| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255182 | A. BUILDING _____ B. WING _____ | 04/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LAKEVIEW NURSING CENTER | 16411 ROBINSON ROAD GULFPORT, MS 39503 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an annual recertification survey at the facility from 03/30/2025 through 04/02/2025. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F584, F646, F656, F689, F812, F851, F867, F868, and F883.<br><br>The facility had a census of 84 and was licensed for 105. | F 000 | | |
| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>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.<br><br>The facility must provide-<br>§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.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are | F 584 | | 5/13/25 |

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

Electronically Signed | 04/21/2025

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| F 584 | Continued From page 1<br>in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§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<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right to a clean, comfortable, homelike environment for two (2) of four (4) days of survey.<br><br>Findings included:<br><br>A review of the facility's policy titled, "Safe and Homelike Environment," revised 07/24/2023, revealed, "... In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment ... Policy Explanation and Compliance Guidelines: ... 3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment..."<br><br>A review of the facility's document related to "Housekeeping," undated, revealed, "... Duties and Responsibilities: Ensures the provision of a clean environment for our residents and staff, | F 584 | 1. The Facility failed to ensure a resident's right to a clean, comfortable, homelike environment. On 03/30/25, Resident #17 family at bedside stated that the floors were always dirty. 4/03/2025, the resident room and floor was deep cleaned.<br><br>2. All residents have the potential to be affected by this deficient practice.<br><br>3. The facility implemented an "Environmental Room Cleaning Checklist" form for housekeepers to fill out and return daily to the housekeeping supervisor, for each room assigned. The form list a complete set of duties to be performed in each room, including cleaning under beds and moving furniture. All current housekeeping management and staff will receive a directed in-service on "Environmental Room Cleaning | |

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| F 584 | Continued From page 2<br>providing high quality services and high standards of cleanliness ...Functions ...2. Ensures that daily and deep cleaning schedules are adhered to ...14. Clean floors, to include sweeping, dusting, damp/wet mopping, stripping, waxing, buffing, disinfecting ...22. Moves furniture and other heavy objects as required ..."<br><br>On 03/30/25 at 11:52 AM, during an observation and interview, Resident #17 was observed in bed with a family member at the bedside. The family member reported that his primary concern was the cleanliness of the room, and he expected his mother's room to be clean when he visits. He stated the floors are always dirty and appear not to be wiped down. Dirt and loose particles were observed under the bed and around the nightstand.<br><br>On 03/31/25 at 2:15 PM, during an interview and observation of Resident #17's room, Housekeeper #2 explained that each housekeeper had assigned halls, but recently the housekeepers were required to split halls due to staffing issues. She stated every room is cleaned daily and that cleaning duties include mopping, dusting, bathroom sanitation, trash removal, and restocking paper supplies. She explained she does not move furniture or beds when residents are present. Housekeeper #2 confirmed debris and dirt were present around the visitor chair, nightstand, and under the resident's bed.<br><br>On 04/01/25 at 3:00 PM, during an interview with Housekeeper #4, she stated that all rooms are cleaned daily, including sweeping, mopping, wiping furniture, and cleaning bedrails. She stated that if a resident is present, she will return later to clean, and that although she attempts to | F 584 | Checklist" form beginning on 4/17/2025 by staff development coordinator and will be completed on 04/30/2025. All new housekeeping staff will receive in-servicing on the "Environmental Room Cleaning Checklist" form at hire by the housekeeping supervisor.<br><br>4. The housekeeping supervisor is responsible for training and conducting daily assessments of the facility environment and resident's rooms with the housekeeping staff beginning 4/21/25 and ongoing. To ensure improvements are sustained the "Environmental Room Cleaning Checklist" forms will be retrieved everyday and brought to the interdisciplinary meeting starting on 04/21/2025 daily for three (3) weeks, bi-weekly for one (1) month, then monthly for three (3) months. Results of monitoring will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) meeting on 5/13/25 and monthly for three months.<br><br>5. All corrective actions will be completed 09/09/2025. | |

