STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255232	A. BUILDING _____ B. WING _____	01/23/2025

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CORNERSTONE REHABILITATION AND HEALTHCARE CENTER	302 ALCORN DRIVE CORINTH, MS 38834

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification Survey and two (2) Complaint Investigations (CI MS #26868 and CI MS #27040) at the facility from 01/21/25 through 01/23/25. During the survey the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F644, F656, F677, F686, F761, and F851. The SA determined the facility was in compliance for CI MS#26868 related to abuse with no deficiencies cited and determined noncompliance for CI MS#27040 related to quality of care and cited F656 and F677. The census at the time of the survey was 78 and the facility held a license for 95 beds.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a	F 644		2/24/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/05/2025

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F 644	Continued From page 1 related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to obtain a Level II Preadmission Screening and Resident Review (PASARR) status change for a resident following an inpatient psychiatric hospital stay for one (1) of three (3) PASARRs reviewed. Resident # 57. Findings include: A review of the facility policy titled "PASRR Policy and Procedure" with a revision date of 7/18/18 revealed, "(Facility proper name) uses the most current version of PASRR Rules of the Mississippi Division of Medicaid: Administrative Code, Medicaid Title 23: Part 207, Chapter 1: Long Term Care Pre-Admission Screening as they pertain to the Level 1 (PAS) and Level 2 (PASRR) long term care processes and procedures." Record review of Resident #57's Admission Record revealed that she was admitted to the facility on 06/09/2023 with diagnoses that included Parkinsonism, Anxiety Disorder, Bipolar II Disorder, and Major Depressive Disorder, Recurrent. Record review of Resident #57's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of May 2, 2024, revealed under Section A2105. Discharge Status 07. Inpatient Psychiatric Facility (psychiatric hospital or unit) In an interview on 1/22/25 at 2:45 PM, the former	F 644	Preparation and submission of this plan of correction by Cornerstone Rehabilitation and Healthcare Center, Corinth, MS does not constitute an admission of agreement by the provider of the truth, or the facts alleged, or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is submitted and prepared solely pursuant to the requirements under the federal and state laws. -F644- Coordination of PASARR and Assessments- 1. The facility failed to obtain a Level II Preadmission Screening and Resident Review (PASARR) status change for a resident following an inpatient psychiatric hospital stay for Resident #57. A new Level II PASARR was done for Resident #57 and submitted successfully on 02-05-2025. The Administrator and Social Services Director also completed an audit on 01-24-2025 of the current residents with inpatient psychiatric hospital stays within the past year. Level II PASARRs are being done on any current resident meeting the criteria within that year. 2. The facility determined that each of the 78 residents in the facility could be affected. 3. On 1/24/2025 current staff who perform	

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F 644	Continued From page 2 Social Services Director revealed when Resident #57 went out for inpatient psychiatric treatment, she was responsible for completing the PASARRs. She confirmed she did not submit a new change of status form for a Level 2 PASARR because she thought that since the resident had a negative Level I Preadmission Screening (PAS), they were exempt from sending anything further for the resident. During an interview on 1/22/25 at 3:15 PM, the Administrator revealed that the purpose of the Level 2 evaluation is to ensure the residents get the proper psychiatric care they need. He revealed he was unaware that a change in status form was not completed for Resident #57 after her psychiatric hospital stay but confirmed that it should have been.	F 644	PASARRs were in-serviced by the Regional Clinical Specialist on the PASARR process, when they should be performed and how to perform them appropriately. 4. On 1/24/2025 PASARR checks were started and will be conducted by Social Services Director on each resident that has a behavioral health stay or diagnose change for two (2) times a month for the next six (6) months to ensure that all Level II PASARRs are completed when they should be completed. Check log will be reviewed five (5) days a week by the Interdisciplinary Team (IDT) and once monthly in the Quality Assurance (QA) Meeting on 2-24-25 and continue for six (6) months.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		2/24/25

