STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255116	A. BUILDING _____ B. WING _____	C 01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND NURSING AND REHABILITATION CENTER LLC	3680 LAKELAND LANE JACKSON, MS 39216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and complaint investigations (CIs), MS #27735, CI MS #27678, and CI MS #27680 at the facility from 1/27/25 through 1/30/25. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid . The SA investigated CI MS #27735 for medications administration and quality of care and there were no citations regarding this complaint. CI MS #27678 was investigated for concerns regarding staffing, grooming, weightloss, bowel and bladder and falls, and F725 was cited. CI MS# 27680 was investigated for concerns of sufficient staffing levels and F725 was cited. Citations regarding the recertification survey included F584, F641, F656, F725, F761, F812, F842, and F880. The facility had a census of 87 and was licensed for 105 beds.	F 000		
F 584 SS=E	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	F 584		3/10/25

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

Electronically Signed | 02/17/2025

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F 584	Continued From page 1 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are 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, interview, record review, and facility job description review, the facility failed to ensure the residents' right to a homelike environment for one (1) of eighteen (18) sampled residents, Resident #5. Findings included: A review of the facility's "Job Description," dated 08/01/2012, for the Director of Maintenance revealed, " ...General Description ...the Director of	F 584	1. Resident #5 was moved to rm#316 on 1.29.25 while floor in residents room was repaired. Laminate was removed and replaced with tile by maintenance director on 1.31.25. 2. All residents that require to maintain homelike environment have the potential to be affected by this deficient practice.	

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F 584	Continued From page 2 Maintenance ... is accountable for the upkeep of the grounds, Facility, and equipment in a safe and efficient manner ...Essential Duties 1. Provides a safe, clean environment for residents in accordance with Resident Care Policies and Procedures ..." On 01/27/2025 at 3:26 PM, during an observation, Resident #5 was seated in her wheelchair in her room. The resident was confused but able to make simple needs known. The linoleum flooring in the resident's room was torn and folded back under the resident's wheelchair. The flooring was also buckling up under the resident's bed. On 01/27/2025 at 4:00 PM, during an interview, Resident #5's sister stated that the resident's flooring had been torn for several months. She reported that she had complained to the nursing staff and the Administrator because she felt the flooring was a fall risk. On 01/28/2025 at 4:05 PM, during an interview, Certified Nursing Assistant (CNA) #3 stated that the flooring had been in ill repair for at least a month. CNA #3 explained that when housekeeping mopped the floor, they laid the torn flooring back down, but the edges lifted again within a day. CNA #3 also stated that she had reported the issue to the Maintenance Director. On 01/28/2025 at 4:15 PM, during an interview, Licensed Practical Nurse (LPN) #5 stated that the floor had been torn for as long as he could remember. He noted that the sharp edges at the base of the bed continued to rip the flooring each time the bed was moved. He stated that he had placed the information on the clipboard at the	F 584	3. Maintenance director was in serviced by Executive Director on 1.30.25 to ensure that all resident rooms will maintain homelike environment. Resident rooms should be free of hazards related to flooring. 4. On 1.31.25 Maintenance Director and Executive Director conducted room rounds of all resident rooms to ensure no tears in flooring or damages to tile related to flooring existed in any other rooms. Executive Director and Maintenance Director to conduct safety rounds beginning 2.3.25 (2) times per week for 3 weeks and weekly for 4 weeks. Results of round to be reviewed in Quality Assurance Meeting on 3.10.25 then monthly for 2 months.	

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F 584	Continued From page 3	F 584		

nurse's station for the Maintenance Director.

On 01/28/2025 at 4:35 PM, during an interview, the Maintenance Director stated that he had known about the torn flooring for about a month. He reported that he had installed the linoleum flooring approximately a year ago. He stated that he was the only maintenance staff in the facility and had not had the opportunity to repair the floor. The Maintenance Director confirmed that the torn linoleum presented a potential fall hazard for the resident.

On 01/28/2025 at 4:40 PM, during an observation and interview, the Administrator confirmed the linoleum in Resident #5's room was torn. The Administrator stated that she was aware of the linoleum coming up and planned to have new tile installed. She reported that she had not had time to complete the repair. The Administrator stated that she expected CNAs to elevate the bed onto its wheels to prevent it from dragging across the floor. She explained that the bed was a crank bed and required staff to manually adjust it. The Administrator confirmed that Resident #5 transferred herself from bed to wheelchair without assistance and was at high risk for falls.

