

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/05/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER PLAZA COMMUNITY LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4403 HOSPITAL ROAD PASCAGOULA, MS 39581		
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F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification Survey with three (3) Complaint Investigations (CI MS #26993, CI MS #26961, and CI MS #26842), at the facility from 1/06/25 through 1/09/25. The SA investigated CI MS #26993 for abuse and neglect and CI MS #26842 for quality of care and dignity and there were no citations related to those CIs. The SA investigated CI MS #26961 related to resident on resident abuse, dignity, safety and infection control and cited F600, F607, and 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 F584, F600, F607, F641, F689, F812, and F880.	F 000			
F 584 SS=E	The facility had a census of 95 and was licensed for 100 beds. Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		2/13/25	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/02/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to ensure residents' rights for a clean, sanitary, and home-like environment as evidenced by resident rooms with holes in the walls and leaks in the ceilings in the dining room and hallways for one (1) of four (4) days of survey. Findings included: A review of the facility's policy titled "Resident Rights," dated 11/23/2016, revealed, "It is the	F 584	The facility failed to ensure residents ☐ rights for a clean, sanitary, and homelike environment. The area in the main dining area was mopped up by housekeeping and repaired by maintenance of 01/06/2025. Maintenance Supervisor and Assistant repaired Room South-8's wall and Room North-1's wall around the mounted air-conditioning unit on 01/07/2025. All residents have the potential to be affected.		

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F 584	Continued From page 2 policy of this facility to promote the rights of residents residing in this facility ...Procedure ...3. The facility will make every effort to provide residents a homelike environment ..." On 1/6/2025 at 10:30 AM, during an observation, water was dripping from the roof in the main dining room. A large puddle of water was observed on the floor with a wet floor sign placed over it. On 1/6/2025 at 10:40 AM, during an observation in Room South-8, a hole the size of a large ball was noted in the sheetrock, filled with pieces of cardboard. Resident #11 On 1/6/2025 at 10:45 AM, during an interview, Resident #11 confirmed the water was dripping from the roof and stated it had rained the day before. The resident noted that leaks typically occurred in the hallway near the nurses' station on both the north and south wings. The resident added that staff usually placed barrels in these areas to catch the water. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/16/24 revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Resident #26 On 1/6/2025 at 10:50 AM, during an interview, Resident #26, who was sitting in the main dining room, confirmed that leaks occurred in various parts of the facility when it rained. The resident	F 584	All staff were educated on residents ☐ rights for a clean, sanitary, and homelike environment on 01/10/25 and ending 01/31/2025. The Quality Assurance Performance Improvement (QAPI) team met on 01/10/25 and discussed residents ☐ rights to a clean, sanitary, and homelike environment and dignity policies and procedures with no revisions needed at this time. QAPI team also discussed work order completions, routine maintenance and areas of concern. Maintenance and administrative staff will make weekly room rounds using a room inspection check off list starting 01/13/25 and ending 04/30/2025. The check off list ☐s will be reviewed weekly by Administrator and Maintenance to ensure all issues are addressed in a timely manner. Areas of concern include chipped paint, sheet rock repairs, roof leaks on north and south units and dining room to be completed by 04/17/2025. All findings that include areas of concern will be reported to the QAPI Team monthly beginning 02/13/25 and ending 04/30/25 for review and recommendations.		

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F 584	Continued From page 3 stated that repair work had been done in the past, but the leaks persisted, with new areas leaking unpredictably. Record review of the MDS with an ARD of 11/6/24 revealed Resident #26 had a BIMS score of 15 indicating the resident was cognitively intact. Resident #35 On 1/6/2025 at 10:50 AM, during an interview, Resident #35 confirmed the ceiling was leaking in the dining room. The resident said the ceiling leaked in multiple areas when it rained, and staff typically placed wet floor signs and barrels to address the issue. Record review of the MDS with an ARD of 1/23/24 revealed Resident #35 had a BIMS score of 14 indicating the resident was cognitively intact. On 1/6/2025 at 11:00 AM, during an interview, Housekeeper #1 stated he was instructed to document environmental problems in the maintenance log at the nurses' station. He mopped up water on the dining room floor and noted that while the dining room rarely leaked, the north and south hallways leaked frequently during rain. Resident #67 On 1/6/2025 at 11:30 AM, during an interview, Resident #67 confirmed the roof leaked near the nurses' station on the north and south halls. The resident stated that repairmen had patched the roof multiple times, but the leaks shifted to other areas. The resident expressed frustration, saying	F 584			

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F 584	Continued From page 4 the entire roof needed to be fixed. On 1/6/2025 at 11:31 AM, during an observation in Room North-1, a large open area was noted around the wall-mounted air conditioning unit, allowing visibility to the outside. Record review of the MDS with an ARD of 11/27/24 revealed Resident #67 had a BIMS score of 15 indicating the resident was cognitively intact. Resident #43 On 1/6/2025 at 12:05 PM, during an interview, Resident #43 expressed concern that animals, such as snakes, could enter the room through the gap. Record review of the MDS with an ARD of 12/13/24 revealed Resident #43 had a BIMS score of 12 indicating the resident had moderate cognitive impairment. On 1/9/2025 at 1:00 PM, during an interview, the Maintenance Director confirmed roof leaks in the north and south halls and acknowledged being unaware of the dining room leak. He noted that patches and silicone coatings had been applied to the roof, but the flat design caused water to shift to other areas. The Maintenance Director also confirmed awareness of paint chips and holes in the walls but had not received maintenance slips for the affected rooms. On 1/9/2025 at 3:45 PM, during an interview, the Administrator confirmed awareness of roof leaks in the north and south halls but stated she was unaware of the dining room leak. The	F 584			