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F 656	Continued From page 3 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, record review and facility policy review, the facility failed to implement an Activities of Daily Living (ADL) care plan for residents that were dependent on staff for assistance with personal hygiene for five (5) of 21 sampled residents. Resident #15, Resident #31, Resident #55, Resident #67, and Resident #71.	F 656	-F656- Develop/Implement Comprehensive Care Plan- 1. The facility failed to implement an Activities of Daily Living (ADL) care plan for residents that were dependent on staff for assistance with person hygiene for five (5) of 21 sampled residents. Resident #15, Resident #31, Resident # 55,	

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F 656	Continued From page 4 Findings Include Review of the facility policy titled, "Care Plans, Comprehensive, Person Centered" with a revision date of 10/2022 revealed under, "Policy Statement...A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident". Resident #15 Record review of Resident #15's Care Plan date initiated 12/27/24 revealed that she had an ADL self-care performance deficit related to weakness and impaired mobility. Resident #15's interventions included that she required partial to moderate assistance by staff for personal hygiene and to offer assistance with any shaving needs. On 01/21/25 at 10:30 AM an observation and interview revealed Resident #15 with numerous scattered facial hairs that were approximately one-half inch long on her chin and upper lip. She stated she use to could take care of it herself, but not anymore. She admitted that no one had offered to shave or remove her facial hair since she had been there and stated, "I've been here about a month. " On 01/22/25 at 10:38 AM an interview with Registered Nurse (RN) Supervisor #1, confirmed the facial hair on Resident #15's chin and upper lip needed to be removed. She confirmed that shaving is part of grooming during their bath and since it was not done then her ADL care plan was not followed.	F 656	Resident #67, and Resident #71. Assistance with personal hygiene was performed immediately by wound care nurse and Certified Nursing Assistant for each listed Resident. On 1/23/2025 Resident #15's facial hair was trimmed, Resident #71's nails were trimmed, Resident #31's nails were trimmed and he was shaved, Resident #55's nails were trimmed, and Resident #67's nails were cleaned and trimmed. A 100% audit of all current residents was started on 1-24-25 and completed by the Medical Records Nurse and Wound Nurse and those issues found were fixed during the audit. 2. The facility determined that each of the 78 residents in the facility could be affected. 3. On 1/24/2025 current nursing staff was in-serviced by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on appropriate personal hygiene to be performed for dependent residents and its frequency related to the Residents Plan of Care, which is followed to care for the resident. If any changes are noted to the Resident□s Care Plan report it to the Supervisor so the Care Plan can be updated. 4. On 1/24/2025 personal hygiene checks started and will be conducted by Nursing Administration on dependent residents three (3) days a week, on ten (10) residents, for eight (8) weeks then once monthly for three (3) months to assure substantial compliance that Activity of	

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F 656	Continued From page 5 Record review of Resident #15's "Admission Record" revealed an admission date of 12/23/24 and that she had diagnoses that included Other Fracture of Right Lower Leg, Unspecified Fall, and Chronic Obstructive Pulmonary Disease. Record review of Resident #15's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 11 which indicated that she had moderate cognitive deficits. Resident #71 Record review of Resident #71's Care Plan date initiated 12/11/24 revealed that he had an ADL self-care performance deficit related to weakness and poor balance. Resident #71's interventions included that he required partial to moderate assistance with personal hygiene and to check nail length and trim and clean on bath day and as necessary. On 01/21/25 at 10:00 AM an observation and interview with Resident #71 revealed long, jagged fingernails that were approximately one-half to three-fourths inch long bilaterally. Resident #71 stated that his fingernails were too long. On 1/22/25 at 10:34 AM, an observation and interview with RN Supervisor #1 confirmed that Resident #71 had long jagged fingernails on both hands. She confirmed that the staff were supposed to take care of their fingernails on bath day and revealed that the residents' ADL care plan was not followed. Record review of Resident #71's "Admission	F 656	Daily Living (ADL) care on residents is being followed according to Care Plan by staff. Check log will be reviewed five (5) days a week by Interdisciplinary Team (IDT) and once monthly in the Quality Assurance (QA) Meeting on 2-24-25 and continue for three (3) months.	

