STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255288	A. BUILDING _____ B. WING _____	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF QUITMAN	191 HIGHWAY 511 EAST QUITMAN, MS 39355

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and two (2) Complaint Investigations (CI MS #26660 and CI MS #27032), at the facility from 12/15/24 through 12/18/24. The SA investigated CI MS #26660 for resident/patient/client neglect, quality of care, resident/patient dignity. The SA investigated CI MS #27032, a facility reported incident, for facility resident to resident/ client abuse and cited F689. 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 F550, F656, F658, and F725. The facility had a census of 100 and was licensed for 120 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		1/14/25

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

Electronically Signed | 01/11/2025

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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure residents' rights to privacy by allowing wandering residents to enter resident rooms without invitation or permission (Resident #5 and Resident #57) and failing to cover a urinary drainage bag (Resident #74) for three (3) of 22 sampled residents. Findings included: A record review of the facility's policy titled "Resident Rights & Quality of Life Policy," dated March 13, 2020, revealed, " ...All patients and residents have the right to a dignified existence, self-determination, and communication with	F 550	1. Resident #5 and Resident #57 were provided nightstand with key lock for personal item securement by Maintenance Director on 1/8/25. On 1/10/25, stop signs were also placed on the doors of residents #5 and #57 to discourage wandering residents from coming into their rooms. Privacy covering for Resident #74 urinary drainage bag was placed 12/16/24 by the Director of Nursing Services(DNS). 2. All residents of the center who have a urinary drainage bag has the potential to be affected by the deficient practice. DNS audited all residents with urinary drainage	

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F 550	Continued From page 2 access to people and services inside and outside the center... Procedure: A patient or resident has the right ...To personal privacy and confidentiality of personal and clinical records ..." Resident #5 On 12/15/2024 at 10:37 AM, during an interview, Resident #5 stated that a female resident in a wheelchair often entered her room without permission, during the daytime and nighttime hours. She reported this to staff several times, but the behavior has continued. She explained she kept the door to her room closed at all times, whether she is in her room or not to prevent wandering residents from coming in. On 12/17/2024 at 12:05 PM, during an interview, Licensed Practical Nurse (LPN) #3 reported that Resident #5 often kept her door closed to prevent wandering residents from entering. She explained that while wandering residents frequently entered rooms, Resident #5 had not specifically complained to her about an individual resident. A record review of Resident #5's "Admission Record" revealed the facility admitted her on 08/15/2023 with diagnoses including Unspecified Mood Affective Disorder. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/29/2024 revealed in Section C, Resident #5 had a Brief Interview for Mental Status (BIMS) score of twelve (12), indicating moderate cognitive impairment. Further review of Section F revealed it was very important to her to take care of her personal belongings and things and to have a place to lock your things to keep	F 550	bags and ensured all had privacy coverings on 12/16/24. All wandering residents were assessed 12/18/24 by DNS and Assistant Director of Nursing Services (ADNS) on 12/18/24 to assure care plan interventions were in place to prevent accidents and hazards. Residents affected by violation of rights through interview will be offered a stop sign, locking night stand, or room change. 3. Social Services Director(SSD) and Activity Director interviewed all residents on 1/7/25 and 1/8/25 to ensure resident privacy was being maintained. Director of Nursing Services(DNS)/Director of Clinical Education(DCE) in-serviced staff on resident's rights and dignity to include privacy in room and privacy covering of urinary drainage bags on 1/6/25-1/9/25. Activity Director reviewed resident's rights to privacy and securement of belongings in Resident Council on 1/7/25 to residents who attended the Council meeting. 4. To monitor the performance of our corrective action and to assure sustainability, the SSD will interview/audit for resident's privacy/security and DNS will audit urinary drainage bag covering of 5 residents 3 days per week x 12 weeks beginning 12/23/24 to ensure resident's rights and dignity is provided. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 1/13/25, by the SSD or DNS for review and revision as necessary.	

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F 550	Continued From page 3	F 550		

them safe.

Resident #57

On 12/15/2024 at 10:25 AM, during an interview, Resident #57 stated that residents frequently entered his room uninvited, rummaging through his belongings. He recounted an incident in July 2024 where a resident rummaged through his snacks, causing him to fall while trying to intervene.