A record review of the "Admission Record" revealed Resident #5 was admitted to the facility on 4/21/2017 with diagnoses that included Spinal Stenosis.

A record review of Resident #5's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/15/2024 revealed a Brief Interview for Mental Status (BIMS) score of eight (8), which indicated the resident's cognition was moderately impaired.

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to accurately code a Minimum Data Set (MDS) assessment for a resident who was coded as discharged to the hospital but was discharged to home instead of the hospital for one (1) of 18 sampled residents. (Residents #83) Findings included: A record review of the Discharge MDS with an Assessment Reference Date (ARD) of 11/09/24 revealed the Resident #83 was discharged to a short-term general hospital. A record review of a "Physician's Telephone Orders", dated 11/09/24, revealed Resident #83 had an order to be discharged home. On 01/29/25 at 08:07 AM, an interview with the Social Services Director (SSD), revealed Resident #83 was admitted for a brief time as she was there for skilled care and had planned to return home. The SSD stated she prepared the discharge summary based on the physician orders on the day Resident #83 left the facility. On 01/29/25 at 08:45 AM, in an interview with Registered Nurse (RN) #1/MDS, she acknowledged the MDS was coded incorrectly as being discharged to the hospital because he went back home after his stay at the facility. The RN stated the MDS nurse is responsible for assuring	F 641	1. Resident #83 MDS was corrected on 1.31.25. Transmitted and accepted on 2.2.25 by Minimum Data Sheet coordinator. 2. All residents requiring completion of Minimum Data set completed have to potential to be affected by this deficient practice. 3 Executive Director in-serviced MDS nurses regarding ensuring the accuracy of the MDS on 2.3.25. MDS nurses to completed a 100% audit on 2.14.25 for discharged residents to ensure accuracy of discharge coding. 4. MDS coordinator to audit 5 MDS completed weekly beginning 2.17.25 for 4 weeks then monthly for 2 months. These finding will be provided to Executive Director weekly and reviewed in Quality Assurance Meeting to be held 3.10.2025 and monthly for 2 months	3/10/25

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F 641	Continued From page 5 that the MDS is coded correctly prior to submission. The RN noted the purpose of the MDS is to have an accurate reflection of the patient. On 01/29/25 at 09:10 AM, in an interview with the Administrator, she acknowledged the discharge MDS for Resident #83 was incorrectly coded for the resident because he went home after his stay and did not go to the hospital. The Administrator stated the MDS Coordinator is responsible for making sure the MDS is coded correctly. The Administrator stated that the importance of accurate MDS coding is to have an overall outlook of care provided to the patient. A record review of the "Admission Record" revealed the facility admitted Resident #83 on 10/23/24 with diagnoses including Muscle Weakness.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		3/10/25

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F 656	Continued From page 6 (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 interview, record review, and facility policy review, the facility failed to develop a person-centered care plan regarding a resident's impaired vision for one (1) of (18) care plans reviewed. Resident #68. Findings included:	F 656	1. Resident #68 was assessed by Director of Nursing Services and Director of Rehab services to identify level of impairment to implement additional interventions. Facility placed brightly colored signage in residents room to remind him to wear glasses and lock wheelchair. Brightly colored tap placed on	

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F 656	Continued From page 7 A review of the facility's policy titled "Comprehensive Care Plan Policy," revised on 01//2025, revealed, "Each resident will have a person-centered plan of care to identify problems, needs, strengths, preferences, and goals that will identify how the interdisciplinary team will provide care. All disciplines work together to develop a plan of care that meets the resident's needs, preferences, and goals." A record review of the "Comprehensive Care Plan" revealed Resident #68 did not have a care plan regarding impaired vision. A record review of the "Admission Record" revealed the facility admitted Resident #68 on 6/23/23 and he had current diagnoses including Paralytic Ptosis of Left Eyelid. A record review of the "Eye Examination," dated 09/19/2024, revealed Resident #68 was seen by a local optometrist and was diagnosed with Dry Eye Syndrome of bilateral lacrimal glands, Paralytic Ptosis of the left eyelid, and Contusion of the left eyelid and periocular area (active since 08/14/2024). The optometrist ordered glasses for Resident #68. On 01/28/2025 at 11:00 AM, during an interview, Licensed Practical Nurse (LPN) #3 stated the resident had poor vision in the left eye and that she must approach him from the right side. On 01/29/2025 at 10:00 AM, during an interview, LPN #2 stated she was responsible for adding new diagnoses to the care plan with interventions. LPN #2 stated she did not know the resident had seen the optometrist, had orders for glasses, or had a diagnosis of impaired vision.	F 656	wheelchair breaks, call light and over bed light so resident can easily identify these devices. Resident care plan updated to reflect vision impairment and interventions on 1.30.25. Resident Kardex updated on 1.31.25 for Certified Nursing Assistants staff to remind resident to wear glasses for vision impairment and observe for safety. 2. All residents had the potential of being affected by not having a person centered care plan developed. 3 Nursing staff educated on developing person centered care plans 2.4.25 by Staff Development Coordinator 4. Director of Nursing Services and Minimum Data Sheet Coordinator to audit beginning 2.3.25 (5) residents care plan per week for 4 weeks. Then monthly for 2 months to ensure person centered care plans are developed with appropriate interventions addressed. Audit to be submitted to Executive Director weekly. Audit to be reviewed in Quality Assurance Meeting to be held 3.10.25 then monthly for 2 months.	