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F 656	Continued From page 6	F 656		

Record" revealed an admission date of 12/09/24 and that he had diagnoses that included Unspecified Dementia, Parkinson's Disease, and Need for Assistance with Personal Care.

Record review of Resident #71's MDS with ARD of 12/16/24 under Section C revealed a BIMS Score of 11 which indicated that he had moderate cognitive deficits.

Resident #31

Record review of Resident #31's "Care plans" revealed, "Focus: I have an ADL self-care performance deficit r/t (related to) Cerebral infarction, weakness, need for assistance with personal care ...with interventions initiated on 03/11/2020 that included, "Perform AM/PM care including oral care, peri-care, bathing, dressing, hygiene, shaving and nail care.

On 1/21/25 at 10:05 AM an observation and interview revealed Resident #31's fingernails were long and jagged with a brown substance under every nail. The resident had facial hair that was approximately one inch long on his cheeks, chin, and above the resident's lip and admitted that he had tried to get someone to shave him, but they still have not. Resident #31 stated, "I've been trying to get shaved, and I want it all shaved off."

On 1/22/25 at 9:15 AM, an interview and observation CNA #1 confirmed that Resident #31 needed to be shaved, and his fingernails needed trimming. She admitted that nail care and shaving is part of grooming.

A record review of Resident #31's Admission

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Record revealed the facility admitted the resident on 09/25/2020 with diagnoses that included Hypertensive Heart Disease with Heart Failure and Major Depressive Disorder.

Record review of the MDS with an ARD of 11/29/24 revealed Resident #31 had a BIMS score of 06, which indicated the resident had severe cognitive impairment.

Resident #55

Record review of Resident #55's "Care plans" revealed, "Focus: I have an ADL self-care performance deficit r/t weakness, impaired mobility ...with interventions initiated on 06/01/2023 that included "Bathing/Showering: Check nail length and trim and clean on bath day and as necessary."

On 1/21/25 at 10:25 AM an observation and interview with Resident #55's, he stated he likes his fingernails short. An observation at this time revealed the resident's fingernails were all long and jagged.

On 1/22/25 at 9:20 AM, an observation and interview CNA #2 confirmed that Resident #55's fingernails on both hands were too long. She revealed his fingernails should be taken care of when he gets his baths.

A record review of Resident #55's Admission Record revealed the facility admitted the resident on 05/31/2023 with diagnoses that included Pneumonia, Essential (Primary) Hypertension, and Major Depressive Disorder.

Record review of the MDS with an ARD of

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F 656	Continued From page 8 11/8/24, revealed Resident #55 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment. Resident #67 Record review of a care plan for Resident #67 titled, "I have an ADL self-care performance deficit r/t (related to) impaired mobility," revealed Interventions: personal hygiene: "I am totally dependent on staff for personal hygiene." On 11/21/25 at 9:25 AM, an observation of Resident # 67 revealed the resident had a brown substance on every fingernail on the resident's right hand. On 1/22/25 at 9:40 AM, in an observation and interview with Licensed Practical Nurse (LPN) #2 she confirmed there was a dried brown substance on each fingernail on Resident #67's right hand. She confirmed that Resident #67 had not received nail care and the resident's care plan had not been implemented. Review of the "Admission Record" revealed Resident #67 was admitted by the facility on 7/29/24 with a diagnosis of Nontraumatic Subarachnoid Hemorrhage. Record review of Resident #67's MDS with an ARD of 11/05/24, revealed GG0130: Self Care : Personal Hygiene: coded 01 Dependent.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		2/24/25