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| F 584 | Continued From page 3<br>complete all cleaning tasks, sometimes it is difficult due to picking up extra rooms.<br><br>On 04/02/25 at 2:14 PM, during an interview with the Administrator, she stated that the facility had been actively working on improving the facility's cleanliness and had recently hired a new housekeeper. She stated that her expectation was that staff complete all duties, even on weekends, and ensure rooms are maintained in a clean condition. | F 584 | | |
| F 646 SS=D | MD/ID Significant Change Notification<br>CFR(s): 483.20(k)(4)<br><br>§483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews, record review, and facility policy review, the facility failed to complete a Change in Status Form to generate a request for a Preadmission Screening and Resident Review (PASRR) Level Two (II) Assessment, for a resident with a mental status change, for one (1) of 18 residents reviewed for PASRR. Resident #37.<br><br>Findings include:<br><br>A record review of the facility's policy "Resident Assessment-Coordination with PASARR (Preadmission Screening and Resident Review) Program", dated 01/10/25 revealed " ...This facility coordinates assessments with the | F 646 | 1. Facility failed to complete a Change in Status Form to generate a request for a Preadmission Screening and Resident Review (PASRR) Level Two (II) Assessment, for a resident with a mental status change. Resident #37 did not have PASSR completed after returning from Behavioral Health. Social Services completed a change in status form for resident #37 on 03/31/2025. An in-service was conducted and completed by Minimum Data Set (MDS) department with Social Services on 4/1/25 on the requirements for completing a change in status form for any resident that is transferred, admitted, or readmitted to the | 5/13/25 |

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| F 646 | Continued From page 4<br>preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs ... Policy Explanation and Guidelines ...9. Any residents who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include ...c. A resident transferred, admitted, or readmitted to the facility following an inpatient psychiatric stay or equally intensive treatment."<br><br>On 03/30/25 at 11:31 AM, during an interview, Resident #37 reported that he was sent to a Behavioral Health Unit (BHU) last year because he would throw his unwanted food on the floor.<br><br>A record review of the "Transfer/Discharge Report" revealed the facility admitted Resident #37 on 11/15/2019 with current diagnoses including Anxiety Disorder,<br><br>A record review of the "Physician's Order Sheet" dated 05/15/24 revealed " ...Send to (Proper Name) Behavioral Health for eval (evaluation) and treatment ..."<br><br>A record review of the Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 03/07/25 revealed Resident #37 required a staff assessment for mental status and his cognitive skills for daily decision making he made decisions regarding tasks of daily life with modified independence with some difficulty in new situations only. | F 646 | facility following an inpatient psychiatric stay or equally intensive treatment."<br><br>2. Any residents who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition are at risk for this deficient practice.<br><br>3. Director of Nursing (DON) will notify social services and quality assurance nurse (QA) on 4/1/25 of any resident(s) that has/have admitted from any behavior health facility or has had any change in psychotropic medications in the facility. An audit was completed on 4/1/25 by Social Services to determine if any other residents needed a level II, no other residents were identified at this time.<br><br>4. The Quality Assurance nurse will maintain and monitor the significant change notification form starting 4/21/25 weekly for three (3) weeks, bi-weekly for one (1) month, then monthly for three (3) months. Results of monitoring will be brought to the Quality Assurance and Performance Improvement Committee (QAPI) meeting on 5/13/25 and monthly ongoing.<br><br>5. All corrective actions will be completed by 09/09/2025. | |

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| F 646 | Continued From page 5<br><br>Record review of the medical record revealed there was no Change in Status Form completed or submitted to the mental health authority for a Level II resident review after Resident #37 returned from an inpatient psychiatric facility in which he was admitted on 5/15/24.<br><br>On 03/31/25 at 10:05 AM, during an interview with Social Services #1, she confirmed a Change in Status Form was not completed for Resident #37 that would have generated a request for a PASRR Level II assessment. She explained that the only time a Change in Status form for a Level II assessment was completed was when a resident received a new diagnosis of mental illness.<br><br>On 04/01/25 at 03:00 PM, during an interview with the Director of Nursing (DON), she confirmed Resident #37 was admitted to a BHU in May of 2024. | F 646 | | |
| F 656 SS=E | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable | F 656 | | 5/13/25 |

