STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255110	A. BUILDING _____ B. WING _____	01/30/2025

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MS CARE CENTER OF ALCORN COUNTY, INC-SNF	3701 JOANNE DRIVE CORINTH, MS 38834

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Re-Certification Survey along with one (1) Complaint Investigation (CI MS # 27465), at the facility from 1/28/25 through 1/30/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA identified non-compliance and cited F600, F609, F656, F697 for CI MS #27465 related to Abuse and Neglect, failure to implement a care plan, failure to notify the SA of an allegation of abuse and failure to monitor pain. The SA also cited F565, F584, F644, F656, F699, and F812 on the annual recertification survey. The census at the time of the survey was 90 and the facility is licensed for 119 beds.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon	F 565		2/24/25

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

Electronically Signed | 02/19/2025

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 565	Continued From page 1 the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review, and facility policy review, the facility failed to act upon and resolve resident grievances regarding cold food and lack of hot water for six (6) of eight (8) residents in the Resident Council meeting. Resident #5, Resident #13, Resident #28, Resident #43, Resident #64, and Resident #73 Findings Include: Review of the facility policy titled "Grievances" undated, revealed under, " ... 2. The resident has the right and the facility will make prompt efforts to resolve grievances the resident has..." Record review of the "Resident Council Meeting Agenda" dated 10/29/24 revealed Resident #73, Resident #43, and Resident #5 voiced concerns: "Food is getting cold by the time it gets to us	F 565	1) Residents #5, #13, #28, #43, #64, and #73 have been interviewed and assured we are correcting their concerns immediately with follow up to ensure their satisfaction with food temps is maintained. All above listed residents stated they are satisfied on 2/17/25. 300 Hall shower was temporarily repaired on 1/30/25 by Maintenance Supervisor. Permanent repair was done on 2/14/25 by plumbing contractor. 2) All residents who receive food in our facility or get a shower on 300 hall have the potential to be affected. 3) a.Purchase order 30840928 from food vender to purchase 14 cases of domes and 14 cases pellet underliners on 2/17/28 to replace damaged pellet	

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F 565	Continued From page 2 (Breakfast, Lunch, Supper)." Record review of the "Resident Council Meeting Agenda" dated 11/26/24 revealed, Resident #43 voiced a complaint of "bacon being cold." Resident #64 voiced, "The food is cold because staff doesn't start passing trays until about 10-15 minutes after trays are on the hall." Also revealed under, "Dietary... talked with staff about serving hot food." Record review of the "Resident Council Meeting Agenda" dated 12/31/24 revealed, under, "Dietary: ... talked with cook about cold food." Record review of the "Record of Complaint" for Resident #73 dated 1/15/25 revealed under, "Nature of Complaint: Says gravy is always cold, eggs are cold ..." Record review of the "Grievance/Complaint Report" for Resident #43 dated 1/20/25 revealed under, "Grievance/Complaint... food cold on 1/17/25 at lunch." Also revealed under, "Details: Friday in dining room at lunch - trays came out and it was about 10 minutes before staff came to pass trays and my fries were cold." During a Resident Council meeting held on 1/28/25 at 4:00 PM, Resident's #13, #28, #43, #64, and #73 revealed, cold food had been a problem for a while, and it had been discussed in the Resident Council meetings. Resident #13 voiced at lunch that her chicken pot pie was cold. She revealed that she got the dietary department to come down to her room and asked for it to be heated. Resident #28 revealed, he ate in the dining room at lunch and his soup was cold. Residents #5, #13, #43, #64, and #73 revealed	F 565	underliners and domes for food service. b. In-service for Water Temperatures / Resident Showers was done on 2/11/25 for all Certified Nursing Staff by Staff Development Nurse requiring water temps to be checked prior to administering all showers and document using the Shower Temp Log. Exhibit #5 c. Employee Questionnaire Related to Recent Survey Corrections is being done by Director of Nursing or designee for 9 employees per day beginning 2/14/25, then weekly X1 month to ensure nursing staff knows what to do if a resident complains of cold food or water. Results will be reported by Director of Nursing to the Quality Assurance Committee. Exhibit #3 d.. Grievance Policy and Procedure was reviewed by Administrator on 2/7/25 with no revisions necessary. All staff were inserviced on 2/7/25 by Staff Development Nurse. 4. a. The Tray Delivery Audit was implemented on 2/14/25 by Director of Nursing and is to be done daily on all three meals by the Nurse Supervisor for two weeks, weekly X 4 weeks then monthly X 4 months, then quarterly. Director of Nursing will take the audits to the Quality Assurance Committee by Dietary Manager. Exhibit #1 b.The Dietary Manager will perform the Room Test Tray Evaluation beginning 2/14/25 once a day for 6 weeks, then weekly for 8 weeks, then quarterly to ensure residents receive their food warm. Results of audit will be taken to Quality	

