The Director of Nursing/ Assistant Director of Nursing will monitor Care plans through rounds and review of care plans for resident requiring assistance with	

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F 656	Continued From page 10 On 10/28/24 at 10:50 AM, observation of Resident #3 revealed sporadic facial hair approximately one-half (1/2) inch long to the chin and above the upper lip and sides of her mouth. Fingernails on bilateral hands were approximately one-fourth (1/4) inch long and jagged past the tips of her fingers with a brown substance under the fingernails. On 10/28/24 at 4:40 PM, an interview and observation Registered Nurse (RN) #1 confirmed Resident #3's facial hair needed to be shaved, and her fingernails needed to be cleaned and filed. She confirmed the resident's ADL care plan was not being followed, and it should have been. In an interview on 10/29/24 at 10:10 AM, the Director of Nurses (DON) confirmed that Resident #3's ADL care plan was not being followed, and it should have been. During an interview on 10/30/24 at 11:46 AM, the Minimum Data Set (MDS) Coordinator revealed she and the team are responsible for developing the resident's individualized person-centered care plan. She revealed that when the residents were not being shaven and their nails cleaned and trimmed, then their ADL care plan was not being followed. She also revealed that everyone wants to look nice and neat, and the facility is responsible for ensuring this is being done. Record review of Resident #3's "Admission Record" revealed the resident was admitted to the facility on 04/06/2022 with medical diagnoses that included Chronic Obstructive Pulmonary Disease, Osteoporosis with current pathological fracture, and Paroxysmal Atrial fibrillation.	F 656	Activities of Daily Living one time per week for three weeks then monthly for three months beginning 11/05/24. All findings will be reported to the monthly Quality Assurance Performance Improvement Committee meeting beginning 11/21/24 and will continue monthly for three months then as needed for revision and review.	

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F 656	Continued From page 11 Resident #4 Record review of Resident #4's "Care Plan" revealed that she had an ADL self-care performance deficit with interventions that included checking nail length and trim and clean on bath day and as necessary. On 10/28/24 at 10:45 AM, observation and interview revealed Resident #4 lying in bed with long, jagged fingernails approximately one-half inch long past the tips of her fingers bilaterally with a brown substance underneath. Resident #4 also had two dime size patches of white curly hair on her left and right lower jaw area. On 10/28/24 at 4:35 PM, observation and interview with RN #1 confirmed that Resident #4's fingernails were long and jagged with a brown substance underneath and that she had facial hair. RN #1 revealed that nail care, shaving and oral care were all included in personal hygiene provided in the Care Plan and confirmed that since it was not done, then they did not follow the care plan. Record review of Resident #4's "Admission Record" revealed an original admission date of 09/28/23 and diagnoses that included Peripheral Vascular Disease and Muscle Weakness. Record review of Resident #4's MDS with Assessment Reference Date (ARD) of 10/10/24 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 03 which indicated that she had severe cognitive deficits.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		11/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255324	A. BUILDING _____ B. WING _____	10/30/2024

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F 677	Continued From page 12 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident/family and staff interviews, record review, and facility policy review, the facility failed to provide care to maintain hygiene, as evidenced by the failure to provide shaving and nail care for two (2) of the 27 residents reviewed. Resident #3 and Resident #4. Findings include: Review of the facility policy titled "Shaving the Resident," with a revised date of August 25, 2014, revealed, "The purpose of this procedure is to promote cleanliness and to provide skin care." Review of the facility policy titled "A.M. Care (Day Tour of Duty) dated August 25, 2014, revealed "Purpose: 1. To refresh the resident. 2. To provide cleanliness, comfort, and neatness. Resident #3 An observation of Resident #3 on 10/28/24 at 10:50 AM, revealed sporadic facial hair approximately one-half (1/2) inch long to the chin and above the upper lip and sides of her mouth. Fingernails on bilateral hands were approximately one-fourth (1/4) inch long and jagged past the tips of her fingers with a brown substance under the fingernails. During an observation and interview on 10/28/24 at 3:35 PM, Resident #3 was lying in bed with no	F 677	The identified residents #3 and #4 were provided a bed bath to include cleansing of their hair, trimming and cleaning her fingernails and the removal of facial hair on 10/30/24 by a certified nursing assistant. On 10/30/24 a complete audit was completed on all residents in the facility who were dependent residents that require assistance with Activities of Daily Living by the Minimum Data Set (MDS) Coordinator and the Administrator. All dependent residents have the potential to be affected by the deficient practice. The Administrator and Assistant Director of Nursing completed an in-service on 11/01/24, 11/06/24 and 11/14/24 to educate staff on providing Activities of Daily Living care to dependent residents. The Director of Nursing included focuses on ensuring that any resident who is dependent on assistance with Activities of Daily Living will receive necessary services to maintain good nutrition, grooming, personal and oral care. The Director of Nursing and Assistant Director of Nursing will make rounds to perform Bath Audits on 2 residents Monday - Friday to include observations	