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| F 656 | Continued From page 6<br>physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and facility policy review, the facility failed to implement a care-planned intervention related to falls for one (1) of eighteen (18) sampled residents. Resident #13. | F 656 | 1. Resident #13 was lying in bed with a fall mat folded at the head of the bed and not unfolded on the floor positioned in a way to prevent injury in the event the resident fell from the bed. On 4/1/25 resident #13 fall mat was unfolded and | |

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| F 656 | Continued From page 7<br>Findings included:<br><br>A review of the facility's policy, "Comprehensive Care Plans", dated 3/5/2025, revealed, " ...It is the policy of this facility to ... implement a comprehensive person-centered care plan for each resident ... that includes measurable objectives ...and meet professional standards of quality ...Policy Explanation and Compliance Guidelines ...8. Qualified staff responsible for carrying out interventions specified in the care plan will be of their roles and responsibilities for carrying out the interventions, initially and when changes are made ..."<br><br>During an observation on 03/30/25 at 11:16 AM, Resident #13 was lying in bed with a fall mat folded at the head of the bed and not unfolded on the floor positioned in a way to prevent injury in the event the resident fell from the bed.<br><br>During an observation and interview on 04/01/25 at 11:01 AM, Licensed Practical Nurse (LPN) #1 confirmed that Resident #13 was in bed and the fall mat was folded on the left side of the bed, instead of unfolded on the floor bedside the bed in a position to prevent injury from falling. LPN #1 stated the fall mat was not supposed to be folded and should be laid out on the floor beside the bed.<br><br>During an interview on 04/02/25 at 9:56 AM, the Director of Nursing (DON) explained that staff were trained to keep fall mats flat on the floor to prevent injuries from falls. The DON stated that she expected the staff to implement care plan interventions.<br><br>A record review of Resident #13's Admission | F 656 | positioned in a way to prevent injury in the event the resident fell from the bed.<br><br>2. All resident's with fall mats are at risk for this deficient practice.<br><br>3. All resident's with physician orders for fall mats were checked for care plan documentation and correct positioning in resident's room. An in-service was conducted for all nursing staff on implementing care plan interventions to prevent injuries beginning on 4/2/25 by staff development nurse and completed on 4/4/25 and will be ongoing for all new staff.<br><br>Medication nurses will round every shift and document on the Medication Administration Record (MAR) that each resident with fall mats ordered are positioned appropriately.<br><br>4. The MAR will be checked daily by the Quality Assurance (QA) nurse beginning on 4/4/25 and results will be brought to the morning meeting daily for three (3) weeks, then weekly for one (1) month, then biweekly for three (3) months. All findings will be brought to the monthly Quality Assurance Performance Improvement (QAPI) committee meeting for review on 5/13/25 and monthly for three (3) months.<br><br>5. All corrective action will be completed by 9/9/25. | |

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| F 656 | Continued From page 8<br>Record revealed the facility admitted the resident on 8/6/2024 and she had current diagnoses including Alzheimer's Disease.<br><br>A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/21/25 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. Further review revealed she has had falls since admission.<br><br>A record review of the "Comprehensive Care Plan" revealed Resident #13 was at risk for falls related to decreased mobility, generalized weakness, and a history of a fall with a hip fracture. The care plan included an intervention, initiated on 12/6/24, for "Floor mats on both side of bed ..." | F 656 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and facility policy review, the facility failed to ensure the resident environment remained free of accident hazards when a fall mat intended to prevent injury during falls was not properly placed for one (1) of three (3) residents reviewed for | F 689 | 1. Resident #13 was lying in bed with a fall mat folded at the head of the bed and not unfolded on the floor positioned in a way to prevent injury in the event the resident fell from the bed. On 4/1/25 resident #13 fall mat was unfolded and | 5/13/25 |