On 12/17/2024 at 12:20 PM, during an interview, LPN #3 confirmed that Resident #57 often yelled at wandering residents to leave his room. She explained that one wandering resident had been doing so since admission but had reduced the frequency over time.

A record review of Resident #57's "Admission Record" revealed the facility admitted him on 12/02/2022 with diagnoses including Type 2 Diabetes Mellitus.

A record review of the Quarterly MDS with an ARD of 10/17/2024 revealed in Section C Resident #57 had a BIMS score of (15), indicating the resident was cognitively intact. Further review of Section F revealed it was somewhat important to have a place to lock his things and to keep them safe.

Resident #74

On 12/15/2024 at 11:54 AM, during an observation, Resident #74's urinary drainage bag was uncovered and visible from the hallway because her door was open.

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F 550	Continued From page 4 On 12/16/2024 at 11:22 AM, during an observation and interview the Director of Nursing (DON) confirmed that Resident #74's catheter bag was not covered and emphasized the need to cover it to maintain the resident's dignity. On 12/18/2024 at 10:30 AM, during an interview the DON and Administrator acknowledged the facility had several wandering residents and confirmed staff had been educated on redirecting wandering residents to respect others' privacy. They stated that residents' rights to privacy and dignity must always be upheld. A record review of Resident #74's "Admission Record" revealed the facility admitted her on 08/12/2022 with diagnoses including Stage 4 Pressure Ulcer of the Sacral Region. A record review of the Quarterly MDS with an ARD of 10/24/2024, in Section C revealed a BIMS score of four (4), indicating severe cognitive impairment. Further review of Section H revealed the resident had an indwelling catheter.	F 550		
F 656 SS=E	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 -	F 656		1/14/25

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F 656	Continued From page 5 (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. (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 plans related to a Continuous Positive Airway Pressure (CPAP) machine	F 656	1. Resident #2 was assessed by the facility's Family Nurse Practitioner(FNP) on 12/17/24 with no complications noted from the absence of Continuous Positive	

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F 656	Continued From page 6 (Resident #2) and an indwelling catheter (Resident #74) for two (2) of 22 sampled residents. Findings included: A record review of the facility's policy "Comprehensive Care Plan" dated May 1, 2012, revealed, "Standard: Social services staff and/or designee will participate in the development of a comprehensive care plan for each resident. Practice Guidelines: 1. The interdisciplinary care plan is implemented to guide healthcare center staff in the provision of necessary care and services to obtain and maintain the highest practical physical, mental, and psychosocial well-being of the resident and promotion of the resident and family in planning care ..." Resident #2 A record review of the "Discharge Summary", dated 11/27/2024, for Resident #2 revealed, " ...There was concern for obstructive sleep apnea ...11/25 (2024) ...will have to have outpatient referral for sleep study ...11/27 (2024) - sleep study referral placed and pcp (Primary Care Provider) follow-up placed, both should be addressed by facility with in a week of discharge ...Other Obstructive sleep apnea syndrome Will order cpap at night ...Final Active Diagnoses ...Obstructive sleep apnea syndrome ...Follow Up ...needs sleep study referral ..." The medical record revealed no care plan was developed for the diagnosis of obstructive sleep apnea, including the referral for a sleep study, or the physician's orders for CPAP usage at night following the resident's return from the hospital on	F 656	Airway Pressure (CPAP) usage. On 12/17/24, the FNP gave an order to consult the local hospital's Sleep Lab for a sleep study related to sleep apnea. On 12/18/24, resident #2 was scheduled for a sleep study on 1/23/25 at 10:45am at local hospital's Sleep Lab in preparation for CPAP. On 12/18/24, a comprehensive care plan with interventions was initiated for an indwelling foley catheter on resident #74 and sleep apnea for Resident #2 by the Registered Nurse Assessment Coordinator (RNAC). 2. All residents with CPAP and foley catheters have the potential to be affected by this deficient practice of lack of comprehensive care plans. 3. On 12/17/24, all residents with CPAP and foley catheters were audited by the Director of Nursing Services (DNS) and Assistant Director of Nurses(ADNS) to ensure implementation of comprehensive care plans timely. Director of Nursing Services(DNS)/Director of Clinical Education(DCE)/Administrator in-serviced nursing staff on initiating comprehensive care plans on 1/6/25-1/9/25. 4. Started 12/19/24 and ongoing, Unit Manager/Registered Nurse and Licensed Practical Nurse will note all admit orders, discharge summaries, discharge instructions, aftercare instructions, and nursing interventions within 24 hours to ensure care plan is initiated. The facility's interdisciplinary team will monitor for care plan implementation daily Monday-Friday	