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F 677	Continued From page 9 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident, and resident representative interview, record review and facility policy review the facility failed to provide personal hygiene for five (5) of 21 sampled residents. Resident #15, Resident #31, Resident #55, Resident #67, and Resident #71. Findings Include Review of the facility policy titled, "Activities of Daily Living (ADL), Supporting," revised March 2018, revealed, "Policy Statement: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain grooming and hygiene needs...." Resident #15 An observation and interview on 01/21/25 at 10:30 AM, revealed Resident #15 sitting up on the side of her bed with facial hairs scatted over her chin and upper lip that was approximately one-half inch long. She stated that she use to be able to use tweezers when she was at home and kept her facial hair plucked. She revealed that her hair needed to be removed but she didn't have a way to do it, and no one had offered to shave or remove her facial hair since she had been there. She stated that she knew they get busy and probably forget about her but she didn't like to have hair on her face. An observation and interview on 01/22/25 at 10:30 AM with Certified Nursing Assistant (CNA) #3, revealed that facial hair was supposed to be	F 677	-F677- ADL Care Provided for Dependent Residents 1. The facility failed to implement an Activities of Daily Living (ADL) care plan for residents that were dependent on staff for assistance with person hygiene for five (5) of 21 sampled residents. Resident #15, Resident #31, Resident # 55, Resident #67, and Resident #71. Assistance with personal hygiene was performed immediately by wound care nurse and Certified Nursing Assistant for each listed Resident. On 1/23/2025 Resident #15's facial hair was trimmed, Resident #71's nails were trimmed, Resident #31's nails were trimmed and he was shaved, Resident #55's nails were trimmed, and Resident #67's nails were cleaned and trimmed. A 100% audit of all current residents was started on 1-24-25 and completed by the Medical Records Nurse and Wound Nurse and those issues found were fixed during the audit. 2. The facility determined that each of the 78 residents in the facility could be affected. 3. On 1/24/2025 current nursing staff was in-serviced by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on appropriate personal hygiene to be performed for dependent residents	

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addressed during a resident's bath or shower time and as needed and confirmed that Resident #15 had scattered facial hair on her chin and upper lip. She admitted that most ladies do not want facial hair, and it should be removed unless they refuse.

An interview on 01/22/25 at 10:38 AM with Registered Nurse (RN) Supervisor #1, confirmed the facial hair on Resident #15's chin and upper lip. She revealed that most ladies were concerned about their appearance and would want it removed. She confirmed that facial hair should be addressed and removed during the resident's bath or shower and as needed.

Record review of Resident #15's "Admission Record" revealed an admission date of 12/23/24 and that she had diagnoses that included Other Fracture of Right Lower Leg, Unspecified Fall, and Chronic Obstructive Pulmonary Disease.

Record review of Resident #15's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/24 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 11 which indicated that she had moderate cognitive deficits.

Resident #71

An observation and interview with Resident #71 on 01/21/25 at 10:00 AM revealed him lying in bed with long, jagged fingernails on his bilateral hands and was approximately one-half to three-fourths long. Resident #71 stated that his fingernails were too long, and they had started to "split and crack." He revealed that no one had offered to trim his fingernails since he came there

and its frequency.

4. On 1/24/2025 personal hygiene checks started and will be conducted by Nursing Administration on dependent residents three (3) days a week, on ten (10) residents, for eight (8) weeks then once monthly for three (3) months to assure substantial compliance that personal hygiene care on residents is being performed by staff. Check log will be reviewed five (5) days a week by Interdisciplinary Team (IDT) and once monthly in the Quality Assurance (QA) Meeting on 2-24-25 and continue for three (3) months.

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and stated, "I need them cut."

An observation and interview with Resident #71 on 01/22/25 at 9:38 AM, revealed no change in the appearance of the resident's fingernails. He stated that he used to be able to take care of his own nails when he was home, but not anymore and he liked to keep his nails a lot shorter than they are now.

An observation and interview on 01/22/25 at 10:24 AM with CNA #3, revealed that nail care was part of personal hygiene and should be looked at and taken care of every day and as needed. CNA #3 revealed that Resident #71's fingernails appeared like they had not been clipped in a while.