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| F 689 | Continued From page 9<br>accidents/hazards, Resident #13.<br><br>Findings included:<br><br>A review of the facility's policy titled "Accidents and Supervision," dated 2/19/2019 and revised 12/9/2020, revealed, "...The resident environment will remain free of accidents hazards as is possible ...this includes ...3. Implementing interventions to reduce hazard(s) and risk(s) ..."<br><br>On 03/30/25 at 11:16 AM, during an observation, Resident #13 was lying in bed with a fall mat folded at the head of the bed and not unfolded on the floor positioned in a way to prevent injury in the event the resident fell from the bed.<br><br>On 04/01/25 at 11:01 AM, during an observation and interview, Licensed Practical Nurse (LPN) #1 confirmed that Resident #13 was in bed and the fall mat was folded on the left side of the bed, instead of being unfolded on the floor bedside the bed in a position to prevent injury from falling. LPN #1 stated the fall mat was not supposed to be folded and should be laid out on the floor beside the bed.<br><br>On 04/02/25 at 9:56 AM, during an interview with the Director of Nursing (DON), she explained that staff were trained to keep fall mats flat on the floor to prevent injuries from falls.<br><br>A record review of Resident #13's Admission Record revealed the facility admitted the resident on 8/6/2024 and she had current diagnoses including Alzheimer's Disease.<br><br>A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date | F 689 | positioned in a way to prevent injury in the event the resident fell from the bed.<br><br>2. All resident's with fall mats are at risk for this deficient practice.<br><br>3. All resident's with physician orders for fall mats were checked for care plan documentation and correct positioning in resident's room. An in-service was conducted for all nursing staff on implementing care plan interventions to prevent injuries beginning on 4/2/25 by staff development nurse and completed on 4/4/25 and will be ongoing for all new staff.<br><br>Medication nurses will round every shift and document on the Medication Administration Record (MAR) that each resident with fall mats ordered are positioned appropriately.<br><br>4. The MAR will be checked daily by the Quality Assurance (QA) nurse beginning on 4/4/25 and results will be brought to the morning meeting daily for three (3) weeks, then weekly for one (1) month, then biweekly for three (3) months. All findings will be brought to the monthly QAPI committee meeting for review on 5/13/25 and monthly for three (3) months.<br><br>5. All corrective action will be completed by 9/9/25. | |

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| F 689 | Continued From page 10<br>(ARD) of 2/21/25 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. Further review revealed she had falls since admission. | F 689 | | |
| F 812 SS=D | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility policy review, the facility failed to store food using sanitary methods to prevent cross-contamination, as evidenced by a plastic cup used as a scoop stored directly inside a container of cornmeal for one (1) of four (4) days of kitchen observations.<br><br>Findings included: | F 812 | 1. 03/30/2025, The facility failed to store food using sanitary methods to prevent cross contamination by leaving a plastic cup used as a scoop stored directly inside a container of cornmeal. The plastic cup and container of cornmeal were disposed of 3/30/2025.<br><br>2. All residents have the potential to be | 5/13/25 |

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| F 812 | Continued From page 11<br>A review of the facility's document "ServeSafe Manager", undated, revealed, "...Preventing Cross-Contamination ...Food, equipment, utensils ...must be stored in ways that prevent cross-contamination ...Storing ...you need to store items in a way that prevents cross-contamination ..."<br><br>On 03/30/25 at 10:34 AM, during an observation of the kitchen and interview with the Dietary Manager, there was a clear plastic cup inside the fish fry/corn meal container dry goods container. The Dietary Manager confirmed the clear plastic cup was being used as a scoop and acknowledged this constituted cross-contamination.<br><br>On 04/01/25 at 12:25 PM, during an interview with the Registered Dietitian (RD), she explained the dietary department uses Serve Safe guidelines for policy and procedures related to food handling. She confirmed she had been made aware of a plastic cup used as a scoop was stored inside the corn meal container. | F 812 | affected by this same deficient practice.<br><br>3. Dietary supervisor will monitor all containers daily for improper utensils and will dispose of immediately and document the findings on the "Dietary Cross-Contamination" form. All new and current dietary staff will be in-serviced on "Food Safety and Dietary Guidelines Policy - ServeSafe Manger, Preventing Cross-Contamination. An in-service with dietary staff started 3/30/25 and is ongoing for new hires.<br><br>4. To ensure improvements are sustained, the quality assurance nurse will monitor all food storage containers starting 4/3/25 weekly for three (3) weeks, then bi-weekly for one (1) one month, and then monthly for three (3) months following thereafter. All findings will be brought to the monthly Quality Assurance Performance Improvement (QAPI) committee meeting for review on 5/13/25 and monthly for three (3) months.<br><br>5. All corrective actions will be completed by 09/09/2025. | |
| F 851 SS=E | Payroll Based Journal<br>CFR(s): 483.70(p)(1)-(5)<br><br>§483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format.<br>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 | F 851 | | 5/13/25 |