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F 656	Continued From page 7 11/27/2024. During an interview on 12/17/2024 at 10:00 AM, the facility's Nurse Practitioner (NP) expressed concerns about the resident's diagnosis of obstructive sleep apnea and the CPAP not being initiated as directed. She emphasized the care plan needed to be updated appropriately. During an interview on 12/17/2024 at 10:30 AM, the Director of Nursing (DON) acknowledged a breakdown in communication and emphasized the importance of verifying hospital discharge orders to support continuity of care. She confirmed the facility policy requires admitting nurses to enter all clinical data timely upon admission or readmission. During an interview on 12/17/2024 at 10:45 AM, Licensed Practical Nurse (LPN) #1 confirmed the facility failed to follow hospital discharge orders related to CPAP usage and did not develop interventions for obstructive sleep apnea in Resident #2's care plan. A record review of the "Admission Record" revealed the facility admitted Resident #2 on 09/25/2023 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD). Resident #74 During an observation on 12/15/2024 at 11:54 AM, Resident #74 was observed with an indwelling catheter with clear yellow urine flowing into an uncovered drainage bag. A record review of the "Progress Notes" revealed Registered Nurse (RN) #1 placed an 18 French	F 656	to ensure assigned nurses have completed the care plan. To monitor the performance of our corrective action and to ensure sustainability, the DNS/ADNS will review 3 resident's comprehensive care plan 3x/week x 4 weeks beginning 12/23/24, then monthly to ensure all foley and CPAP orders are care planned. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 1/13/25 by the Director of Nursing for review and revision as necessary. Quality Assurance team will review the findings and determine if a need to alter our corrective action.	

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indwelling catheter for Resident #74 on 08/14/2024 at 3:30 PM.

A review of the Comprehensive Care Plan revealed there was no care plan with interventions developed for the indwelling catheter for Resident #74.

A record review of the "Admission Record" revealed the facility admitted Resident #74 on 08/12/2022 with diagnoses including a Stage 4 Pressure Ulcer of the Sacral Region.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/24/2024 revealed Resident #74 had a Brief Interview for Mental Status (BIMS) score of four (4), indicating severe cognitive impairment. Further review revealed she had an indwelling catheter.

During an interview on 12/16/2024 at 11:22 AM, the DON confirmed the facility failed to develop a comprehensive care plan for the catheter care. She explained the care plan ensures continuity of care and stated care plans must reflect current diagnoses to guide staff effectively.

During an interview on 12/16/2024 at 11:27 AM, the Administrator confirmed the failure to develop a comprehensive care plan for the catheter. She stated care plans are essential for guiding staff on the proper care and cleaning of the catheter and emphasized the need for all care areas to be included in the care plan.

On 12/18/2024 at 10:00 AM, during an interview, Registered Nurse (RN) #2 confirmed she was responsible for developing Resident #74's care