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F 677	Continued From page 13 change in appearance. Resident #3's sister was present in the room and revealed that she was sure her sister would like to have those facial hairs removed. An interview and observation on 10/28/24 at 4:20 PM, with the Certified Nurse Aide (CNA) #2 revealed hospice bathes the resident three days a week and the facility CNAs are responsible for the other days. She confirmed the resident's facial hair should have been shaven and her nails cleaned. In an interview and observation on 10/28/24 at 4:30 PM, with Licensed Practical Nurse (LPN) #1 revealed we've talked to the hospice staff several times about ensuring Resident #3's facial hair is shaved when they bathe her. She confirmed that the resident had long facial hair and her fingernails were jagged with a brown substance under them. She revealed that she was unsure how long it had been since the resident's facial hair had been shaved and stated, "The resident needs to be cleaned up." In an interview and observation on 10/28/24 at 4:40 PM, Registered Nurse (RN) #1 revealed we are all responsible for making sure the resident is properly groomed; even though she is on hospice services. She stated they are ultimately responsible for ensuring the resident's facial hair is shaved, and her fingernails are clean and trimmed. RN #1 confirmed Resident #3's facial hair needed to be shaved, and her fingernails needed to be cleaned and filed. Record review of Resident #3's "Admission Record" revealed the resident was admitted to the facility on 04/06/2022 with medical diagnoses	F 677	of residents grooming and hygiene such as facial hair, body odors, unkept hair and fingernail cleanliness on Dependent residents requiring assistance with Activities of Daily Living beginning 11/05/24 for 3 weeks, then 3 Bath Audits per week for 3 weeks, then weekly bath audit for 3 months. The RN/LPN Supervisors will perform rounds and two audits per shift for 3 weeks, then one round and one audit per shift for 3 weeks. All findings will be reported to the monthly Quality Assurance Performance Improvement Committee meeting beginning 11/21/24 and will continue monthly for 3 months then as needed for revision and review.	

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that included Chronic Obstructive Pulmonary Disease, Osteoporosis with current pathological fracture, and Paroxysmal Atrial Fibrillation.

Resident #4

An observation and interview on 10/28/24 at 10:45 AM, revealed Resident #4 lying in her bed with long, jagged fingernails, approximately one-half inch long past the fingertips bilaterally with brown substance underneath. Resident #4 also had two dime size patches of white curly hair on her left and right lower jaw area. She was pleasant and was fidgeting with her hair bonnet she held in her hands and when she was asked if she would like to have her facial hair removed, she stated, "I think I would."

An observation and interview with CNA #1 on 10/28/24 at 4:25 PM, revealed Resident #4 sitting up in her wheelchair across from the nurse's desk. CNA #1 confirmed that Resident #4 had long jagged fingernails with a brown substance underneath. CNA #1 also confirmed that Resident #4 had facial hair on both sides of her face that needed to be removed. CNA #1 revealed that it was the nurses' job to cut the fingernails, and the CNAs cleaned out from under the nails and took care of the facial hair. She revealed that Resident #4 was not assigned to her, but her nails should have been cleaned and her facial hair should have been removed during her bath or shower. CNA #1 revealed that long, jagged, dirty fingernails could cause infection if she scratched herself and stated, "We can get that facial hair off."

An interview on 10/28/24 at 4:35 PM with RN#1,

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F 677	Continued From page 15	F 677		

confirmed that the nurses clipped resident fingernails, and the CNAs cleaned fingernails and shaved residents during their bath or shower time. RN #1 confirmed Resident #4 had long, jagged fingernails with a brown substance underneath and they should have been taken care of. She also confirmed the two patches of facial hair on both sides of Resident #4's face and agreed that this needed to be shaved.

A phone interview with Resident #4's Resident Representative (RR) on 10/29/24 at 9:23 AM, revealed that he came to the facility and visited often. He revealed that the facility needed to do better about keeping her nails clipped. He also stated that he had noticed some facial hair and that she would want it to be removed.

An interview on 10/29/24 at 10:20 AM, with the Director of Nursing (DON), revealed that seeing facial hair on ladies was one of her "pet peeves" and agreed that facial hair on ladies should be removed. She also confirmed that resident fingernails should be clipped and kept clean.

Record review of Resident #4's "Admission Record" revealed an original admission date of 09/28/23 and diagnoses that included Peripheral Vascular Disease and Muscle Weakness,.

Record review of Resident #4's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/10/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 03 which indicated that she had severe cognitive deficits. Section GG revealed that she required substantial to maximal assistance with her personal hygiene.