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F 584	Continued From page 5 Administrator explained that corporate consultants communicated with the roofing company, and repairs were limited to specific areas based on budget constraints.	F 584			
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to protect residents' right to be free from physical abuse when Resident #62 received scratches to his neck and face in an altercation with Resident #48 and Resident #41 received a hematoma to her head during an altercation with Resident #78 for four (4) of 20 sampled residents. Findings included: A review of the facility's "Abuse, Neglect, Exploitation, and Misappropriation Prevention Program," updated October 2022, revealed,	F 600	The facility failed to protect residents' right to be free from physical abuse for resident # 62, #48, #78 and #41. Residents #62 and #48 were interviewed by the Social Service Director concerning the incident that occurred on 11/2/24 on 01/10/25. No adverse effects were noted. There have been no further issues between resident # 62 and #48 since 11/2/24. Residents #78 and #41 were interviewed by the Social Service Director concerning the incident on 01/07/25. Both residents have no adverse effects.		2/13/25

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F 600	Continued From page 6 "Residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms." Resident #48 and Resident #62 Altercation Record review of the facility's investigation dated 11/2/24 revealed Resident #62 and Resident #48 were involved in an altercation in the dining room. Resident #62, who was assisting with handing out clothing protectors, was punched by Resident #48 when he attempted to place a clothing protector on him. In response, Resident #62 hit Resident #48 back, and both residents fell to the floor. A dietary aide witnessed the incident, reported it to Registered Nurse (RN) #4 and both residents were separated. Resident #62 sustained scratches to his face and neck, while Resident #48 had no noted injuries. The physician, Director of Nursing (DON), and Administrator were notified. Interventions included instructing staff to prevent Resident #62 from distributing clothing protectors in the dining room and referring Resident #48 to the in-house psychiatric Nurse Practitioner. During an observation on 1/6/2025 at 10:50 AM, Resident #48 was noted sitting in his wheelchair in his room. Resident #48, who has expressive aphasia, communicated with head nods. During an interview on 01/06/2025 at 11:00 AM, Registered Nurse (RN) #3 explained that Resident #48 can talk but may not want to communicate because he cannot speak clearly.	F 600	All residents have the potential to be affected. All staff were educated beginning 01/10/25 and ending 0/31/2025 on abuse, neglect and exploitation policy the Director of Nursing and Nursing Administration staff. The Social Service Director conducted a person-centered in-service on resident #62 for all staff. On 01/07/2025, the dining area which leads to the smoking area was opened to residents to wait for smoke break so they can spread out more. On 01/07/2025, staff were informed that residents, when grouping together before smoke break or during mealtimes, must be supervised in the main dining room. The dining room will only be open for activities, mealtimes and when waiting to smoke. The administrator met with the smokers on 01/13/25 and explained that the area to wait for smoke break will not be opened until 20 minutes prior to scheduled smoke time. Residents were asked to please not come down an hour before smoke breaks. Resident #62 will be monitored to ensure he does not hand out clothing protectors starting 01/10/25 and ending 03/01/2025. The Quality Assurance Performance Improvement (QAPI) Team met on 01/10/25 and discussed policies and procedures on abuse, neglect, and exploitation with no revisions needed at this time. All residents will be supervised while in the main dining area while gathering for smoke breaks, mealtimes, and activities. The Life Connections		

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F 600	Continued From page 7 RN #3 reported she did not recall many details about the night Resident #48 and Resident #62 were involved in an altercation in the dining room. She noted both residents have a history of other altercations, which usually occurred due to Resident #62 wandering into rooms. RN #3 added that Resident #48 had hit Resident #62 previously when Resident #62 wandered into his room. During an observation and interview on 01/08/2025 at 09:30 AM, Resident #48 was observed sitting in his wheelchair in his room. When asked if he could answer yes or no questions, the resident nodded yes. When asked if he remembered the altercation in the dining room with Resident #62, the resident nodded yes. When asked if he and Resident #62 had previous issues, he nodded yes. When asked if he was upset about the clothing protector, he nodded no. When asked if he became upset when he saw it was Resident #62, he nodded yes. When asked if he landed on the floor during the incident, he nodded yes. When asked if he was hurt, he nodded no. When asked if he had punched Resident #62 before, he nodded yes. When asked if this occurred when Resident #62 came into his room, he nodded yes. When asked if he had any further altercations with Resident #62 since the dining room incident, he nodded no. When asked if everything was better now, he nodded yes and smiled. During an interview on 01/08/2025 at 12:15 PM, Dietary Aide #4 confirmed she provided a witness statement for the incident between Resident #48 and Resident #62. She stated the incident occurred around 5:20 PM as the dining room trays are typically distributed starting at 5:25 PM.	F 600	Department will use a daily monitoring tool beginning 01/13/25 ending 03/01/25 to ensure the main dining area is being supervised during smoke breaks, mealtimes, and activities. Any adverse findings will be reported to the Administrator or Director of Nursing. All findings will be reported to the QAPI Team monthly beginning 02/13/25 and ending 03/31/25 for review and recommendations.		