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| F 851 | Continued From page 12 | F 851 | | |

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, 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

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| F 851 | Continued From page 13<br>engaged by the facility under contract or through an agency.<br><br>§483.70(p)(4) Data format.<br>The facility must submit direct care staffing information in the uniform format specified by CMS.<br><br>§483.70(p)(5) Submission schedule.<br>The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to accurately report staffing data to the Centers for Medicare and Medicaid Services (CMS) using payroll and other verifiable sources in a uniform format, for one (1) of four (4) quarters reviewed, resulting in the facility triggering for excessively low weekend staffing, no Registered Nurse (RN) hours, and no licensed nursing coverage 24 hours/day.<br><br>Findings included:<br><br>A record review of the "Payroll Based Journal (PBJ) Staffing Data Report" for the fourth (4th) quarter (July 1-September 30, 2024) revealed the facility triggered for "Excessively Low Weekend Staffing, No RN Hours, and Failed to Have Licensed Nursing Coverage 24 Hours/Day." Further review revealed the "Infraction Dates" for No RN Hours and Failure to Have Licensed Nursing Coverage 24 Hours/Day were 7/6, 7/7, 7/13, and 7/14 of 2024.<br><br>A record review of the "Staffing Grid" completed by the Director of Nursing (DON) revealed the | F 851 | 1. Facility failed to accurately report staffing data to CMS using payroll and other verifiable sources in a uniform format, for one (1) of four (4) quarters reviewed, resulting in the facility triggering for excessively low weekend staffing, no Registered Nurse (RN), and no licensed nursing coverage twenty-four (24) hours/day. The Director of Nursing (DON) provided a record review of the "Staffing Grid" which revealed the facility had RN and nursing coverage for 07/06/2024, 07/07/2024, 07/13/2024, and 07/14/2024.<br><br>2. All residents are at risk for this deficient practice.<br><br>3. It was determined that there was a coding error in the reporting by the payroll vendor system. On 9/30/24 the administrator began maintaining and reviewing the Payroll Based Journal (PBJ) staffing data report from the payroll vendor system and reviewed for accuracy against actual staffing hours worked. | |

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| F 851 | Continued From page 14<br>facility had RN and nursing coverage on 7/6/24, 7/7/24, 7/13/24 and 7/14/24.<br><br>On 03/31/25 at 1:30 PM, during an interview with the Administrator, DON, Human Resources (HR) Director, and Billing Manager, the Administrator explained the facility became aware there was a reporting issue at the end of the quarter, ending September 2024. She confirmed the facility had nursing coverage for those dates; however, by the time the issue was identified, it was too late to submit corrections. The Administrator explained the current process is that nurses and Certified Nurse Aides (CNAs) clock in using their handprint. The Billing Manager manually enters time and makes adjustments when salaried staff perform direct care, such as when the Minimum Data Set (MDS) nurse takes a medication cart. The Billing Manager believed there was a coding error in the reporting by the payroll vendor system. The HR Director now reviews daily hours worked for RNs, Licensed Practical Nurses (LPNs), and CNAs and balances this data against what is submitted in PBJ to ensure accuracy. The Administrator stated the facility does not have any contract direct care nurses or CNAs. The error was discovered while reviewing the MDS PBJ Report 17025, which provides a breakdown of staffing hours. The Administrator stated they worked hard to determine what occurred during the two weekends in question and believes the issue was a reporting and/or coding error. | F 851 | 4. To ensure improvements are sustained, the co-owner will review daily staffing grids starting 4/4/25 for three (3) weeks, bi-weekly for one (1) month, then monthly for three (3) months. All findings will be brought to the monthly QAPI committee meeting for review on 5/13/25 and monthly ongoing.<br><br>5. All corrective action will be completed by 09/09/2025. | |
| F 867 SS=D | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written | F 867 | | 5/13/25 |