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F 656	Continued From page 9 plan. She acknowledged she did not see any orders for the indwelling catheter and did not inquire further.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to implement physician orders for the use of a Continuous Positive Airway Pressure (CPAP) machine (Resident #2) and for an indwelling catheter (Resident #74) for two (2) of 22 sampled residents. Findings included: A review of the facility's document, "Standards of Practice," dated 12/19/2024 and signed by the Administrator, revealed, "The expectation set forth by management is that nurses comply with current standards of practice in terms of following physician's orders..." A record review of the facility's policy, "Electronic Clinical Records System Timely Admission-Readmission Data Entry," undated, revealed, " Guideline: The practice of the center clinicians is to enter specific patient critical and pertinent clinical data and documentation related to the patient's admission or readmission in a timely manner into the patient's electronic record	F 658	1. Resident #2 was assessed by the facility's Family Nurse Practitioner (FNP) on 12/17/24 with no complications noted from the absence of Continuous Positive Airway Pressure (CPAP) usage. On 12/17/24, the FNP gave an order to consult the local hospital's Sleep Lab for a sleep study related to sleep apnea. On 12/18/24, Resident #2 was scheduled for a sleep study on 1/23/25 at 10:45am at the local hospital's Sleep Lab in preparation for CPAP. On 12/17/24, the FNP assessed Resident #74 for complications of existing indwelling foley catheter with no complications noted and FNP ordered an indwelling foley catheter for Resident #74. 2. All residents with CPAP and foley catheters have the potential to be affected by this deficient practice of lack of meeting professional standards. 3. On 12/17/24, all residents with CPAP and foley catheters were audited by Director of Nursing Services	1/14/25

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F 658	Continued From page 10 ... Processes: 2. Entry of Physician's Orders is the responsibility of the Health Information Management Coordinator (HIMC) and/or the admitting nurse. If Physician's Orders are entered by the admitting nurse, the HIMC is responsible to review orders entered during this stated time period for accuracy ...." Resident #2 A record review of the "Admission Record" revealed the facility admitted Resident #2 on 09/25/2023, with diagnoses including Chronic Obstructive Pulmonary Disease (COPD). A record review of the "Discharge Summary", dated 11/27/2024, for Resident #2 revealed, " ...There was concern for obstructive sleep apnea ...11/25 (2024) ...will have to have outpatient referral for sleep study ...11/27 (2024) - sleep study referral placed and pcp (Primary Care Provider) follow-up placed, both should be addressed by facility with in a week of discharge ...Other Obstructive sleep apnea syndrome Will order cpap at night ...Final Active Diagnoses ...Obstructive sleep apnea syndrome ...Follow Up ...needs sleep study referral ..." Review of the medical record for Resident #2 revealed the new diagnosis of Chronic Obstructive Sleep Apnea, the referral for a sleep study, or a physician's orders for the use of CPAP machine at night was not added to the resident's medical record following the return from the hospital on 11/27/2024. On 12/17/2024 at 10:00 AM, during an interview, the Nurse Practitioner (NP) expressed concerns about the resident's new diagnosis of obstructive	F 658	(DNS)/Assistant Director of Nurses(ADNS) to ensure all had physician orders. Director of Nursing Services(DNS)/Director of Clinical Education(DCE)/Administrator in-serviced nursing staff on 1/6/25-1/9/25 on following professional standards including implementation of physician orders timely. 4. Starting 12/19/24 and ongoing, Unit Manager/Registered Nurse and Licensed Practical Nurse will note all admission physician orders, discharge summaries, discharge instructions, aftercare instructions, and nursing interventions within 24 hours to ensure physician orders are implemented. The facility's interdisciplinary team will monitor for initiation and implementation of physician orders daily Monday-Friday to ensure assigned nurses have completed physician orders accurately. To monitor the performance of our corrective action and to ensure sustainability, the DNS/ADNS will review 3 resident's physician orders 3x/week x 4 weeks beginning 12/23/24, then monthly to ensure all physician orders are implemented. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 1/13/25 by the Director of Nursing for review and revision as necessary. Quality Assurance team will review the findings and determine if a need to alter our corrective action.	

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F 658	Continued From page 11	F 658		

sleep apnea and the CPAP directive. She revealed the CPAP order from 11/27/2024 was not implemented by facility staff.

On 12/17/2024 at 10:30 AM, during an interview, the Director of Nursing (DON) acknowledged the importance of verifying hospital discharge orders to ensure continuity of care. She confirmed that facility policy requires admitting nurses to enter all clinical data timely.

Resident #74

During an observation on 12/15/2024 at 11:54 AM, Resident #74 had a urinary drainage bag hanging at the foot of the bed uncovered.