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F 656	Continued From page 8	F 656		

On 01/30/2025 at 1:00 PM, during a phone interview, the Optometrist Assistant confirmed that the resident ordered glasses in September 2024 due to impaired vision and stated the resident should always wear his glasses while awake.

On 01/30/2025 at 3:15 PM, during an interview, LPN #4 confirmed that Resident #68 was not care planned for impaired vision. LPN #4 also explained that she did not know the resident had a diagnosis of Contusions/Ptosis to the left eye because it was not on the chart. LPN #4 stated that neither the resident nor staff informed her that his vision was impaired. She further stated that the current care plan reflected generic interventions because she was unaware of the diagnosis. LPN #4 explained that the Nursing Supervisor should have documented the care plan for the diagnosis as well as the resident's orders for glasses. She also stated that the eye examination and results were not on the chart and that she only included information on the care plan when nursing staff documented it or placed it in the chart. LPN #4 stated she was unaware that the resident had ordered glasses.

On 01/30/2025 at 3:30 PM, during an interview, the Administrator stated she did not know the resident's left eye was impaired or that the resident had been seen by the optometrist. She stated she found the eye examination documentation in the medical records. The Administrator stated that the Nursing Supervisors were responsible for ensuring the orders were placed on the care plan and that the Care Plan Nurse served as a backup for the Nursing Supervisors. The Administrator stated she did not

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F 656	Continued From page 9 know how this had been missed and was unsure why the optometrist's report and admission diagnosis were not addressed.	F 656		
F 725 SS=F	Sufficient Nursing Staff 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, staff interviews, and record review, the facility failed to ensure sufficient nursing staff to meet the needs of	F 725	1.Facility ensures that adequate staffing in place with the use of additional as needed staff.	3/10/25

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F 725	Continued From page 10 residents for four (4) of 14 staffing days reviewed in January, 2025. (1/19/25, 1/20/25, 1/25/25, and 1/27/25). Findings Include: Record review of a typed document on facility letterhead dated January 30, 2025, and signed by the Executive Director (Administrator) revealed "There is no Staffing policy" A review of anonymous complaints, received 1/20/25 and 1/21/25, revealed "3-11 and 11-7 shifts are always short CNAs" and "there was one CNA working the floor Central Unit by herself on 3-11 Sunday 1/19/25." A record review of the "PBJ (Payroll Based Journal) Data Report" for the 4th Quarter (July 1-September 30) revealed the facility triggered for "One Star Staffing Rating" and "Excessively Low Weekend Staffing." A record review of the "Facility Assessment Tool" dated 1/10/2025, revealed "...There are 3 units: South, Central, and North ...Staffing plan ...Nurse aides ...3-11 CNA (3 South/2 Central/4 North) 11-7 CNA (2-3 south/2 central/ 3 north unit) ..." The facility assessment indicated the resident acuity and population required 9 total CNAs for 3-11 shift and 7-8 CNAs for 11-7 shift. A record review of the staffing grid completed by the facility revealed on 1/27/24 there were three (3) CNAs on the 11-7 shift (85 census), on 1/25/24 there were three (3) CNAs on the 11-7 shift (87 census), on 1/20/25, there were three (3) CNAs on the 11-7 shift (85 census), and on 1/19/24 there were four (4) CNAs on the 3-11	F 725	2. All residents in the facility have the potential to be affected by this deficient practice. 3. Staff Development Coordinator, Director of Nursing Services, and nurse manager in-serviced on 1.31.25 by Executive Director regarding maintaining desired staffing level and notifying Executive Director immediately when staffing falls below required levels. 4. Facility will utilize on call, administrative, and agency staff to ensure adequate staffing is maintained. Staff Development Coordinator to provide Executive Director with daily staffing totals and updates regarding call-in and no shows beginning 2.4.25 so that contingency can be arranged. Registered Nurse Supervisor to notify Executive Director on weekends beginning 2.4.25 regarding staffing, call-ins, and no shows so that contingency staff can be arranged. Staff Development Coordinator, Director of Nursing, and Executive Director to have staffing/recruitment beginning 2.10.25 meeting weekly for 4 weeks. Then monthly for 2 months. Minutes to be reviewed in Quality Assurance Committee 3.10.25, then for 2 months	