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| F 867 | Continued From page 15 | F 867 | | |

policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

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| F 867 | Continued From page 16<br>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.<br><br>§483.75(d)(2) The facility will develop and implement policies addressing:<br>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;<br>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and<br>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.<br><br>§483.75(e) Program activities.<br><br>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.<br><br>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.<br><br>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct | F 867 | | |

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| F 867 | Continued From page 17<br>distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interview, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of previously cited deficiencies, specifically, the facility was cited for failing to maintain a clean environment and implement comprehensive care plan interventions during an annual recertification survey on | F 867 | 1. The facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to sustain corrective actions to prevent recurrence of previously cited deficiencies, specifically, the facility was cited for failing to maintain a clean environment and implement comprehensive care plan interventions during an annual recertification survey on | |

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| F 867 | Continued From page 18<br>7/20/2023 and was cited again for the same deficiencies during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for two (2) of eight (8) deficiencies cited. F584 and F656.<br><br>Findings Include:<br><br>Record review of the facility's policy, "Quality Assessment and Performance Improvement", dated 2/24/2021, revealed, " ...It is the policy of this facility to ...maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life ...Policy Explanation and Compliance Guidelines ...2. The QA Committee shall ...c. Develop and implement appropriate plans of action to correct identified quality deficiencies ..."<br><br>Record review of the "Provider History Profile" revealed the facility received a citation for F584-Safe/Clean/Comfortable/Homelike Environment and F656-Develop/Implement Comprehensive Care Plan.<br><br>Record review of the CMS-2567 (a record that identifies the federal regulation in violation and describes the findings of noncompliance and the facility's plan of correction), with a survey date of 7/20/2023, revealed the facility received a citation for F584, " ...Based on observation, interviews, record review, and facility policy review, the facility failed to maintain a clean environment for two (2) of 20 resident rooms ..." and for F656, " ...Based on interview, record review, and facility policy review, the facility failed to develop a comprehensive care plan ..." | F 867 | 7/20/2023 and was cited again for the same deficiencies during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence. An in-service was conducted for all staff on implementing care plan interventions and maintaining a clean environment beginning on 4/4/25 by staff development nurse and completed on 4/9/25.<br>A Quality Assurance (QA) meeting was held with the consulting company on 3/24/25. The QAPI committee was expanded to hire and include outside resources to help with monitoring and oversight to prevent recurrence of prior deficiencies.<br><br>2. All residents are at risk for this deficient practice.<br><br>3. The facility obtained a Quality Assurance consulting company on 3/15/25 to consult on the QAPI committee monthly and as needed, on sustainable monitoring and oversight to prevent reoccurring deficiencies. The facility will implement room checks divided between the administrative staff to be done monthly and recorded on the Environmental Checklist. The Director of nursing (DON) and the Assistant (A)DON began monitoring staff weekly and ongoing on 4/3/25 to ensure nursing interventions are being followed.<br><br>4. To ensure improvements are sustained, the Quality Assurance consultant will maintain and monitor Environmental | |

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| F 867 | Continued From page 19<br><br>Record review of the Statement of Deficiencies and Plan of Correction (Form 2567) from the previous annual survey in July 2023, revealed F584 was cited due to stains on the privacy curtain and large pieces of missing paint on the wall behind the bed and F656 was cited regarding prescription medicine being left on the residents overbed table.<br><br>During the current recertification survey, failed to ensure a resident's right to a clean, comfortable, homelike environment for two (2) of four (4) days of survey and failed to implement a care-planned intervention related to falls for one (1) of eighteen (18) sampled residents.<br><br>On 04/02/25 at 03:52 PM, during an interview with the Administrator, she affirmed that deficiencies from the previous annual survey were found during the current survey. The Administrator reported the facility has hired several new staff and particularly a floor tech to keep the facility clean. The Administrator stated the facility staff are working to make things better and keep the facility clean and free of odors. The Administrator stated she will have a meeting with the nursing staff to come up with a plan to meet the residents' needs and promote individualized care. | F 867 | Checklist and nursing care plan interventions for completion and compliance weekly for three (3) weeks, biweekly for one (1) month, then monthly for three (3) months. All findings will be brought to the monthly Quality assurance meeting for review. All findings will be brought to the monthly QAPI committee meeting for review on 5/13/25.<br><br>5. All corrective actions will be completed by 09/09/2025. | |
| F 883 SS=D | Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)<br><br>§483.80(d) Influenza and pneumococcal immunizations<br>§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-<br>(i) Before offering the influenza immunization, | F 883 | | 5/13/25 |