A record review of the "Admission Record" revealed the facility admitted Resident #74 on 08/12/2022 with diagnoses including a Stage 4 Pressure Ulcer of the Sacral Region.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/24/2024 revealed in Section C Resident #74 had a Brief Interview for Mental Status (BIMS) score of four (4), indicating severe cognitive impairment. Further review of Section H revealed she had an indwelling catheter.

A record review of the "Progress Notes" revealed Registered Nurse (RN) #1 placed an 18 French indwelling catheter for Resident #74 on 08/14/2024 at 3:30 PM.

A record review of the electronic medical record revealed there were no Physician's Orders indicating Resident #74 had an indwelling catheter.

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F 658	Continued From page 12 A record review of the Treatment Administration Records (TARs) from August 2024 to December 2024 revealed there was no documentation indicating the facility completed catheter care. During an interview on 12/16/2024 at 11:00 AM, Registered Nurse (RN) #1 confirmed she placed the indwelling catheter on 08/14/2024 for Resident #74, however, she was helping another nurse. She explained that she did not receive the order from the physician or the Nurse Practitioner and had assumed the other nurse had taken care of it. RN #1 acknowledged it was her responsibility to verify all orders. On 12/16/2024 at 11:27 AM, during an interview, the Administrator, who also served as the Resident Representative (RR) for Resident #74, confirmed the absence of a documented physician's order. She stated the physician's order must be documented in the resident's file and that moving forward, all orders would be written promptly upon receipt. During an interview on 12/17/2024 at 8:22 AM, the DON confirmed the lack of a documented physician's order for the indwelling catheter. She stated verbal orders must be entered into the electronic medical record and emphasized the importance of ensuring orders are recorded properly.	F 658		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		1/14/25

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F 689	Continued From page 13 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to provide supervision to prevent a resident-on-resident altercation when Resident #61 wandered into another resident's room, which resulted in Resident #61 receiving a hematoma to her forehead and an emergency department (ED) visit for one (1) of 22 sampled residents, Resident #61. Findings included: A record review of the facility's "Investigation Template," dated 11/11/2024, revealed that at approximately 6:20 AM on 11/11/2024, a floor tech summoned help to Resident #91's room. Staff found water on the floor, a water pitcher spilled, and Resident #91 sitting on her bed holding her purse. Resident #91 stated she thought a man was trying to take her belongings and said she "protected herself." Resident #61 was removed from the room and was noted to have a hematoma on the left side of her forehead and redness on the left side of her face. Resident #61 was assisted to her room and transported to a local hospital's ED. A record review of the local hospital's ED report, dated 11/11/2024, revealed that Resident #61 arrived at the ED at 4:51 PM and was discharged at 5:35 PM ...History: Head Injury: Another resident at nursing home hit pt (patient) on head	F 689	1. On 11/11/24, resident #61 was removed from resident #91's room and was immediately assessed for injuries sustained after the resident to resident altercation. Neurochecks were initiated and resident later was evaluated at local emergency room due to altered level of awareness. On 11/11/24, wander barrier/stop sign was placed on the entrance door of Resident #91's room to prevent resident #61 from wandering into resident #91 room. On 12/18/24, caregivers were in-serviced by the Administrator on the importance of visual checks and redirection of resident #61 from other resident's rooms for safety. 2. All residents have the potential to be affected by this deficient practice of lack of supervision to prevent accidents. 3. All wandering residents were assessed by the Director of Nursing Services (DNS) and Assistant Director of Nursing Services (ADNS)on 12/18/24 to prevent accidents/hazards. To ensure that the deficient practice does not recur, the DNS/Director of Clinical Education/Administrator in-serviced all staff on redirecting wandering residents to prevent accidents/hazards on 1/6/25-1/9/25. On 1/13/25, to increase	