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F 565	Continued From page 3 they had been getting cold food at times for breakfast, lunch, and supper. All residents agreed they get cold food commonly when they eat in their room but agreed it does happen in the dining room. Resident #5 (the Resident Council President) revealed he was not aware of anything the facility had done to address the cold food. Resident #43, #64, and #73 voiced once the kitchen brings the meal carts out, it normally takes 10-15 minutes before anyone touches the trays to begin passing them out to the residents. An interview with Social Services #1 on 1/29/25 at 10:00 AM revealed she attends the Resident Council meetings every month. She confirmed the residents had been complaining about cold food, but she thought the issue had gotten better. SS #1 revealed she writes up the things discussed in the meetings and afterward she distributes the concerns to whoever was over the department, and they were to handle it. She revealed if there was a dietary concern, such as cold food, it would have been given to the Dietary Manager to handle. She revealed the Dietary Manager had started overhead paging to notify the staff when the meal trays were out and ready to be served. SS #1 acknowledged cold food was a topic trend in the past couple of Resident Council meetings and confirmed the issue with cold food was an unresolved grievance. An interview with the Dietary Manger (DM) on 1/29/25 at 10:18 AM confirmed she was aware of the concerns coming from the Resident Council meetings related to cold food. She revealed she had talked to the dietary staff and explained to them, they needed to cut the hot box on sooner, so the plates would get warm. The DM revealed she had also started announcing when the meal	F 565	Assurance Committee. Exhibit # 2 c. The Maintenance Supervisor will conduct once a day for 2 weeks, weekly X2, then monthly inspections of the water temps on 300 hall shower using the Daily Water Temperature Log beginning 2/14/25 and results taken to Quality Assurance Committee. Exhibit #4 d. Resident interviews are being done daily for 2 weeks, then weekly for 2 weeks, then monthly for 3 months, then quarterly by the Quality Assurance Nurse using the Resident Satisfaction Audit Form for food and water temperatures beginning 2/10/25 and taken to the Quality Assurance Committee Exhibit #6 The Quality Assessment and Assurance Committee will meet on 2/21/25 and monthly for 3 months to review findings and make recommendations and changes as needed to ensure continued compliance.	

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F 565	Continued From page 4	F 565		

trays were ready, so there would not be a delay in pass time.

An interview with the Administrator (ADM) on 1/29/25 at 2:00 PM revealed he was not aware of any resident concerns related to cold food. He revealed they did have trouble at one point in the past with cold food, but that had gotten better. The ADM confirmed resident grievances should be acted upon promptly and resolved. He stated, "Nobody wants cold food."

Record review of the "Admission Record" revealed the facility admitted Resident #5 on 5/21/12.

Record review of the "Brief Interview for Mental Status (BIMS) Evaluation" dated 12/20/24 revealed a BIMS summary score of 12, indicating Resident #5 was moderately cognitively impaired.

Record review of the "Admission Record" revealed the facility admitted Resident #13 on 7/26/24.

Record review of the BIMS dated 1/10/25 revealed a BIMS summary score of 14, indicating Resident #13 was cognitively intact.

Record review of the "Admission Record" revealed the facility admitted Resident #28 on 3/29/24.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/14/24 revealed a BIMS summary score of 15, indicating Resident #28 was cognitively intact.

Record review of the "Admission Record"

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F 565	Continued From page 5 revealed the facility admitted Resident #43 on 9/09/19. Record review of the BIMS dated 1/17/25 revealed a score of 15, indicating Resident #43 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #64 on 7/15/22. Record review of the BIMS dated 1/07/25 revealed a score of 15, indicating Resident #64 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #73 on 4/04/23. Record review of the BIMS dated 1/01/25 revealed a score of 15, indicating Resident #73 was cognitively intact.	F 565		
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		2/24/25

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F 584	Continued From page 6 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, resident and staff interviews, record review, and facility policy review, the facility failed to ensure a home-like environment, as evidenced by cold water temperatures in the 300-hall shower room for one (1) of two (2) shower rooms observed. Findings include: Review of the facility policy titled, "Resident Rights" undated revealed, "Facility will treat each	F 584	1. The 300 hall shower was temporarily repaired on 1/30/25 by Maintenance Supervisor. Permanent repair was done on 2/14/25 by plumbing contractor. Water temperature is now between 100-115 degrees. 2. All residents who receive a shower have the potential to be affected by this practice.	