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F 725	Continued From page 11	F 725		

shift and three (3) CNAs on the 11-7 shift (84 census).

On 01/28/25 at 9:39 AM, during an interview with Licensed Practical Nurse (LPN) #1/Staffing Coordinator, she revealed the facility faces challenges keeping the building staffed on weekends due to frequent call-ins. She noted that while the required number of staff is scheduled appropriately, the high rate of call-ins creates difficulties in maintaining weekend staffing levels. She indicated that this month, January 2025, the facility has had to operate with only one (1) CNA on halls that should have had two (2).

During an observation and interview on 1/28/25 at 5:00 PM, LPN #5 confirmed a resident's medication was left on the resident's table because the resident was slow taking her medication. The nurse stated there was no time to encourage the resident to take her medication because there was only one CNA assigned to the unit to assist with the residents' care, provide showers and meals.

On 1/29/25 at 09:28 AM, during a follow-up interview with LPN #1/Staffing Coordinator, she confirmed the staffing grids accurately reflect all staff that were assigned to the halls, including any agency staff. She said she knows that having one CNA on the units is not appropriate because there should be two on each unit to cover the resident needs.

In an interview with the Administrator on 1/29/25 at 2:31 PM, she indicated that it was because of illnesses due to COVID-19 and constant call ins as to why they had low staffing on the weekends.

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F 761	Continued From page 12	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure medications were secured and inaccessible to unauthorized residents and staff one (1) of four (4) days of survey observations. Findings included: A review of the facility's policy titled "Medication	F 761	1. Residents #5,#56, identified as having medications at bedside. Medications immediately removed by Licensed Practical Nurse on 1.28.25. 2. All resident had the potential of being affected by this deficient practice. 3. Nursing staff in-serviced on 2.3.25 by	3/10/25

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F 761	Continued From page 13	F 761		

Storage," dated 01/2015, revealed, " ...All drugs, treatments, and biologicals must be stored securely..."

Resident #5

A record review of the "Admission Record" revealed the facility admitted Resident #5 on 04/21/2017 with diagnoses including Spinal Stenosis.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/15/2024 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of eight (8), which indicated the resident's cognition was moderately impaired.

On 01/28/2025 at 4:40 PM, during an observation and interview with the Administrator, an unattended medicine cup was observed on Resident #5's bedside table alongside a glass of water. The resident was lying flat in bed, and no staff were present to monitor the resident taking the medication.

On 01/28/2025 at 5:00 PM, during an interview, Licensed Practical Nurse (LPN) #5 confirmed he left the medication on the table because the resident was slow to take her medication. He stated he did not have time to encourage the resident to take her medication as she normally took one pill at a time. He acknowledged that he knew he should not have left the medication unattended because the resident could choke, or another resident could enter the room and take the medication. LPN #5 reported that the medication in the cup included Vitamin C, Multivitamin, Levothyroxine, Metoprolol and

Staff coordinator regarding not leaving medication in residents rooms. Nurse should verify that resident has taken all medications prior to leaving room. Resident cannot have medicated creams in room.

4. Unit Managers and Director of Nursing to make rounds beginning 2.3.25 to ensure no medications are left at bedside 3 times per week for 4 weeks. Then weekly for 3 weeks. Audit tools to be reviewed in Quality Assurance Meeting on 3.10.25, then monthly for 2 months

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F 761	Continued From page 14	F 761		

Pravastatin.

On 01/28/2025 at 5:15 PM, during an interview, the Administrator confirmed that LPN #5 left the medication in a medicine cup unattended on the resident's bedside table. The Administrator stated she expected nurses to ensure residents swallowed their medications before leaving the room.

Resident #56

A record review of Resident #56's "Admission Record" revealed the facility admitted the resident on 03/05/2024 and currently has diagnoses that include Pruritus.

A record review of the "Order Summary Report" with active orders as of 1/30/2025, revealed Resident #56 had a Physician's Order, dated 10/25/24 for Nystatin External Cream.