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F 600	Continued From page 8 She was at the kitchen window and saw Resident #62 walking around placing clothing protectors on other residents. Resident #48 was seated at the back table. When Resident #62 attempted to place a clothing protector on Resident #48, Resident #48 punched Resident #62, who punched him back, leading to a tussle. Dietary Aide #4 stated she told other kitchen staff the residents were fighting and then saw Resident #48 fall from his wheelchair to the floor. She immediately sought help from a nurse and Certified Nursing Assistant (CNA). She stated that residents were temporarily prohibited from being in the dining room without staff for about a week after the incident, but that policy was not maintained because residents would often gather unsupervised in the hallways instead. During a phone interview on 01/08/2025 at 05:40 PM, RN #5 stated she did not witness the incident between Resident #48 and Resident #62. She explained that Dietary Aide #4 informed her about the altercation. While walking down the hall, she encountered RN #4, who was with Resident #62. RN #4 informed her that Resident #62 had been fighting with another resident. RN #5 then escorted Resident #62 to his room and completed a body audit. She observed scratches on Resident #62's neck and face, noting that the scratches were superficial and required only first aid. RN #5 stated she completed the incident report for Resident #62, while RN #3 completed the incident report for Resident #48. She also confirmed she notified the Administrator and Director of Nursing (DON) about the incident. During a interview on 01/09/2025 at 03:50 PM, the Administrator stated that on the night of the incident, she was notified, and the Registered	F 600			

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F 600	Continued From page 9 Nurses (RNs) completed the incident reports. She used the incident reports and statements from RN #4 and Dietary Aide #4 to complete her final report. She explained that she does not know if any other residents were present in the dining room at the time of the incident, except for Resident #26, whose interview was included in one of the incident reports. She acknowledged there were no staff in the dining room at the time of the altercation, as they were busy assisting other residents to the dining room. She confirmed interventions implemented included informing Resident #62 that he could no longer distribute clothing protectors and instructing staff not to allow him to pass out the clothing protectors. A record review of progress notes dated 6/3/2024 at 5:45 PM revealed that Resident #48 and Resident #62 had a prior altercation. The progress notes stated, "This writer was walking the hallway and noticed a wheelchair flipped up in the room. Upon entering the room, the resident was noted sitting in his wheelchair, and another male resident was on the floor underneath Resident #48's wheelchair. Both residents were exchanging punches and holding each other's shirts." When asked how the altercation occurred, Resident #48 stated, "He came in my room, and I asked him to get out and he wouldn't and got smart with me." When asked, "Who struck who first?" Resident #48 admitted to striking the other resident first. Both residents were separated by this writer and two other staff members and assessed for injuries. Upon assessment, Resident #48 was noted to have two small scratches on his left cheek. The areas were cleaned and left open to air. The family, physician, Director of Nursing (DON), and Administrator were notified of the incident.	F 600			

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F 600	Continued From page 10 A record review of the "Admission Record" revealed the facility admitted Resident #48 on 05/07/20 with the diagnoses including Hemiplegia And Hemiparesis Following Cerebral Infarction. A record review of the Quarterly MDS with an ARD of 10/09/24 revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. A record review of Resident's "Physical Aggression Initiated" report dated 11/02/24 prepared by RN #3 revealed " ... I did not witness event. I was told by resident 48 and resident #62, that Resident #62 put on the clothing protector. Resident #62 put it on Resident #48 took it off then resident #48 hit Resident #62 in the gut, Resident #62 returned hit to Resident #48 in the torso ... Nursing supervisor notified by RN #5. Residents were separated ... no injuries observed at time of incident ... No statements found ..." A record review of the "Admission Record" revealed the facility admitted Resident #62 on 01/26/22 with the diagnoses including Unspecified Dementia. A record review of the Quarterly MDS with an ARD of 12/11/24 revealed Resident #62 had a BIMS score of 7 which indicated he was severely cognitively impaired. A record review of Resident's "Physical Aggression Initiated" report dated 11/02/24 prepared by RN #3 revealed " ... I did not witness event. I was told by resident #48 and Resident #26, that Resident #62 put bib on Resident #48	F 600			

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F 600	Continued From page 11 took it off then Resident #48 hit Resident #62 in the gut, Resident #62 returned hit to Resident #48 torso ... Nursing supervisor notified by RN #5, residents were separated ... no injuries observed at time of incident ... No statements found ..." Resident #41 and Resident #78 Altercation On 1/7/2025 at 5:15 PM, during an observation, several residents were standing in the hallway near the main dining room without staff supervision. Residents were overheard using profanity, and Resident #78 was observed hitting Resident #41 with her walker, knocking her to the floor. Staff intervened and separated the residents. A record review of the facility's incident reports dated 1/7/2025 revealed Resident #41 sustained a hematoma to the back of her head and was sent to the emergency room for evaluation. Resident #78 denied hitting Resident #41 with her walker and reported no injuries. A record review of the "Admission Record" revealed the facility admitted Resident #41 on 3/21/2023 with diagnoses including Chronic Obstructive Pulmonary Disease. A record review of the Quarterly Minimum Data Set (MDS) with an assessment Reference Date (ARD) of 11/20/2024 revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of three (3), indicating severe cognitive impairment. A record review of the "Admission Record" revealed the facility admitted Resident #78 on	F 600			

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F 600	Continued From page 12 3/22/2023 with diagnoses including Dementia. A record review of the Quarterly MDS with an ARD of 10/24/2024 revealed Resident #78 had a BIMS score of seven (7), indicating severe cognitive impairment.	F 600			
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d) (3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.	F 607		2/13/25	