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F 584	Continued From page 7 resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life..." During an interview on 1/28/25 at 10:15 AM, Resident #28 revealed that the shower room on the 300 hall where we take our showers is often without hot water. He revealed that it was a big problem last week, and when my aide brought me back to my room after the cold shower, I saw the Administrator in the hallway and told him about the issue. An interview on 1/29/25 at 9:50 AM, Certified Nurse Aide (CNA) #1 revealed she has had several residents complain of the water being cold in the 300-hall shower room. She revealed last week that she took Resident #28 to the 300-hall shower room for his shower, turned the water on, and waited for about a minute; it got a little warm but not warm enough for a shower. She stated, "I kept apologizing to (Resident #28), I felt so bad for him. When I was taking (Resident #28) back to his room, we saw the Administrator in the hallway, and (Resident #28) told him about the water being cold." She revealed that she had reported the issue to the unit manager before, and maintenance would test the water in the shower room, and they would say that it was ok. She revealed that the water still does not get warm enough. During an interview on 1/29/25 at 9:55 AM, CNA #2 revealed that multiple residents complained of the cold water in the 300-hall shower room. She revealed that she had not reported it to anyone because maintenance was already aware of the issue.	F 584	3. a. All shower water temperature will be taken and documented on Shower Temp Log beginning 2/15/25 prior to every shower by the Nurse Aides, and bath will be given in an alternate method if the temperature is not between 100-115 degrees. Staff will report any shower temp problems to the Maintenance Supervisor immediately. Quality Assurance Nurse will report to Quality Assurance Committee. Exhibit #5 b. In-services was done on 2/11/25 for staff by Staff Development Nurse to require water temps to be checked prior to administering a shower and bed baths and document using the Shower Temp Log. Director of Nursing will report to Quality Assurance committee monthly. Exhibit #5 c. Employee Questionaire Related to Recent Survey Corrections beginning 2/14/25 is being done for 9 employees per day for one week, then weekly X1 month to ensure nursing staff knows what to do is a resident complains of cold food or water. Results will be reported to the Quality Assurance Committee by Director of Nursing. Exhibit #3 4. The Maintenance Supervisor will conduct once a day beginning 2/14/25 for 2 weeks, weekly X2, then monthly inspections of the water temps on 300 hall shower using Daily Water Temperature Log and taken to QA Committee. Exhibit #4 Results of the water temp checks will be taken to the Quality Assessment and Assurance Committee on 2/21/25, then	

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F 584	Continued From page 8 In an interview on 1/29/25 at 11:10 AM, Resident #28 revealed he got a bed bath today. He also revealed that CNA #1 was assigned to him today and she told him that the water was cold in the shower and "that it would be better for me to have a bed bath, so I did that." During an interview on 1/29/25 at 11:20 AM, CNA #3 revealed that residents have been complaining of the 300-hall shower room water being cold, and she revealed that she had reported it to maintenance in the past. In an interview on 1/29/25 at 11:30 AM, Maintenance worker #1 revealed that he is aware of complaints about the cold water in the shower room on 300 Hall. He revealed that he checked the water this morning, which was 105 degrees. During an interview and observation on 1/29/25 at 11:45 AM, Maintenance worker #2 revealed he checks the water temperatures two times daily and does it at random rooms. The water temperature is always running between 105-110. He revealed that he didn't understand how the water temperature in the 300-hall shower room was running colder. Maintenance worker #2 offered to check the water temperature in the shower room and stated, "We can check it in the shower room sink since they are on the same water line." The State Agent (SA) encouraged the Maintenance worker to check the water from the middle shower stall, where the staff gave the residents their showers instead. Maintenance worker #1 tested the water temperature with a digital thermometer and after two minutes of running the water, an observation of the digital thermometer temperature gauge revealed that	F 584	monthly x3 Months for review. Changes will be made as needed to ensure continued compliance.	