An observation and interview with RN Supervisor #1 on 1/22/25 at 10:34 AM confirmed Resident #71's nails needed to be trimmed and stated that long jagged fingernails could cause scratches, skin tears and possible spread of infection.

An interview with Director of Nursing (DON) on 01/22/25 at 10:50 AM revealed that fingernails should be cleaned every day and facial hair should be addressed with the resident's bath or as needed.

Record review of Resident #71's Admission Record revealed an admission date of 12/09/24 and that he had diagnoses that included Unspecified Dementia, Parkinson's Disease, and Need for Assistance with Personal Care.

Record review of Resident #71's MDS with an ARD of 12/16/24 under Section C revealed a BIMS score of 11 which indicated that he had

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moderate cognitive deficits.
Resident #31

An observation and interview on 1/21/25 at 10:05 AM revealed Resident #31's bilateral fingernails were approximately one and one-half (1 ½) inches long and jagged past the tip of fingers; a brown substance was under each nail. Resident #31 revealed "they need to be cut; they are too long." Facial hair was approximately one inch long and was noted on the cheeks, chin, and above the resident's lip. Resident #31 stated, "I've been trying to get shaved, and I want it all shaved off."

During a phone interview on 1/21/25 at 2:57 PM, Resident #31's Representative (RR) stated "We had visited before and found him to have long fingernails and not be shaved. We have brought it to the staff's attention before."

An observation and interview on 1/22/25 at 9:05 AM revealed that Resident #31 was lying in bed with no change in appearance from the prior day. Resident #31 again confirmed that he wants to be shaved, and his nails cut.

In an interview and observation on 1/22/25 at 9:15 AM, CNA #1 confirmed Resident #31's nails were very long, and that he needed to be shaved and stated, "I'm not sure when his nails or shaving has last been." She revealed the resident had refused to have his nails cut in the past, so she doesn't ask him anymore if he wants them to be done.

During an observation and interview on 1/22/25 at 9:25 AM, the DON confirmed Resident #31's fingernails were long and jagged, with a brown

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substance under them and that he needed shaving. She stated that this is not how we operate. Regardless, if he has refused in the past, he should still be offered to have his nails cleaned and cut and his facial hair shaven, which is part of his daily grooming.

A record review of Resident #31's Admission Record revealed the resident was admitted to the facility on 09/25/2020 with diagnoses that included Hypertensive Heart Disease with Heart Failure and Major Depressive Disorder.

Record review of the MDS with an ARD of 11/29/24 revealed Resident #31 had a BIMS score of 06, which indicated the resident had severe cognitive impairment.

Resident #55

An observation and interview on 1/21/25 at 10:25 AM revealed Resident #55's bilateral fingernails were approximately one-half (1/2) inch long and jagged past the tip of his fingers. Resident #55 revealed he likes them to be cut shorter and neater.

An observation on 1/22/25 at 8:45 AM revealed Resident #55's fingernails remain one-half inch long and jagged past the tip of his fingers.

An observation and interview on 1/22/25 at 9:20 AM, CNA #2 revealed she was assigned to Resident #55 today and confirmed that his fingernails on bilateral hands were long and jagged. She revealed his fingernails should be looked at every day when he gets either a bed bath or a shower and that they should be kept trimmed to prevent him from scratching himself

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and causing a skin tear.

A record review of Resident #55's Admission record revealed the resident was admitted to the facility on 05/31/2023 with diagnoses that included Pneumonia, Essential (Primary) Hypertension, and Major Depressive Disorder.

Record review of the MDS with an ARD of 11/8/24, revealed Resident #55 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment.
Resident #67

An observation of Resident # 67 on 11/21/25 at 9:25 AM, revealed all the resident's fingernails on the right hand to have a dried dark brown substance surrounding the nail cuticles and under the nail beds.

An observation on 11/21/25 at 1:45 PM, revealed Resident #67's fingernails to the right hand were still observed to have a dried dark brown substance surrounding the nail cuticles and under the nail beds.