A record review of Resident #56's MDS with an ARD of 11/20/2024 revealed a BIMS score of 15, which indicated the resident was cognitively intact.

On 01/28/2025 at 9:08 AM, during an observation and interview with Resident #56, the resident was observed sitting up in bed with two medication dispensing cups containing an unidentified cream on the bedside table. One cup was nearly empty, and the other contained a moderate amount of cream. Resident #56 stated that the weekend nurse gave her the cream to apply as needed for itching.

On 01/28/2025 at 9:12 AM, during an observation and interview, LPN #3 acknowledged the

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F 761	Continued From page 15 medication cups containing some type of cream were left on Resident #56's bedside table. LPN #3 stated that nurses were not supposed to leave any medications at the bedside. After reviewing the physician orders, LPN #3 confirmed the unidentified cream was Nystatin External Cream.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources 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 and staff interview, the facility failed to ensure proper food handling and sanitation practices to prevent cross-contamination when Dietary Cook (DC) #2 failed to sanitize the thermometer when checking food temperatures on the tray line for one (1) of two (2) kitchen observations	F 812	1.Dietary cook in-services 1:1 on 1.28.25 regarding proper sanitation of thermometer when taking food temperatures. 2. All residents that receive meals from dietary services have the potential to by this deficient practice,	3/10/25

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F 812	Continued From page 16 Findings included: On 01/27/2025 at 11:15 AM, during an observation of the tray line, DC 2 was observed checking food temperatures. DC #2 used a brown paper towel to clean the thermometer between food items. DC #2 wiped food residue off onto a brown paper towel and then tested each food item on the tray line without properly sanitizing the thermometer. On 01/27/2025 at 12:10 PM, during an interview, the Dietary Manager (DM) #1 stated that staff should always use an alcohol pad to clean the thermometer when checking tray line temperatures. DM #1 explained that using a paper towel instead of an alcohol pad constitutes cross-contamination. She confirmed that dietary staff had been trained to use alcohol swabs when performing tray line temperature checks. On 01/29/2025 at 1:56 PM, during a phone interview, DC #2 confirmed that she had used a brown paper towel instead of an alcohol pad when checking tray line temperatures on 01/27/2025 at 11:15 AM. DC #2 stated that she had been trained to use an alcohol pad but was nervous and forgot to follow the procedure. She acknowledged that her actions constituted cross-contamination and could cause residents to develop gastrointestinal issues.	F 812	3. Dietary staff in-serviced on 1.27.25 by Dietary Manager regarding proper sanitizing of thermometer when taking food temperatures. 4. Dietary Manager to monitor tray line during temperature beginning 2.3.25 once daily for 4 weeks then 2 times weekly for 3 weeks to ensure proper sanitization of thermometer. Monitoring tools to be provided to Executive Director weekly and reviewed in Quality Assurance Meeting 3.10.25, then monthly for 2 months	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F 842		3/10/25

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resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

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F 842	Continued From page 18 §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain complete and accurate medical records by failing to document that residents were informed of their rights regarding Advance Directives for three (3) of (18) resident records reviewed, Residents #22, #27, and #61. Findings included: A record review of the "Admission Record" revealed the facility admitted Resident #22 on 06/10/2024 with diagnoses including Unspecified Dementia, Resident #27 on 06/14/2024 with diagnoses including Atherosclerotic Heart Disease, and Resident #61 on 9/20/2024 with diagnoses including Vascular Dementia.	F 842	1. Residents #22, #27, and #61 advance directives were updated to reflect current preferences and filled to chart. Resident #27 advance directive updated 1.25.25; resident #22 advance directive updated 1.25.25; resident #61 Advance Directive updated 1.25.25 2. All residents had the potential to be affected by this deficient practice. 3. Social Services Director in-serviced on 1.31.25 by Executive Director ensuring Advance Directives are completed on admission and annually per policy. Also to conduct follow-up on forms not updated.	