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F 584	Continued From page 9 the water temperature was 88 degrees. Maintenance workers #1 and #2 confirmed the water was too cold for a shower and revealed they needed to fix this. An observation of the water temperature in the shower room sink revealed the hot water temperature at 106 degrees. Maintenance workers #1 and #2 revealed they always checked the sink in the 300-shower room and didn't check the water from the shower faucet because they felt like the water in the sink gave a more accurate reading, which was always around 105 degrees. During an interview on 1/29/25 at 2:00 PM, the Administrator revealed he wasn't aware of an issue with the cold water until his maintenance department notified him today. He revealed he did recall talking with Resident #28 last week in the hallway but did not recall the context of his conversation. He confirmed that there was obviously a problem with the valves in that shower stall. He confirmed this is the resident's home, and we were not promoting a homelike environment by not ensuring the residents get a warm shower. A record review of Resident #28's Admission Record revealed the resident was admitted to the facility on 03/29/2024. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/14/24 revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.	F 584		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F 644		2/24/25

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F 644	Continued From page 10 §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 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 submit a status change for a resident with a new mental illness diagnosis to the Preadmission Screening and Resident Review (PASRR) program for one (1) of four (4) residents reviewed. Resident #41 Findings include: Record review of facility letterhead revealed, "Admissions Coordinator uses the Division of Medicaid Pre-Admission Screening (PAS) Instruction Manual to determine the admission PAS process. Social Services uses the Maximus guide to determine status change or potential status change that require submission of a Resident Review status change in MS (Mississippi)."	F 644	1. Resident #41 had a Pre-admission Screening and Resident Review (PASRR) completed on 1/29/25 by Social Services. All residents were reviewed by Social Services and no other resident was found to be in need of Pre-admission Screening and Resident Review (PASRR) 2. All residents who require a Pre-admission Screening and Resident Review (PASRR) due to a status change have potential to be affected. 3. a. Licensed Minimum Data Set (MDS) staff and Social Services Director were inserviced on 2/18/25 by the Quality Assurance Director regarding the implementation on 2/18/25 of the New	

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F 644	Continued From page 11 Record review of guidelines titled, "Mississippi PASRR Identifying Status Changes", dated 8/3/22, revealed, "The nursing facility (NF) must submit a Status Change (SC) to Maximus using the Level I PASRR Resident Review process whenever a Significant Change in Condition occurs for an individual with a PASRR identified condition (i.e., Serious Mental Illness (SMI), Intellectual and/or Developmental Disability (ID/DD), and/or Related Condition (RC). ... The MS division of Medicaid Administrative Code also defines a Significant Change as being applicable to persons with newly discovered or suspected MI, ID/DD, and/or RC". During an interview on 1/29/25 at 2:00 PM, Social Service #1 revealed it was her responsibility to submit the Status Change into the PASRR system for any resident with a new serious mental illness diagnosis. The resident was admitted to the facility on 8/23/23 and had the PAS dated 8/23/23 and did not require a Level II at that time. On 1/29/24, Resident #41 had a new diagnosis of Schizoaffective Disorder, which required a status change to be submitted, but that was not done. She confirmed she was not notified of the diagnosis and therefore, did not submit as required. An interview with the Director of Nursing (DON) on 1/29/25 at 2:15 PM, revealed it was important to accurately follow the PASRR process to ensure each resident was properly placed and received needed services. She confirmed the facility failed to submit a PASRR status change for a resident with a new mental health diagnosis of Schizoaffective Disorder.	F 644	Diagnosis Audit form to be completed by Minimum Data Set (MDS) Staff and given to Social Services weekly x4, monthly X3 months, then quarterly to alert Social Services of any new mental illness diagnosis requiring Pre-admission Screening and Resident Review (PASRR). b. Antipsychotic Diagnosis Form was revised on 2/18/25 by the Director of Nursing to include a reminder to nursing to refer to Social Services. MDS and Social Services were inserviced on 2/18/25 by Quality Assurance Director Exhibit #10 4. a. Social Services is to take audit results to Quality Assurance Committe to be reviewd monthly for 3 months. Exhibit #9 b. The Quality Assessment and Assurance Committee will meet 2/21/25 then monthly X3 to review findings and make recommendations and changes as needed to ensure continued compliance.	

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F 644	Continued From page 12 During an interview on 1/29/25 at 2:55 PM, the Administrator confirmed the facility failed to submit a PASRR change of status for Resident #41's new diagnosis of Schizoaffective Disorder. Record review of Resident #41's Preadmission Screen (PAS) dated 8/23/23, revealed the resident did not have a diagnosis of a serious mental illness and was determined that, "level of care automatically approved due to recommended outcome from submitted assessment". Record review of Resident #41's "Admission Record" revealed the resident was admitted to the facility originally on 10/19/17 with the most recent admission being 8/23/23. Diagnosis included Schizoaffective Disorder with an onset date of 1/29/24 and Cerebral Infarction with an onset date of 10/19/17. Record review of Resident #41's Minimum Data Set (MDS) Section C with Assessment Reference Date (ARD) of 11/23/24 revealed a Brief Interview for Mental Status (BIMS) was unable to be obtained and noted as "resident is rarely/never understood" Section I Active Diagnoses item I6000 revealed Schizophrenia was coded "yes".	F 644		
F 656 SS=G	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	F 656		2/24/25