In an observation and interview with Licensed Practical Nurse (LPN) #2 on 1/22/25 at 9:40 AM confirmed that Resident # 67's fingernails on the right hand had a dried dark brown substance around the nail cuticles and under the nail beds and it appeared to be feces. She then stated that Resident #67 had not received nail care or hand hygiene lately and confirmed that failing to perform hand hygiene and nail care could lead to infections.

In an interview with CNA #4 on 1/22/25 at 9:45 AM, she revealed that Resident #67 was prone to

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F 677	Continued From page 15 playing in her stool and confirmed she had not made rounds on the resident and seen the condition of her nails this shift. In an interview with the DON on 1/22/25 at 9:49 AM, she confirmed that not performing nail care was an infection control concern. Review of the "Admission Record" revealed Resident #67 was admitted by the facility on 7/29/24 with a diagnosis of Nontraumatic Subarachnoid Hemorrhage. Record review of Resident #67's MDS with an ARD of 11/5/24 revealed a BIMS score of 99 indicating the resident was unable to complete the interview. Section GG revealed that Resident #67 was dependent on staff for personal hygiene.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record	F 686	-F686- Treatment/Svcs to Prevent/ Heal	2/24/25

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F 686	Continued From page 16 review, and facility policy review, the facility failed to provide necessary services, to promote healing, and prevention of developing new pressure ulcers for (1) one of (3) three residents with wounds reviewed. (Resident #49) Findings include: Review of the facility policy titled, "(Proper Name) Pressure Injury Prevention Program," with a revision date of 09/2024 revealed all residents will be assessed for the risk of pressure injury... specific interventions will be implemented to prevent the development of avoidable pressure injuries, or to treat new/existing pressure injuries. ... An observation on 1/21/25 at 9:15 AM revealed Resident #49 lying asleep in bed, an air-mattress control box was attached to the foot of the bed, with no lights on indicating the mattress was not on. An observation of the mattress revealed the resident was lying in the middle of the bed, with the mattress completely deflated and sunken in the middle. Review of the Order Summary Report for Resident #49 revealed an active order dated 7/12/23 for a low air loss mattress for pressure redistribution. An observation of Resident #49 on 1/21/25 at 11:20 AM, revealed the mattress remained sunken in the middle, with Resident #49 lying in the sunken area. Certified Nurse Assistant (CNA) #4 was in the room preparing to get the resident out of bed. She revealed the air-mattress was sunken in the middle earlier in the morning before breakfast when she provided care to Resident	F 686	Pressure Ulcer 1. The facility failed to provide necessary services, to promote healing, and prevention of developing new pressure ulcers for one (1) of three (3) residents with wounds reviewed. Resident was Resident #49. Upon discovery of the deflated air mattress under this resident on 1-21-25 the Maintenance Supervisor checked and turned the mattress power on immediately. 2. The facility determined that each of the 78 residents in the facility could be affected. 3. On 1/24/2025 current nursing staff was in-serviced by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on checking of air-mattresses to ensure they are functioning properly and letting Maintenance know immediately if they are not. 4. On 1/24/2025 air mattress checks started and will be conducted by Nursing Administration on residents with air mattresses three (3) days a week, on each resident, for eight (8) weeks then once monthly for three (3) months to assure that mattresses remain functional and aired up properly. Check log will be reviewed five (5) days a week by Interdisciplinary Team (IDT) and once monthly in the Quality Assurance (QA) Meeting on 2-24-2025 and continue for three (3) months.	

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#49 and admitted that she had not reported that to anyone.

An observation and interview on 1/21/25 at 11:25 AM with Licensed Practical Nurse (LPN) #1 revealed Resident #49's air-mattress control box was not on. LPN #1 pushed the buttons on the top of the air-mattress control box and stated she could not get the box to come on. LPN #1 touched the mattress and confirmed that it was deflated. She stated that the resident could develop worsening wounds or skin breakdown from lying on a deflated air mattress.