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F 607	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review the facility failed to implement their policy related to abuse, as evidenced by not reporting an allegation of abuse by Resident #54 in a timely manner and allowing an accused staff member to work during the investigation process and not completing a thorough investigation regarding an altercation between Resident#48 and Resident #62 for three (3) of 20 sampled residents. Findings include: A record review of the facility's policy "Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigation" with reviewed date 10/2022 revealed, " ... All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported ... Reporting Allegations to the Administrator and Authorities ... 3. "Immediately" is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury ... Investigating Allegations 1. All allegations are thoroughly investigated. The administrator initiates investigations ... 6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. 7. The individual conducting the investigation as a minimum: c. observed the alleged victim,	F 607	The facility failed to implement policies and procedures related to residents #54, #62 and #48. The Director of Nursing interviewed resident #54 on 01/07/25 to follow up on the allegation of abuse. Residents #62 and #48 were interviewed by the Social Service Director on 01/10/25 concerning the incident on 11/2/24. Both residents reported no adverse effects. The Administrator and Director of Nursing were educated by the Regional Director of Operations on 1/10/25 on facility policies and procedures of reporting abuse allegations in a timely manner and allowing an accused staff member to work during an investigation. 01/10/25, the administrator was also educated on the use of a check off tool to ensure all information is gathered at time of investigation. All residents have the potential to be affected. All staff were educated beginning 01/10/25 and ending 01/31/25 on abuse, neglect, and exploitation policy by the Director of Nursing and Nursing Administration staff. The Social Service Director conducted a person-centered in-service on resident #62 for all staff. The Quality Assurance Performance Improvement (QAPI) team met on 01/10/25 and discussed policies and procedures on abuse, neglect and exploitation and reporting abuse, neglect		

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F 607	Continued From page 14 including his or her interaction with staff and other residents; ... e. interviews any witnesses to the incident; ... h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; ... j. interviews other residents to whom the accused employee provides care or services, k. reviews all events leading up to the alleged incident, and l. documents the investigation completely and thoroughly. 8. The following guidelines are used when conducting interviews: ... d. Witness statements are obtained in writing, signed, and dated. The witness may write his/her statement, or the investigator may obtain a statement ... Follow -Up Report 1. Within five (5) business days of the incident, the administrator will provide a follow-up investigation report. 2. The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegations were verified ... Corrective Actions ... 3. Any allegations of abuse are filed in the accused employee's personnel record along with any statement by the employee disputing the allegation, if the employee chooses to make one ..." Resident #48 and Resident #62 Altercation Record review of the facility's investigation dated 11/2/24 revealed Resident #62 and Resident #48 were involved in an altercation in the dining room. Resident #62, who was assisting with handing out clothing protectors, was punched by Resident #48 when he attempted to place a clothing protector on him. In response, Resident #62 hit Resident #48 back, and both residents fell to the floor. A dietary aide witnessed the incident, reported it to the nurse's station, and both residents were	F 607	and exploitation with no revisions needed at this time. Any allegations of abuse will be reported within 2 hours of receiving the report. Any accused of abuse will not be allowed to work during an investigation. Regional Director of Operations, Director of Nursing and Administrator will use a weekly monitoring tool to ensure all allegations of abuse are reported in a timely manner and to ensure the abuse, neglect, and exploitation policy is followed by not allowing an employee to work while being investigated and that all statements of all witnesses are collected during the investigation starting 01/10/2025 and ending 03/01/2025. All findings will be reported to the QAPI Team monthly beginning 02/13/25 and ending 03/31/25 for review and recommendations.		

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F 607	Continued From page 15 separated. Resident #62 sustained scratches to his face and neck, while Resident #48 had no noted injuries. The physician, Director of Nursing (DON), and Administrator were notified. Interventions included instructing staff to prevent Resident #62 from distributing clothing protectors in the dining room and referring Resident #48 to the in-house psychiatric Nurse Practitioner. On 01/07/25 at 02:00 PM, during an interview with the Administrator when she presented the final report of the Facility Reported Incident (FRI), she explained that is the final report that she submitted to the Attorney General Office (AGO) and to the State Agency (SA). She confirmed the report consisted of her final typed report and the two (2) statements obtained regarding the incident. She confirmed there were no other statements or interviews obtained from any other witnesses, to include who separated the residents and any other residents who may have witnessed the altercation. She confirmed body audits and incident reports were completed for both residents via the residents' nurses. She confirmed no other staff or residents were interviewed regarding the altercation except the ones mentioned in the report, that included Resident #26, Dietary Aide #4, and RN #4. She stated that she felt she completed the investigation. A record review of the "Admission Record" revealed Resident #48 was admitted by the facility on 05/07/20 with the diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date	F 607			