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F 656	Continued From page 13	F 656		

medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(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:

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F 656	Continued From page 14 Based on record review, staff interview and facility policy review, the facility failed to implement pain management care plan interventions and failed to develop a care plan with individualized interventions to include triggers for Post Traumatic Stress Disorder (PTSD) for two (2) of 20 sampled resident care plans reviewed. Resident A and Resident #64. Findings include: Record review of the facility policy "Pain Management" revealed, "Policy: The facility will ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences." A record review of Resident A's Care Plan revealed, "Focus: Risk for altered comfort related to benign hypertrophy of the prostate (BHP) and pain related to fractures, with interventions including: " ...Administer pain medication as needed ..." A record review of the "Grievance/Complaint Report" documented by Social Services/Grievance Official on 10/22/24 revealed that Resident A reported staff refused to administer his pain medication. The investigation findings noted: "Resident pain left unattended." A record review of "Progress Notes" for Resident A, dated 10/21/24 at 1:39 AM, revealed that the resident yelled out, stating, "I asked for my medicine an hour ago. Do you just not have any help?"	F 656	1. Resident A was discharged home after completing therapy on 10/26/24 and Resident #64 care plan was reviewed on 1/30/25 by the MDS Nurse. with revisions made to include residents triggers. 2. All residents with care plans for mental illness and with orders for pain meds have the potential to be affected. 3. a. All interdisciplinary care plan team members responsible for writing care plans were in-service on 2/13/25 by the Director of Nursing on the facility's Policy and Procedure for Developing Appropriate Care Plans for Pain and Post Traumatic Stress Disorder (PTSD). 4. a. Care plans will be reviewed for pain by the Director of Nursing using the Comprehensive Care Plan for Pain Audit form by chart review and resident interviews beginning on 2/14/25 then weekly x4, then monthly x4, then quarterly x3. Post Traumatic Stress Disorder (PTSD) triggers will be audited using the Post Traumatic Stress Disorder(PTSD) Audit form by Social Services beginning 2/14/25, then weekly x4, then monthly x4, then quartlery x3 and given to Quality Assurance Committe monthly. Exhibit #7 and #11. b. The Quality Assessment and Assurance Committee will meet on 02/21/25 and them monthly X3 to review findings and make recommendations and changes as needed to ensure continued compliance.	

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A record review of the Medication Administration Record (MAR) revealed that Resident A had an active order for Hydrocodone-Acetaminophen Oral Tablet 5-325 mg (milligrams), with instructions to administer one (1) tablet orally every six (6) hours as needed for pain. Further review of the MAR revealed that on 10/20/24, Resident A received a dose of pain medication at 1:34 PM. However, there was no documentation that the resident received any additional pain medication until 9:58 AM on 10/21/24.

In an interview with the Director of Nursing (DON) on 1/29/25 at 10:05 AM, she stated that when she arrived at work on 10/21/24, Resident A's son voiced concerns that the nurse did not give his father any pain medication last night. The DON stated that she interviewed Licensed Practical Nurse (LPN) #3 regarding not administering pain medications to the resident and the nurse stated that she withheld the pain medication because the resident was constipated.

On 1/30/25 at 9:41 AM, during an interview with the Minimum Data Set (MDS) Coordinator and the MDS LPN, they stated that the purpose of the care plan is to guide staff in providing appropriate care for the resident. The MDS Nurses confirmed that the nurse failed to follow the care plan when she did not administer pain medication as needed and that were requested by the resident. They further explained that the potential negative outcomes of untreated pain include unrelieved pain, increased anxiety, and difficulty participating in therapy and Activities of Daily Living (ADLs).

A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/22/24 revealed that Resident A had a Brief Interview for

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Mental Status (BIMS) score of 15, indicating that he was cognitively intact. The Pain Assessment Interview in section J documented that Resident A had experienced occasional pain over the past five (5) days, which limited his daily activities. He rated his pain as a five (5) on a numeric scale from zero (0) to ten (10), with zero (0) representing no pain and ten (10) representing the worst pain imaginable.

A record review of the Admission Record revealed that Resident A was admitted to the facility on 10/1/24 with diagnoses including Left-sided Maxillary Fracture, Left-sided Fracture of the Medial Orbital Wall, Multiple Left-sided Rib fractures, other Physical Fracture of the Lower End of the Radius, and Unspecified Pain. Resident A was discharged home on 10/26/24.