In an observation and interview on 1/21/25 at 11:27 AM with the Maintenance Director, he confirmed Resident #49's air-mattress was deflated because the control box was cut off. He turned the box on, and it immediately came on and inflated the mattress. He then confirmed staff should check the air-mattress often to ensure it is on and functioning and report any concerns.

In an interview with the Director of Nursing (DON) on 1/22/25 at 9:48 AM confirmed that Resident #49 could develop worsening of wounds because of his small stature and lead to more skin breakdown from lying on a deflated air mattress. She then confirmed CNA #4 should have reported the mattress being deflated immediately when it was observed.

Review of the "Admission Record" revealed the facility admitted Resident # 49 on 4/13/22 with a diagnosis of Huntington's Disease.

Record review of Resident # 49's Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/01/24, revealed

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F 686	Continued From page 18 Section M: 0300: Number of Stage 4 pressure ulcers coded as (1) one. Item M:1200 was coded as having a pressure reducing device for bed.	F 686		
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, resident and staff interview, record review and facility policy review, the facility failed to ensure medications were safely and securely stored for one (1) of three (3) survey days.	F 761	-F761- Label/Store Drugs and Biologicals 1. The facility failed to ensure medications were safely and securely stored for one (1) of three (3) survey days. On this day	2/24/25

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F 761	Continued From page 19 Findings Include: Record review of the facility policy, "Storage of Medications" with a reviewed date of July 2024, revealed, "The facility stores all drugs and biologicals in a safe, secure, and orderly manner." An observation and interview with Resident #72 on 01/21/25 at 9:35 AM, revealed him lying on his bed in his room and there were ten pills inside a medication cup placed on the top of his over bed table. Resident #72 revealed that the nurse brought his medicine in about five minutes ago and he asked her to leave it there, and he planned to take it in a few minutes. He revealed that the nurse had set the medicine down and left it and a cup of water for him to take it with. An observation and interview on 01/21/25 at 9:40 AM with Licensed Practical Nurse (LPN) #3 confirmed that there were ten pills in a medicine cup on Resident #72's over bed table. She revealed that she had just prepared his 9:00 AM medications and brought them to him. LPN #3 confirmed that she should have stayed in the room and watched him take the medications and not left them with him. She revealed that by leaving medications at the bedside, she would not know what medication the resident took and someone else could come in and take them. LPN #3 confirmed that she was supposed to watch the residents take their medicine and not leave them at the bedside. LPN #3 validated with the Medication Administration Record (MAR) that those medications in the cup were the ones she had just prepared and brought in for Resident #72 to take.	F 761	the LPN Cart nurse left pills laying on resident #72's overbed table for him to take and exited the room. Upon notification on 1-21-2025 that the resident hadn't taken the medications the LPN then returned to the room and observed the resident take those medications immediately. An 100% audit of all residents rooms was started on 1-24-25 and completed by the Administrator with no new findings. 2. The facility determined that each of the 78 residents in the facility could be affected. 3. On 1/24/2025 current nursing staff was in-serviced by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on med passes and how appropriately perform a med pass as well as the appropriate ways to store medications. 4. On 1/24/2025 Med Pass checks started and will be conducted by Nursing Administration on residents three (3) days a week, on ten (10) residents, for eight (8) weeks then once monthly for three (3) months to assure residents are being given their meds properly and medications aren□t being stored incorrectly. Check log will be reviewed five (5) days a week by Interdisciplinary Team (IDT) and once monthly in the Quality Assurance (QA) Meeting on 2-24-25 and continue for three (3) months.	

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An observation and interview with Registered Nurse (RN) Supervisor #2 on 01/21/25 at 9:50 AM confirmed that it was against the facility policy to leave medications at a resident's bedside. She confirmed that there were ten pills in the medication cup left at Resident #72's bedside and that the nurses were supposed to watch the residents swallow the medications before they left the room. RN Supervisor #2 revealed that by leaving medications at the bedside, there was a risk of another resident taking the medications which could possibly be something they were not supposed to have.