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F 607	Continued From page 16 (ARD) of 10/09/24 revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. A record review of the "Admission Record" revealed Resident #62 was admitted by the facility 1/26/22 with diagnoses including Unspecified Dementia. A record review of the Quarterly MDS with an ARD of 12/11/24 revealed Resident #62 had a BIMS score of 7 which indicated severely cognitively impaired. Resident #54 Allegation of Abuse On 01/06/25 at 02:20 PM, during an interview with Resident #54, she reported on Friday around 2 PM she had a Certified Nurse Aide (CNA) tell her that she wasn't going to put her back to bed and she would have to wait on the next shift to put her back to bed. She went to the nurse's station and complained about wanting to go to bed. The CNA did come back and put her to bed but while doing so the CNA whirled her around fast and made her cry. She stated she had not reported this to the Director of Nursing (DON) or the Administrator yet. She was so upset on Friday she could not tell anyone. The resident's roommate (unsampled resident #1) reported she heard the CNA on Friday tell Resident #54 she had to wait for the next shift. On 01/06/25 at 02:53 PM, during an interview in Resident #54's room with the DON and Administrator, she explained to both the incident that occurred on Friday in which the CNA told her that she was not going to put her back to bed and she would have to wait on next shift and about	F 607			

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F 607	Continued From page 17 her quickly turning her around in her wheelchair. Both the DON and Administrator confirmed that they did not know anything about the issue and assured the resident to report any concerns to them right away. The DON and Administrator reported they will start their investigation regarding Resident #54's complaint. On 01/07/25 at 02:05 PM, during an interview with the Administrator, she stated she did not report the allegation to anyone because she did not feel it was abuse or neglect due to the CNA did put resident to bed before she left work on Friday and there were no problems. She reported she was not aware of the requirements to report any allegations of abuse if it was just allegations. She thought it had to be reported if the abuse was substantiated, and the abuse was not substantiated at this time, but the investigation continues. On 01/07/25 at 03:00 PM, during an interview with the DON, she confirmed she obtained the statements from both CNAs and the CNAs denied the allegations. She reported since Resident #54 was put to bed on Friday and changed, there was no need to suspend the CNA from working. A review of the facility's policy Abuse-Investigation was reviewed with the DON, she confirmed the policy indicates that allegations of abuse should be reported within two hours of an allegation involving abuse and that any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. The DON reported she is still doing more interviews and investigations regarding the allegations and the final report is not completed.	F 607			

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F 607	Continued From page 18 On 01/08/25 at 10:30 AM, during an interview with CNA #4, she denied any abuse toward the resident, but confirmed she has been working this current week since 1/6/2025 at the facility on day shift. On 01/09/25 at 04:00 PM, during an interview with the Administrator and the DON, they both confirmed the investigation regarding Resident #54 is almost complete and the facility has five (5) days to send the final report. A review of the facility's policy with the Administrator and the DON, they both confirmed the facility policy explained any witnesses of the allegations should be interviewed and/or a statement given. The policy revealed the accused worker should be suspended while the investigation continues and should not have any resident care. Both confirmed the CNA continued to work and the allegation of abuse was not reported within two (2) hours. The Administrator reported she thought since the CNAs denied the allegations, there was no need to suspend or to report within two (2) hours because there was no abuse. A record review of the facility's assignment logs for days 01/03/25, 01/06/25, 01/07/25, and 01/08/25 confirmed CNA #4 worked and had resident assignments. A record review of the "Admission Record" revealed Resident #54 was admitted by the facility on 8/03/24 with current diagnoses including Cerebral Palsy. A record review of the Quarterly MDS with an ARD of 11/13/24 revealed Resident #54 had a BIMS score of 14, which indicted she was cognitively intact.	F 607			

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F 641 SS=C	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to accurately code Minimum Data Set (MDS) assessments when bedrails that were used as an enabler were coded as physical restraints on the MDS for three (3) of 20 sampled residents. (Residents #14, #73, and #43). Findings included: The facility did not provide a policy addressing MDS discrepancies. Resident #14 On 1/6/2025 at 10:40 AM, during an observation, Resident #14 was noted to have 1/2 bedrails at the top of the bed, but they were not raised at the time of observation. A record review of the "Admission Record" revealed the facility admitted Resident #14 on 9/14/2022 with diagnoses including Epilepsy and Hemiplegia. A record review of the Quarterly MDS with an Assessment Reference Date (ARD) of 11/6/2024 revealed in Section P of the MDS that Resident #14 had a bedrail used as a physical restraint. A record review of the "Side Rail Evaluation", dated 10/17/24, revealed Resident #14 had	F 641	The facility failed to accurately code Minimal Data Set (MDS) assessments when bed rails were used as enablers were coded as physical restraints for resident # 14, #73, and #43. Regional Nursing Consultant completed and submitted a corrected MDS assessment for Resident□s #14, #73, and #43 on 01/06/2025. All residents have the potential to be affected. Regional Nursing Consultant educated the MDS nurse and CarePlan nurse on the requirements of accuracy of MDS assessment coding on 01/06/2025. The Quality Assurance Performance Improvement (QAPI) team met on 01/10/25 and discussed the requirements of accurate coding and submission of MDS assessments. The Regional MDS nurse will monitor all MDS assessments prior to submission weekly starting 01/13/2025 and ending 03/01/2025. All submitted MDS assessments will be reported to the QAPI team monthly beginning 02/13/25 and ending 03/31/25 for review and recommendations.		2/13/25