Resident #64

Record review of facility policy titled, "Trauma-Informed Care" undated, revealed, "The general idea of trauma-informed care is to provide increased sensitivity to residents who have experienced trauma. Educating staff on how to interact with residents in an effort to limit triggering events and provide sensitive psychosocial interventions. A Care Plan for a resident who has experienced requires the same structure as all resident care plans - there is an identified problem, a goal and interventions. The problems must be measurable and time-based. Broad generalizations are insufficient. ... Goal: ... Resident will describe any triggers or stresses related to traumatic events and how they cope with it." The policy also revealed, "Person centered care plan is the key to Trauma Informed

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Care, Resident Centered Care mandates include: address training needs of staff to improve knowledge and sensitivity; identify an individual's hope, capacities, interests, preferences, needs, and abilities; the individual is the expert of his/her life; practice is a collaborative process; individual choice is evident; resident's voice is used in treatment plans - goals are in his/her own words; strength based, recovery-oriented principles; assess for traumatic histories and symptoms; recognition of culture and practices that are re-traumatizing".

Record review of Resident #64's Care Plan, date initiated 10/10/24, revealed, "Focus: Psychiatric diagnosis related to post traumatic stress disorder", but the care plan did not include specific triggers that the resident experienced due to his diagnosis.

During an interview on 1/28/25 at 11:55 AM, Resident #64 revealed he was in the Vietnam War, and he suffered from Post Traumatic Stress Disorder (PTSD) from his military service. He stated he was left for dead and the two soldiers with him were killed and it was a miracle he survived. He said that during that event, he was praying for God to keep him still so they would think he was dead and then he talked about how his mother prayed constantly for him to safely return home. He believed that God gave him the strength not to move even though he was getting kicked and beaten. He acknowledged he had triggers such as loud thunder or a loud noise from something being dropped, and when he heard these things, "I almost hit the floor". While he was talking about his experience, he became teary eyed and cried softly.

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During an interview on 1/29/25 at 4:15 PM, the Director of Nursing (DON) revealed the resident had a diagnosis of PTSD and a care plan was developed for this. She stated a care plan should guide staff in the individualized care of each resident. She confirmed a PTSD assessment was not done, and triggers were not identified, therefore, the care plan did not give staff information needed for the triggers that affected this resident's mental health status.

An interview with Registered Nurse (RN) MDS Coordinator on 1/30/25 at 9:30 AM, revealed she was responsible for developing and updating care plans to provide the staff with a guide for the resident's care. She stated that since the resident was not assessed for his PTSD needs and triggers, the care plan did not contain these items. She stated for a resident with PTSD, the staff should be aware of triggers that could cause the resident to have increased anxiety and they needed to be included in the care plan. She confirmed the facility failed to individualize a care plan by including triggers for a resident with PTSD.

Record review of Resident #64's "Admission Record" revealed the facility admitted the resident on 7/15/22. Diagnoses included PTSD.

Record review of the MDS Section C dated 1/7/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #64 was cognitively intact.

Record review of Resident #64's admission MDS Section I dated 7/21/22 and the most recent quarterly assessment dated 1/7/25 revealed a diagnosis of PTSD.

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F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. 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 provide trauma care and services for a resident with a diagnosis of Post Traumatic Stress Disorder (PTSD) for one (1) of 20 sampled residents. Resident #64 Findings include: Record review of facility policy titled, "Trauma-Informed Care" undated, revealed, "The general idea of trauma-informed care is to provide increased sensitivity to residents who have experienced trauma. Educating staff on how to interact with residents in an effort to limit triggering events and provide sensitive psychosocial interventions." On 1/28/25 at 11:55 AM, an interview with Resident #64 revealed he was in the Vietnam War and he suffered from PTSD from his military service. He stated he was left for dead and the two soldiers with him were killed and it was a miracle he survived. He said that during that event, he was praying for God to keep him still so they would think he was dead and then he talked	F 699	1. Resident # 64 had a Cultural Assessment for trauma on 1/30/25 by Social Services Director and determined to have triggers of loud noises, westerns and claps of thunder. 2. All residents who have diagnosis of Post Traumatic Stress Disorder (PTSD) have potential to be affected. 3. a. Inservice was done for all licensed staff on 2/11/25 and 2/17/28 by Staff Development Nurse regarding Post Traumatic Stress Disorder (PTSD) diagnosis and treatment to address resident triggers. b. Resident received outside mental health evaluation on 2/5/25 by mental health services. c. All residents have been reassessed using Post Traumatic Stress Disorder Checklist for Diagnostic and Statistics Manual (PCL-5) with Life Events Checklist (LEC-5) and Criterion, Part 1 and Part 2 form to ensure proper documentation and treatment of Post Traumatic Stress Disorder (PTSD) and triggers included in plan of care by Social	2/24/25