An interview on 01/22/25 at 2:00 PM with the Director of Nursing (DON), revealed that medications should never be left at a resident's bedside. She revealed that someone else could have rolled in there and taken the medications while the resident was asleep. She went on to say that Resident #72 could have also put off taking them until later when other medications were due and received too much. The DON confirmed that LPN #3 should have watched the resident swallow the pills prior to leaving the room.

Record review of Resident #72's Medication Administration Record (MAR) revealed that on 01/21/25 at 9:00 AM, LPN #3 signed out ten medications for administration to Resident #72.

Record review of Resident #72's "Admission Record" revealed an admission date of 12/18/24 and that he had diagnoses that included Major Depressive Disorder, Unspecified Mood Disorder, Anxiety Disorder, and Need for Assistance with Personal Care.

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F 761	Continued From page 21 Record review of Resident #72's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/25/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that he was cognitively intact.	F 761		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse,	F 851		2/24/25

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F 851	Continued From page 22 certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to accurately submit the Payroll-Based Journal (PBJ) for the 4th quarter (July 1 - September 30) in the fiscal year (FY) 2024. Findings include: A review of the facility policy titled, "Reporting Direct-Care Information (Payroll-Based Journal),"	F 851	-F581 Payroll Based Journal- 1.On 1/23/2025, the Administrator and Director of Nursing completed an audit of all direct care hours worked 7/1/2024 through 9/30/2024. Any direct care hours worked by Department Managers/Salaried Staff and Agency Staff, that were not submitted correctly for Payroll Based Journal purposes, were immediately	

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F 851	Continued From page 23 last reviewed 3/2023, revealed "Policy Statement: Staffing and census information will be reported electronically to CMS (Centers for Medicare and Medicaid Services) through the Payroll-Based Journal system in compliance with 6106 of the Affordable Care Act...2. Direct-care staffing information includes staff hired directly by the facility, those hired through an agency, and contract employees ...10. Staffing data includes the number of hours worked each day by each staff member ..."" Record review of the PBJ Staffing Data Report revealed that the facility triggered for low weekend staffing for the fourth quarter of 2024. In an interview with the Director of Nursing (DON) and the Administrator on 1/22/25 at 3:12 PM, they revealed during the timeframe the facility triggered for low weekend staffing, the facility was having to use a lot of agency nursing staff. The DON and the Administrator both confirmed that some agency staff hours were not accurately submitted to the PBJ, resulting in the low weekend staffing being triggered.	F 851	corrected in the facility's payroll system. 2. The resident daily population was not affected by the practice of not correctly reporting and submitting Department Managers/Salaried Staff and Agency Staff hours worked in direct care to Centers for Medicare and Medicaid. 3. On 1/24/2025, the Payroll Based Coordinator educated the Administrator and Director of Nurses on mandatory submission of staffing information based on payroll data. On 1/24/2025, all Department Managers/Salaried Staff were in-service by the Director of Nurses on reporting all hours worked in direct care clocking out during meals and working required scheduled time. Staff Development Nurse and Human Resources were also in-serviced on correctly logging and reporting Agency Hours. 4.Beginning 1/24/2025 all Department Managers/Salaried Staff will be required to submit a Missed Punch form to the Director of Nursing and Administrator, for any hours worked in direct care, on a daily basis. Beginning 1/24/2025, the Corporate Payroll Based Journal Coordinator will confirm receipt of direct care hours, worked by Department Managers/Salaried Staff and Agency Staff, bi-weekly for 2 (two) months and then quarterly for 1 (one) year. Agency and Department Manager/ Salaried Staff hours will be reviewed three (3) days a week by the Interdisciplinary Team (IDT) and once	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255232	A. BUILDING _____ B. WING _____	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 851	Continued From page 24	F 851	monthly in the Quality Assurance (QA) Meeting on 2-24-25 and continue for three (3) months.	