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F 641	Continued From page 20 expressed a desire to have bed rails raised while in bed for safety and comfort and "to help turn in bed". Further review revealed that the resident used the bed rails for positioning or support and to help the resident rise from a supine position to a sitting/standing position. The evaluation indicated in the "Summary of Findings" that bilateral rails were used due to the residents' request and served as an enabler to promote independence. Resident #73 On 1/7/2025 at 10:22 AM, during an observation, Resident #73's bed was noted to have 1/4 bed positioning enablers at the head of the bed on both sides. A record review of the "Admission Record" revealed the facility admitted Resident #73 on 6/25/2024 with diagnoses including Acquired Absence of Right and Left Leg Above Knee. A record review of the MDS with an ARD of 12/25/2024 revealed Resident #73 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS indicated in Section P the resident had a bedrail used as a physical restraint. A record review of the "Side Rail Evaluation", dated 10/17/24, revealed Resident #73 had expressed a desire for use of bed rails. The evaluation indicated in the "Summary of Findings" that bilateral rails were used due to the residents' request and served as an enabler to promote independence.			F 641			

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F 641	Continued From page 21 Resident #43 On 1/7/2025 at 10:25 AM, during an observation, Resident #43's bed was noted to have 1/4 bed positioning enablers at the head of the bed on both sides. A record review of the "Admission Record" revealed the facility admitted Resident #43 on 8/30/2024 with diagnoses including Metabolic Encephalopathy. A record review of the Quarterly MDS with an ARD of 12/6/2024 revealed Resident #43 had a BIMS score of 12, which indicated moderate cognitive impairment. The MDS noted in Section P that bedrail usage was less than daily. A record review of the "Side Rail Evaluation", dated 10/17/24, for Resident #43 indicated in the "Summary of Findings" that bilateral rails were used due to the residents' request and served as an enabler to promote independence. On 1/9/2025 at 1:42 PM, during an interview, Licensed Practical Nurse (LPN) #2 acknowledged the residents were miscoded for having a physical restraint because the residents used the rails as enablers. LPN #2 stated she was responsible for ensuring the accuracy of the MDS prior to submission. She explained the purpose of the MDS is to document services provided for insurance purposes and stated she would learn from this mistake and improve. On 1/9/2025 at 1:47 PM, during an interview, the Director of Nursing (DON) acknowledged the residents' MDS assessments were miscoded for having physical restraints related to bedrails. The	F 641			

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F 641	Continued From page 22 DON stated it was the responsibility of the MDS nurse to ensure the MDS is coded correctly prior to submission. She explained that the purpose of correct MDS coding is for accurate billing and data representation. The DON stated she expected the MDS nurse to gather data and verify accuracy. On 1/9/2025 at 1:52 PM, during an interview, the Administrator acknowledged there was an MDS discrepancy related to bed rails being coded as a physical restraint. The Administrator stated the purpose of the MDS was to ensure the facility accurately reflects what is being done for the resident. She stated her expectation is that the MDS nurse carefully verifies information before submission and seeks clarification when necessary.	F 641			
F 689 SS=E	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 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 the facility policy review the facility failed to provide adequate supervision to prevent resident-on-resident altercations between Resident #62 and Resident #48 and between Resident #41 and Resident #78 for four (4) of 22 sampled residents.	F 689	The facility failed to protect residents #62, #48, #78 and #41 from accidents and hazards. Residents #62 and #48 were interviewed by the Social Service Director concerning the incident that occurred on 11/2/24 on 01/10/25. No adverse effects were noted. There have been no further		2/13/25

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F 689	Continued From page 23 Findings included: Resident #48 and Resident #62 Record review of the facility's investigation dated 11/2/24 revealed Resident #62 and Resident #48 were involved in an altercation in the dining room. Resident #62, who was assisting with handing out clothing protectors, was punched by Resident #48 when he attempted to place a clothing protector on him. In response, Resident #62 hit Resident #48 back, and both residents fell to the floor. A dietary aide witnessed the incident, reported it to Registered Nurse (RN) #4 and both residents were separated. Resident #62 sustained scratches to his face and neck, while Resident #48 had no noted injuries. The physician, Director of Nursing (DON), and Administrator were notified. Interventions included instructing staff to prevent Resident #62 from distributing clothing protectors in the dining room and referring Resident #48 to the in-house psychiatric Nurse Practitioner. On 01/06/2025 at 11:51 AM, during an observation in the dining room, Resident #26 was placing clothing protectors on other residents without staff present. On 01/07/2025 at 02:20 PM, during an interview, Resident #26 confirmed he witnessed the altercation between Residents #62 and #48. He stated that no staff were present in the dining room at the time and that it was common for the dining room to be unsupervised. On 01/08/2025 at 12:15 PM, during an interview, Dietary Aide #4 stated she observed the	F 689	issues between resident # 62 and #48 since 11/2/24. All residents have the potential to be affected. All staff were educated beginning 01/10/25 and ending 0/31/2025 on abuse, neglect and exploitation and accidents and incidents-investigating and reporting policies the Director of Nursing and Nursing Administration staff. The Social Service Director conducted a person-centered in-service on resident # 62 for all staff. The dining area which leads to the smoking area was opened to residents to wait for smoke break so they can spread out more. Staff were informed that residents, when grouping together before smoke break or during mealtimes, must be supervised in the main dining room. On 01/10/25, the dining room will only be open for activities, mealtimes and when waiting to smoke. The administrator met with the smokers on 01/13/25 and explained that the area to wait for smoke break will not be opened until 20 minutes prior to scheduled smoke time. Residents were asked to please not come down an hour before smoke breaks. Residents #78 and #41 were interviewed by the Social Service Director concerning the incident on 01/07/25. Both residents have no adverse effects. The administrator met with Resident Council on 01/28/25 concerning supervision in the main dining area for mealtimes, activities, and waiting for smoke break. Residents were told the main dining room will be closed except for		