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F 689	Continued From page 14 (upper eyebrow) ...Review of Systems ... Positive for wound (hematoma to left forehead) ...Final diagnoses ...Contusion of forehead, injury of head ..." On 12/15/2024 at 10:12 AM, during an observation of Resident #91's room where the altercation with Resident #61 occurred, there was a stop sign with a Velcro closure across the width of the door. During an interview with Resident #69 (Resident #91's roommate) she reported that she did not see the altercation between her roommate and Resident #61 because she was asleep. She reported that Resident #61 occasionally entered their room but stated the incidents decreased after the stop sign was installed. On 12/16/2024 from 9:30 AM to 10:00 AM, during an observation, Resident #61 was observed wandering throughout the facility, sleeping in hallways where she does not reside. Staff redirected her to her hallway after approximately 30 minutes. On 12/18/2024 at 9:50 AM, during an interview, the Administrator stated she was informed of the incident that occurred on 11/11/2024 by the DON and it was discussed during the facility's daily "Stand-Up" meeting. Staff determined interventions such as implementing stop signs and monitoring Resident #61 upon waking should be added. On 12/18/2024 at 11:13 AM, during an interview, the Floor Tech stated that on 11/11/2024 at 6:20 AM, he heard a commotion from Resident #91's room. Upon entering, he saw Resident #91 on her bed and Resident #61 in her wheelchair. He reported that a Training Center Account Manager	F 689	accountability, visual checks every 30 minutes for safety (alternated between assigned Certified Nurses Assistant and assigned nurse) were added to residents with high risk for wandering into other resident's room. These visual checks will be documented on the resident's Medication Administration Record (MAR) by the Nurses and on the resident's Point of Care (POC) tasks by the Nursing Assistants. 4. To monitor the performance of our corrective action and to ensure sustainability, the DNS/ADNS will observe 3 high risk residents with increased wandering or agitation for risk of accidents or hazards 3x/week x 4 weeks beginning 12/23/24, then monthly to ensure resident's safety. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 1/13/25 by the DNS for review and revision as necessary. Quality Assurance team will review the findings and determine if a need to alter our corrective action.	

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F 689	Continued From page 15 (TCAM) assisted with removing Resident #61 and cleaning the water on the floor. On 12/18/2024 at 11:16 AM, during an interview, the TCAM stated she entered D-Hall at approximately 6:20 AM and saw the Floor Tech cleaning water. She stated she removed Resident #61 from Resident #91's room and heard Resident #91 say, "Get out, get out, you don't belong in here." On 12/18/2024 at 11:40 AM, during an interview, Registered Nurse (RN) #3 stated she was informed of the incident during her medication pass. She reported the incident to the DON and Nurse Practitioner, completed an incident report, and performed neurological checks. On 12/18/2024 at 11:50 AM, during an interview, the DON stated she was informed of the incident before arriving at the facility. She ensured residents were separated, reported the incident to the State Agency, and started an investigation. She confirmed the implementation of stop signs on doors of residents who complained about Resident #61 entering their rooms. A record review of the facility's "Admission Record" revealed the facility admitted Resident #61 on 10/30/2020 with diagnoses including Unspecified Dementia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/02/2024 revealed staff assessed Resident #61's cognitive status as severely impaired.	F 689		
F 725 SS=D	Sufficient Nursing Staff	F 725		1/14/25

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F 725	Continued From page 16 CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure sufficient nursing staff to provide nursing and related services to meet residents' needs safely and in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being for one (1) of four (4) staffing quarters reviewed.	F 725	1. On 12/18/24, the Administrator/Director of Nursing Services/Human Resource Director/Workforce Manager discussed challenges of inadequate staffing on the weekends during July 2024-December 2024 which included employee morale, attendance, recruiting practices, hiring practices, orientation practices, and	