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F 699	Continued From page 20 about how his mother prayed constantly for him to safely return home. He believed that gave him the strength not to move even though he was getting kicked and beaten. He acknowledged he had triggers such as loud thunder or a loud noise from something being dropped, and when he heard these things, "I almost hit the floor". While he was talking about his experience, he became teary eyed and cried softly. Interviews with Social Service #1 on 1/29/25 at 2:00 PM and 3:10 PM, revealed on admission, each resident or resident's family filled out a "Cultural Assessment" packet and if any of the events in this assessment had been experienced by the resident, they addressed that specific area for the resident's care. She acknowledged this packet was started in 2023 after Resident #64's admission to the facility in 2022, therefore, this evaluation for trauma care needs was not done on his admission. She confirmed that when the facility began the assessments, the staff failed to assess resident for trauma, triggers, interventions, and appropriate treatment for his mental health care needs. She also confirmed this resident was not followed by the facility's mental health care provider to receive specialized mental health care services during his time at the facility, even though he had a PTSD diagnosis. An interview on 1/29/25 at 4:15 PM, the Director of Nursing (DON) revealed Resident #64 was admitted to facility in 2022 with a diagnosis of PTSD, but did not have a trauma assessment done or triggers identified, and he had not received mental health services from the facility's mental health care specialist. She acknowledged that PTSD should be assessed and triggers that interfere with quality of life should be identified in	F 699	Services. Triggers were added on resident's dashboards on 2/13/25 for staff information. d. Resident #64 Care plan was reviewed by Minimum Data Set (MDS) on 1/30/25 and revised to include triggers for Post Traumatic Stress Disorder (PTSD). e. Employee Questionnaire Related to Recent Survey Corrections is being done for 9 employees per day by Director of Nursing beginning 2/14/25 to ensure nursing staff knows what to do if a resident complains of triggers and where to locate triggers in resident electronic medical record then weekly X1 month,then monthly x3, and reported to Quality Assurance Nurse. Exhibit #3 4. a. Comprehensive Care Plan for Post Traumatic Stress Disorder (PTSD) Audit will be done by Social Services weekly times 2 weeks, monthly times 2 months, then quarterly and taken to the Quality Assurance Committee monthly. Exhibit #11 b.The Quality Assurance Committee will meet 2/21/25 monthly X3 months to review findings and make recommendations and changes as needed to ensure continued compliance.	

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F 699	Continued From page 21 order to provide each resident with care to attain their highest possible mental health status. She confirmed the facility failed to adequately assess the resident for his diagnosis of PTSD, determine triggers, and provide mental health services. During an interview on 1/29/25 at 4:25 PM, the Administrator confirmed that any resident with PTSD should be evaluated for appropriate mental health care services and confirmed the facility failed to provide this for a resident with a PTSD diagnosis. Record review of Resident #64's "Admission Record" revealed the facility admitted the resident on 7/15/22. Diagnoses included PTSD. Record review of Resident #64's Minimum Data Set (MDS) Section C dated 1/7/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Record review of Resident #64's admission MDS Section I dated 7/21/22 and the most recent quarterly assessment dated 1/7/25 revealed a diagnosis of PTSD.	F 699		
F 812 SS=F	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	F 812		2/24/25

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F 812	Continued From page 22 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 and resident interviews, record review, and facility policy review, the facility failed to ensure food temperatures were completed and documented adequately for one (1) of three (3) kitchen observations. Findings include: A review of the facility policy titled "Kitchen Thermometers" undated revealed, "A food thermometer should also be used to ensure that cooked food is held at safe temperatures until served. Cold foods should be held at 40 degrees F (Fahrenheit) or below. Hot food should be kept hot at 140 degrees F or above... Temperature Recording Preserves the Food's Quality. If facilities don't keep food at the proper temperature, its quality can quickly deteriorate ..." During the initial tour of the facility with resident interviews on 1/28/25 at 10:10 AM, Resident #28 revealed, "I have received cold chicken soup on more than one occasion. Last week, I requested two bowls of soup; they brought it, but it was cold."	F 812	1. Dietary staff was inserviced on 2/8/25 by Certified Dietary Manager on proper completion and documentation of food temperatures prior to serving food to residents. Disciplinary Actions were done for all employees responsible. 2. All residents who consume food by mouth have the potential to be affected. 3. a. Inservices: On 1/29/25 -- A Serve Safe Video with a Practice test was given. Calibrating thermometers with ice water method. 1/30/25 --- Serve Safe Food Preparation and Handling with video and test, Introduction to Food Safety, Safe food preparation and handling by Staff Development Nurse. In-service training included observation of each employee performing the procedure accurately. Corrective action was provided as needed. 2/8/25 --- Dietary staff has been in-serviced by Certified Dietary Manager for checking temperatures and calibration of thermometers, temperature log for maintaining accurate food temperatures.	