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F 689	Continued From page 24 altercation between Residents #62 and #48 on 11/2/24 from the kitchen window and sought help from a nurse and Certified Nursing Assistant (CNA). She confirmed there were no staff in the dining room at the time. Dietary Aide #4 added that after the incident, residents were temporarily prohibited from being in the dining room without staff, but this restriction was not maintained. A record review of the "Admission Record" revealed Resident #62 was admitted by the facility on 01/26/2022 with diagnoses including Unspecified Dementia and Psychotic Disorder. A record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/11/2024 revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of seven (7), indicating severe cognitive impairment. A record review of the "Admission Record" revealed Resident #48 was admitted by the facility on 05/07/2020 with diagnoses including Hemiplegia and Aphasia. A record review of the MDS with an ARD of 10/09/2024 revealed a BIMS score of 15, indicating the resident was cognitively intact. Resident #41 and Resident #78 On 01/07/2025 at 03:00 PM, during an observation there was an altercation between Resident #78 and Resident #41 near the exit door for smoking, which is near the dining room. No staff were present at the time of the incident. Record review of the facility's, "Incident Report", dated 01/07/25 revealed Resident #41 was	F 689	mealtimes, activities, and 20 minutes prior to smoke break. The Quality Assurance Performance Improvement (QAPI) team met on 01/10/25 and discussed policies and procedures on abuse, neglect and exploitation and accidents and incidents ☐ investigating and reporting with no revisions needed at this time. All incidents and accidents will be monitored 5 times a week in our morning clinical meetings starting 01/13/2025 and ending 02/28/25 to ensure proper investigating and reporting and to ensure interventions are in place. All findings will be reported to the QAPI team of all accidents and incidents starting 02/13/25 and ending 03/31/25.		

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F 689	Continued From page 25 walking in the hallway next to the kitchen when another resident called this resident a (expletive) this resident then called the other resident a (expletive) and then proceeded to slap the other resident in the face. Both residents began pushing each other when the Resident #78 pushed Resident #41 with her wheelchair, knocking Resident #41 to the floor where she hit the back of her head. The staff immediately intervened and assessed the resident for injury. Resident #41 noted to have quarter sized hematoma to the back of her head. Charge nurse took Resident #41's vital signs, and the Medical Director and family was notified the resident was sent to the local emergency room for an evaluation. A record review of Resident #41's "Admission Record" revealed the resident was admitted on 03/21/2023 with diagnoses including Chronic Obstructive Pulmonary Disease and Major Depressive Disorder. A record review of Resident #41's MDS dated 11/20/2024 revealed a BIMS score of (3), indicating severe cognitive impairment. A record review of Resident #78's "Admission Record" revealed the resident was admitted on 03/22/2023 with a diagnosis of Unspecified Dementia. A record review of Resident #78's MDS dated 10/20/2024 revealed a BIMS score of seven (7), indicating severe cognitive impairment.	F 689			
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		2/13/25	

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F 812	Continued From page 26 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources 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, record review, and facility policy review, the facility failed to discard expired food items from the refrigerator, remove opened, exposed, and unlabeled food items from freezer, and ensure dietary staff wore a hair restraint while plating food for two (2) of three (3) observations. Findings included: A review of the facility's policy, "Personal Hygiene," revised 1/18/2019, revealed, " Objective: Participants will learn what guidelines for personal hygiene are needed to promote a safe and sanitary Food and Nutrition Services department...3. Head Covering Worn ...Hair must be appropriately restrained or completely covered. Beards, mustaches, or any body hair	F 812	The facility failed to discard expired food items from the refrigerator, remove opened, exposed, and unlabeled food items from freezer, and ensure dietary staff wore a hair restraint while plating food. The container of mayonnaise with use by date of November 2024 and bag of shredded lettuce with use-by date 12/24/24 were immediately discarded. The freezer items that were exposed, unlabeled, and not dated included pie shells, corn on the cob, biscuits, and cinnamon rolls were also discarded. On 01/10/25, Dietary #2 was educated one on one by the Dietary Manager on the requirements of proper hair restraints to include his beard, mustache or any exposed body hair while plating food.		

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F 812	Continued From page 27 that may be exposed ...must be covered ..." A review of the facility's policy, "Labeling and Dating for Safe Storage of Food," revised 3/6/2020, revealed, " ...All products should be dated upon receipt ... All products should be dated when opened ... Use Use-By dates on all food once opened and stored under refrigeration ... Expiration dates supersede storage guide ..." On 1/6/2025 at 10:43 AM, during an observation and interview with the Dietary Manager (DM), there was one (1) container of mayonnaise with a manufacturer's use-by date of November 2024 and (1) bag of shredded lettuce with a use-by date of 12/24/2024 in Refrigerator #1. In Freezer #2, there was (1) opened, exposed, and uncovered pie shell undated, (1) opened exposed, and unlabeled bag of corn on the cob, (1) opened, exposed, and unlabeled bag of biscuits, and (1) opened, exposed, and unlabeled bag of cinnamon rolls. The DM confirmed the mayonnaise and shredded lettuce were expired and there were opened and exposed food items in the freezer. She expressed that she had reminded the kitchen staff to date and label opened food items in the freezer. On 1/8/2025 at 10:46 AM, during an interview, the Registered Dietitian (RD) revealed that kitchen staff receive monthly in-services, with the last one held in December 2024. Topics covered during monthly in-services included pest control, resident rights, sanitation, gloves, cleaning, and labeling and dating food in refrigerators. The RD stated the expectation for kitchen staff is to work as a team, prepare food per guidelines, maintain sanitation, and follow instructions.	F 812	All residents have the potential to be affected. All dietary staff were educated by the Dietary Manager and Registered Dietician on the proper use of hair restraints to include beards, mustaches, and any other exposed body hair; the requirements for labeling and dating food; and discarding expired foods starting 01/10/25 and ending 01/31/25. The Quality Assurance Performance Improvement (QAPI) team met on 01/10/25 and discussed the policy for Personal Hygiene and Labeling and Dating for Safe Storage of Food with no revisions needed at this time. Starting 01/13/25 and ending 03/01/2025 the Dietary Manager and Assistant will monitor through weekly observation of staff during mealtimes to ensure all proper hair restraints are utilized during plating and will conduct daily checks of refrigerator and freezer for expired and unlabeled foods. All findings will be reported monthly to the QAPI Team starting 02/13/25 and ending 03/31/25.		