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each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the

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| F 883 | Continued From page 21<br>following:<br>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and<br>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews, record review, and facility policy review, the facility failed to ensure timely administration of pneumonia vaccinations for one (1) of five (5) residents reviewed for immunizations (Residents #70).<br><br>Findings include:<br><br>A record review of the facility's policy, "Pneumococcal Vaccine (Series)," dated 6/19/23, revealed ..."It is our policy to offer residents ...immunizations against pneumococcal disease in accordance with current CDC (Center for Disease Control) guidelines and recommendations. Policy Explanation and Compliance Guidelines: 1. Each resident will be assessed for pneumococcal immunization upon admission ...2 ...Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved "standing orders ..."<br><br>A record review of the "Admission Record" revealed the facility admitted Resident #70 on 2/3/25 with diagnoses including Encounter for Surgical Aftercare following surgery on the Digestive System. | F 883 | 1.The facility failed to ensure timely administration of pneumonia vaccination for resident #70. The resident was given the pneumococcal vaccination on 4/3/25 by the local pharmacy.<br><br>2. All residents are at risk for this deficient practice.<br><br>3. The local pharmacy came in the facility 4/3/25 and administered all other needed vaccines. All resident's vaccination records were audited on 4/7/25 by Quality Assurance (QA) consultant to determine if all needed and requested vaccines were administered. The Infection Preventionist (IP) nurse will obtain consent upon admission for preventive vaccinations and the IP nurse will administer vaccinations in the facility beginning 4/7/25 and ongoing by the seventh (7th) day of admission.<br><br>4. To ensure improvements are sustained the QA consultant will monitor all admissions and preventive vaccinations for compliance weekly for three (3) weeks, biweekly for one (1) month, then monthly for three (3) months. All findings will be | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255182 | A. BUILDING _____ B. WING _____ | 04/02/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEVIEW NURSING CENTER | 16411 ROBINSON ROAD GULFPORT, MS 39503 |

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| F 883 | Continued From page 22<br>A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/10/25 revealed Resident #70 had a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment.<br><br>A record review of the "Vaccination Record," dated 2/3/25, revealed Resident #70 had not received the Pneumonia vaccine and requested to receive the vaccine upon the Physician's recommendation.<br><br>On 04/02/25 at 9:58 AM, an interview with the Resident Representative (RR) for Resident #70 revealed she acknowledged the resident was admitted on 2/3/25 and the consent to receive the pneumonia vaccine was signed 2/3/25. The RR acknowledged that she was not informed of any delay in getting the vaccine and was unaware that the resident had not received her pneumonia vaccine. The RR stated she expected the resident to have had his pneumonia vaccine.<br><br>On 04/02/25 at 10:15 AM, an interview with the Infection Preventionist (IP) revealed she acknowledged Resident #70 have not received their pneumonia vaccine from time they were admitted. The IP nurse confirmed it was her responsibility to ensure residents received vaccines and the process was to allow a couple of residents to be admitted to the facility before she calls the pharmacist to administer the vaccines. The IP nurse stated she has been focusing on the flu vaccines and had hoped to get the pneumonia vaccines caught up this April.<br><br>On 04/02/25 at 1:05 PM, an interview with the Director of Nursing (DON) revealed she acknowledged that Residents #70 had not | F 883 | brought to the monthly Quality Assurance Performance Improvement (QAPI) committee meeting for review on 5/13/25 and monthly ongoing.<br><br>5. All corrective actions will be completed by 9/9/25. | |

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| F 883 | Continued From page 23<br>received the pneumonia vaccinations since admission. The DON stated it was the responsibility of the IP nurse to make sure the residents are vaccinated. The DON noted that going forward she will arrange to have the immunizations done in-house rather than outsourcing to pharmacies to help get better control the timeliness of administering the pneumonia vaccine. | F 883 | | |