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F 725	Continued From page 17 Findings included: 1) Cross Reference to F550. 2) Cross Reference to F689. A record review of the facility's policy titled "Staffing Requirements for Resident Care," effective March 2023, revealed, "The facility must ensure that sufficient nursing staff is present at all times to meet residents' individual care needs and maintain a safe and sanitary environment." A record review of the facility's "Payroll-Based Journal (PBJ) Staffing Data Report" for Quarter 4, 2024 (July 1 - September 30), revealed excessively low weekend staffing triggered alerts, indicating that submitted weekend staffing data was consistently low compared to weekday staffing data. A record review of the facility's "Center Assessment Tool" dated 09/23/24 revealed " ... Other 1.8 ... When adjusting staffing for daily care needs, appropriate staff skill set are reviewed to assure that licensed and non-licensed staff are present at all times, 24/7, including nights and weekends, with skills to care for physical and psychosocial needs of patients and residents. Specific staffing needs are based upon individual patients' and residents' diagnosis, care plans, and any change of condition that may have occurred. Patients/residents who may have issues with behaviors are also taken into consideration when staffing is being reviewed ... Staffing Plan. 3.2 ... Our approach to determine the staffing needs to care for and support our patients and residents, along with the information provided in Section 1.8 above, begins at the	F 725	scheduling practices. On 12/18/24 and 12/19/24, all residents were assessed by the Director of Nursing Services (DNS) and Assistant Director of Nursing Services (ADNS) for complications due to lack of staffing with no complications noted. 2. All residents are at risk for lack of supervision due to lack of adequate facility staffing. 3. The Director of Clinical Operations provided education to the Administrator and DNS on 12/18/24 regarding need to provide sufficient staffing. Going forward, the center will ensure sufficient nursing staffing is provided to meet resident's needs safely and in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being. 4. Beginning 12/19/24 and ongoing, the center administrative staff will conduct a workforce manager's meeting Monday through Friday to review the schedule, projected coverage, and call ins. Any need for additional staffing will be addressed at that time. To monitor the performance of our corrective action and to ensure sustainability, the Administrator will indefinitely audit the predicted staffing versus the actual staffing daily starting 12/19/24 to ensure adequate staffing daily. Beginning 12/19/24, Unit Managers, DNS, ADNS, and other administrative nursing staff will be utilized for staffing to meet resident's needs until adequate staff is hired and trained. Any negative findings will be brought to the Quality Assurance	

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F 725	Continued From page 18 bedside. The Administrator facilitates the coordination of care needed each day with the interdisciplinary team. The care team evaluates the resident/patient population and acuity as well as center layout to determine the number of team members needed to provide care and services to the patients/residents ... Position Total Number Needed or Average or Range Licensed nurses providing direct care 5 on days, 4 on evenings, Nurse aides 10 on days, 8 on evenings, 7 on nights ..." On 12/15/2024 at 10:30 AM, during an interview with Certified Nurse Aide (CNA) #1, she reported having 16 residents to care for that day due to short staffing. She stated that staffing was inconsistent and often insufficient, particularly on weekends. She noted that completing her duties with fewer than six (6) CNAs was challenging. On 12/15/2024 at 10:45 AM, during an interview with Licensed Practical Nurse (LPN) #4, she explained that she usually worked in medical records but had been pulled to cover short staffing. She confirmed that low staffing levels had required many staff members to work extra hours. On 12/16/2024 at 10:50 AM, during an interview with LPN #3, she stated the facility had been short-staffed for several months. She reported working with six (6) CNAs on day shifts and five (5) or fewer on evening shifts, which created difficulties in completing all duties. On 12/18/24 at 10:05 AM, during an interview with the Director of Nursing (DON), she confirmed that she was aware of the low staffing issues and reported she has not been able to	F 725	Performance Improvement meeting monthly for a minimum of 3 months beginning 1/13/25 by the Administrator for review and revision as necessary. Quality Assurance team will review the findings and determine if a need to alter our corrective action.	

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F 725	Continued From page 19 have the staffing she desires for the facility. On 12/18/2024 at 10:15 AM, during an interview and record review of the staffing grids with the Workforce Manager, she explained that the facility aimed to staff an average of 10 CNAs on day shifts, seven (7) CNAs on evening shifts, and five (5) CNAs on night shifts. However, staffing had fallen as low as five (5) CNAs on day shifts, four (4) CNAs on evening shifts, and three (3) CNAs on night shifts. The Workforce Manager confirmed that staffing grids for Quarter 4, 2024, showed multiple weekends with low staffing ratios. On 12/18/2024 at 10:40 AM, during an interview with the Administrator, she confirmed that the facility had consistently triggered low staffing alerts on weekends. She outlined ongoing efforts to address staffing shortages, including offering bonuses, recruiting from local vocational schools, and attempting CNA training programs, but acknowledged that staffing challenges remained unresolved.	F 725		