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F 812	Continued From page 28 On 1/8/2025 at 11:34 AM, during an observation, Dietary #2 (Kitchen Aide) was plating food and preparing trays and was not wearing a hair restraint on his beard. On 1/8/2025 at 1:03 PM, during an interview, the DM stated that in-services for kitchen staff are held every other month and as needed. The DM noted the last in-service, held in December 2024, covered topics such as equipment upkeep and gloves. An in-service in October 2024 included topics on hair nets and beard guards. The DM emphasized that staff are expected to follow guidelines, rules, and apply the information from in-services. On 1/8/2025 at 2:27 PM, during a follow-up interview, the DM confirmed Dietary #2 had prepared resident's plates at the steam table for lunch and was not wearing a hair restraint for his beard as required. She commented that she has had to remind dietary staff to wear hair restraints. On 1/9/2025 at 4:20 PM, during a phone interview, Dietary #2 confirmed he had received in-service training on hair restraints but could not recall the dates. He stated he typically washes dishes but plated food on 1/8/2025 because another worker called in. The dishwasher acknowledged the importance of wearing hairnets and beard guards to prevent hair from getting into residents' food. On 1/9/2025 at 4:30 PM, during an interview, the Administrator acknowledged she was aware of the findings in the dietary department. The Administrator stated her expectations included following guidelines to prepare foods in a manner that prevents illness and ensures food is	F 812			

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F 812	Continued From page 29 appealing to residents.			F 812			
F 880 SS=D	A record review of dietary in-service records dated 7/24/2024 and 12/18/24 revealed the dietary staff received training regarding covering labeling, dating, and wearing hair restraints. 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			2/13/25

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F 880	Continued From page 30 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, interview, and facility policy review, the facility failed to prevent the possible spread of infection when a Certified	F 880	The facility failed to prevent the possible spread of infection. All staff were educated on the facilities Infection and		

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F 880	Continued From page 31 Nurse Aide (CNA) placed soiled linens on the floor of a resident's room and against her clothes for one (1) of four (4) days. Findings included: A review of the facility's policy titled "Laundry and Bedding-Soiled," dated October 22, 2008, revealed, " ...Soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen ..." On 1/7/2025 at 3:45 PM, during an interview and observation, there was a strong urine odor at the South Front Hall. While walking past Room S7, soiled linen was observed placed on the floor beside the bed. CNA #1 was in the room and explained the soiled linen should not have been placed there and stated that she "knew better." CNA #1 picked up the soiled linens from the floor, placing them directly against her clothing on her body, before putting them on the bare mattress of the resident's bed. She further explained that she should have placed the soiled linens in a bag because they should not be on the floor. CNA #1 retrieved a plastic bag, placed the soiled linen in the bag, and took it to the soiled linen room. On 1/8/2025 at 9:45 AM, during an interview, Registered Nurse (RN) #1/Infection Preventionist, stated she expected staff to use a bag to place soiled linen in and to avoid placing linen on the floor or against their body. On 1/9/2025 at 10:05 AM, during an interview, the Director of Nursing (DON) explained her expectations for staff to follow infection control guidelines and policies to prevent infections. She	F 880	Control policies to include proper handling of soiled linens and bedding starting 01/10/25 and ending 01/31/25. The Director of Nursing educated CNA #1 on 01/10/25 on Infection and Control policies to include proper handling and transfer of soiled linens and bedding. All residents have the potential to be affected. All staff were educated on the facilities Infection Control policies to include proper handling of soiled linens and bedding starting 01/10/25 and ending 01/31/25. The Quality Assurance Performance Improvement (QAPI) team met on 01/10/25 and discussed the facilities Infection Control policies to include proper handling of soiled linens and bedding with no revisions needed at this time. The facilities infection preventionist and Director of Nursing will utilize a monitoring tool to make infection prevention rounds to include proper handling and storage of soiled linens starting 01/13/25 and ending 03/31/2025. All findings will be reported monthly to the QAPI Team starting 02/13/25 and ending 03/31/25.		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER PLAZA COMMUNITY LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4403 HOSPITAL ROAD PASCAGOULA, MS 39581		
(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 880	Continued From page 32 stated staff are educated to bring clean linen into rooms using trash bags and use the same bags to collect and transport dirty linen immediately to the soiled linen room. She emphasized that no dirty linen or trash bags should be placed directly on the floor or against staff's bodies to prevent the spread of infection.	F 880			