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	255110	A. BUILDING _____ B. WING _____	01/30/2025

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F 812	Continued From page 23 During dining room observation on 1/28/25 at 11:50 AM, Resident #28 was overheard telling a staff member that his soup was cold. The soup was returned to the kitchen, and Dietary Worker #1 confirmed the food item was chicken noodle soup. She checked the temperature of the chicken soup and revealed the temperature was a little under 80 degrees, and she wasn't sure what the temperature for the soup was supposed to be. The Dietary Manager checked the soup temperature and revealed it was 80 degrees when it was supposed to be at least 135 degrees. Dietary workers #2 and #3 confirmed the soup temperature was not checked today. In an interview on 1/28/25 at 12:40 PM, Dietary worker #3 revealed she cooked breakfast and lunch meals today and did not check food temperatures for either meal. She revealed that her initials with the temperatures were on the "Prepared Food Record"; however, she had not checked the temperatures or initialed the sheet. She stated, "I think (Dietary worker #1) filled that sheet out." She confirmed she was supposed to check the temperature of the food items on the steam table but just didn't. A record review and observation on 01/28/25 at 12:30 PM revealed a document titled "Prepared Food Temperature Record" dated January 2025 revealed that all food temperatures were documented for all three meals for the 28th of January with staff member initials under the date of the 28th. In an interview on 1/28/25 at 12:45 PM, the Dietary Manager confirmed the temperatures on the "Prepared Food Temperature Record" were	F 812	b. Employee Questionaire Related to Recent Survey Corrections is being done for 9 employees per day X1 week, then weekly X1 month to ensure nursing staff knows what to do if resident complains of cold food or water and reported to Quality Assurance by the Director of Nursing. Exhibit #3 4. a. The Quality Assurance Director will perform the Dietary Food Temperature Audit beginning 2/15/25 then twice daily for two weeks, once a day for 6 weeks, then quarterly to ensure food temps are adequately taken. The Quality Assurance Director will bring results to the Quality Assurance Committee monthly. Exhibit #12 b. The Dietary Manager will perform the Room Test Tray Evaluation beginning 2/14/25 once a day for 6 weeks, then weekly for 8 weeks, then quarterly to ensure residents receive their food warm.The Dietary Manager will take results to the Quality Assurance Committee monthly. Exhibit #2 The Quality Assurance Committee will meet 2/21/25 then monthly x 3 months to review findings and make recommendations and changes as needed to ensure continued compliance.	

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F 812	Continued From page 24	F 812		

already documented for today despite the temperatures not being taken. She revealed that the temperature record was already filled out for the upcoming dinner meal, which hadn't even happened yet. She stated, "I don't watch my dietary workers take the food temperatures; I trust them to do their jobs correctly, and the way it looks, they are not doing what they should have been." She revealed that it is very important that temperature checks are done for each food item that is put on that steam table and served to the residents. She revealed that a resident could get a foodborne illness by not ensuring all food temperatures are within the normal range. She revealed this is just not acceptable and the dietary workers should ensure the food temps are being done. She confirmed the soup was cold and that, according to her staff admission, they had not checked the temperature of the soup before sending it out to the resident.

In an interview on 1/28/25 at 1:00 PM, Dietary worker #1 confirmed that she had recorded the temperatures but did not check any food items for breakfast or lunch and had already documented the temperatures for the dinner meal for that evening on the log. She confirmed that what she did was false documenting. She stated, "I filled out the sheet because if I didn't do it, it wouldn't get done.

During an interview on 1/29/25 at 2:07 PM, the Administrator revealed he felt the food quality was improving and had not heard any complaints about the food being cold. He revealed it is of the utmost importance that the temperature of the food is checked before serving it to our residents, which ensures good quality of the food being served and ensures no potential food-borne

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F 812	Continued From page 25 illness. He revealed he was unaware that the dietary staff did not check the food temperatures yesterday, which is unacceptable. A record review of Resident #28's Admission Record revealed the resident was admitted to the facility on 03/29/2024. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/14/2024 revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.	F 812		