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F 842	Continued From page 19 A record review of the "Resident Rights/Advance Directive" revealed the Advance Directive was not initialed by the residents or Resident Representatives that confirmed they were informed of information regarding formulating an Advance Directive for Residents #22, #27, and #61. A record review of the "Resident Rights/Advance Directive" revealed the Advance Directive was not initialed by the residents to confirm being informed of information regarding formulating an Advance Directive for Residents #22, #27, and #61. On 01/28/2025 at 11:49 AM, during an interview, the Social Services Director (SSD) confirmed she was responsible for completing the Advance Directive. The SSD acknowledged the Advance Directive was incomplete and was not marked to indicate that the residents had been informed of rights regarding Advance Directives for Residents #22, #27, and #61. On 01/28/2025 at 4:08 PM, during an interview, the Administrator acknowledged that the Advance Directive forms were incomplete and failed to reflect the residents' receipt of information related to Advance Directives. The Administrator stated the Social Services Director was responsible for confirming that all information related to the residents' choices and that it should be documented.	F 842	Social Service Director to complete a 100% audit of all resident chart to ensure Advance Directive are updated and documentation of resident preferences completed on 2.14.25. 4. Social Service Director will audit new admit charts weekly beginning 2.10.25 to ensure accuracy and completeness of Advance Directive weekly for 3weeks then monthly for 2 months. Audits will be provided to Executive Director weekly and reviewed in QA 3.10.25 and monthly for 2 months	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		3/10/25

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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 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

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F 880	Continued From page 21 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, record review, and facility policy review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were followed while providing care to a resident requiring high-contact precautions for two (2) of three (3) care observations, Resident #27. Findings included: A review of the facility's "Enhanced Barrier Precautions" policy, dated 04/2024, revealed, "Enhanced Barrier Precautions are indicated for residents with ...indwelling medical devices,	F 880	1.Licensed Practical Nurse #2 and Licensed Practical Nurse #7 provided in-service on 1.29.25 regarding properly donning gown/Personal Protective Equipment(PPE) when providing direct care to residents on Enhanced Barrier Precautions. 2. All residents requiring Enhanced Barrier Precaution were at risk from this deficient practice. 3. All staff in-serviced 2.3.25 by Staff	

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F 880	Continued From page 22 secretions/excretions that are unable to be covered/contained, and are not known to be infected/colonized with any MDRO (Multidrug-Resistant Organism) during high-contact resident care activities, as these residents are at an increased risk of being infected ..." On 01/29/2025 at 8:50 AM, during an observation, Licensed Practical Nurse (LPN) #2, the Nursing Supervisor, was observed administering medications to Resident #27 via percutaneous endoscopic gastrostomy (PEG) tube. LPN #2 did not wear a gown while accessing the resident's PEG tube. On 01/29/2025 at 10:20 AM, during an observation, LPN #7 was observed performing PEG tube care for Resident #27. The nurse entered the resident's room and explained that she was going to clean the PEG tube site. LPN #7 washed her hands and applied clean gloves but did not apply a gown prior to providing care. On 01/29/2025 at 10:27 AM, during an interview, LPN #7 stated that Enhanced Barrier Precautions are used to protect Resident #27 from staff. She acknowledged that she should have donned (put on) a gown before providing care. On 01/29/2025 at 10:35 AM, during an interview, LPN #2, the Nursing Supervisor, stated that she should have worn a gown when administering PEG tube medications to Resident #27. She acknowledged that her actions put the resident at risk for complications, including infection. On 01/30/2025 at 9:45 AM, during an interview, LPN #6/ Infection Preventionist (IP) stated that	F 880	Development Coordinator regarding Enhanced Barrier Precautions. 4. Infection Preservationist and Staff Development to conduct competency training with staff regarding proper donning of Person Protective Equipment for Enhanced Barrier Resident starting 2.3.25. Completed check offs on 5 staff 3 times per week for 4 weeks then weekly for 3 weeks. Check offs to be provided to Executive Director weekly and reviewed in Quality Assurance Committee on 3.10.25. Then monthly for 2 months	

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nurses should have donned a gown before providing care to Resident #27's PEG site . She explained that the gown protects the resident. She stated that the nurses' failure to follow proper precautions could result in the resident having complications. She explained that her expectation was for staff to don the appropriate Personal Protective Equipment (PPE) when providing care to residents that are at high risk for MDROs.

A record review of the "Admission Record" revealed the facility admitted Resident #27 on 6/14/24 with diagnoses including Metabolic Encephalopathy.

A record review of the "Order Summary Report" with active orders as of 1/29/2025, revealed Resident #27 had a Physician's Order, dated 6/14/24, to clean the PEG site with soap and water, pat dry, and cover with split gauze every night shift.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/17/2024 revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of nine (9), which indicated the resident's cognition was moderately impaired.

A record review of the Enhanced Barrier Precautions signage on Resident #27's door revealed instructions indicating, "Everyone must ...wear gloves and a gown for the following High-Contact Resident Care Activities ...Device care or use ...feeding tube ..."