STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255104	A. BUILDING _____ B. WING _____	04/10/2025

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GRENADA LIVING CENTER	1950 GRANDVIEW DRIVE GRENADA, MS 38901

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 04/07/25 through 04/10/25. During the survey the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F558, F561, F645, F656, F692, and F697. The census at the time of the survey was 83 and the facility held a license for 90 beds.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. 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 call light was accessible for one (1) of 17 residents reviewed for call lights. Resident #45. Findings Include: Review of the facility policy titled "Call Light/Bell" with a revision date of 1/24 revealed under, "Purpose: To provide the resident with a means of communication with staff members ...To provide staff members with a means of summoning assistance when they are with the resident..." An observation and interview with Resident #45	F 558	1) On 04/11/2025, an initial Quality Assurance and Performance Improvement (QAPI) was held and Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 04/11/2025 and based on findings the call light was not accessible of Resident # 45 due to the call light being wrapped around the bed rail and the clip being broken. The call light for Resident #45 was straightened and new clip applied on 04/07/2025 by the Administrator. Certified Nursing Assistant (CNA) #4 and Licensed Practical Nurse (LPN) #3 were educated on 04/09/2025 by the Director of Nurses (DON) to ensure the call light is	5/13/25

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

Electronically Signed | 04/24/2025

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F 558	Continued From page 1 on 4/07/25 at 10:50 AM revealed he was sitting in his wheelchair inside his room watching television. The right side of the bed was turned against the wall with the call light cord wrapped around the bed rail multiple times, and the end of the call light was hanging down behind the bed, unreachable. The resident verbalized that he used the call light to request help but could not do that with it tied to the bed rail where he could not access it. He revealed that if he needed help, he would roll his wheelchair to the door and shout for help in the hallway. An observation of Resident #45 on 4/07/25 at 1:42 PM revealed him sitting in his wheelchair in his room. The call light continued to be wrapped around the right bed rail, which was up against the wall. An observation and interview with Certified Nurse Aide (CNA) #4 on 4/07/25 at 1:50 PM confirmed Resident #45's call light was inaccessible to him. She revealed the resident used the call light and explained that without it being accessible, he would not be able to call for help. An interview with Licensed Practical Nurse (LPN) #3 on 4/07/25 at 1:55 PM revealed the call light should always be in reach for Resident #45, so he could call staff if he needed something. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/17/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 10, which indicated Resident # 45 was moderately cognitively impaired. Record review of the "Admission Record"	F 558	accessible to residents. Resident #45 was assessed on 04/09/2025 by a Registered Nurse (RN) with no adverse effects to not having the call light being accessible. 2) Residents who utilize the call light have the potential to be affected by this deficient practice. 3) On 04/11/2025, an audit was monitored and documented by the Maintenance Director to ensure call lights are functioning properly and accessible to the resident. Beginning on 04/09/2025, licensed nurses, CNAs, housekeeping, and social services staff were educated by the RN Staff Director to ensure call lights have clips and are accessible to the resident and will be completed by 04/25/2025. Newly hired licensed nurses, CNAs, housekeeping, and social services staff will be educated upon hire on ensuring the call lights have clips and are accessible to the resident. 4) Beginning on 04/14/2025, the DON and/or Administrator will audit resident rooms to ensure call lights have clips and are accessible to the resident on 5 residents 5 times a week for 4 weeks and then 5 residents monthly for 3 months. Audits will be monitored, documented, and maintained by the DON. Areas of concern will be reported to the QAPI Committee for review. The QAPI Committee will convene on 05/12/2025 to discuss further recommendations as	

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F 558	Continued From page 2 revealed the facility admitted Resident #45 on 2/29/24 with a medical diagnosis of Epilepsy.	F 558	needed and once a month for 3 months. Additional training and/or disciplinary action will be considered as warranted.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review, and facility policy review	F 561	1) On 04/11/2025, an initial Quality Assurance and Performance	5/13/25

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F 561	Continued From page 3 the facility failed to honor a resident's choice related to food preferences for one (1) of two (2) residents reviewed for choices. Resident #61. Findings Include: Record review of the facility policy "Dignity and Respect" with revision date of 07/22 revealed "A facility must...care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility shall protect and promote the rights of the residents...3. All residents should have autonomy of choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care...4...Resident's individual preferences regarding such things as menus...will be elicited and respected by the facility, and efforts will be made to accommodate these wishes..." An observation and interview on 4/07/25 at 12:10 PM with Resident #61 revealed she was sitting in her room eating her lunch meal. She stated that she did not like rice or greens, and they had those foods on her meal tray today. An observation of the resident's lunch tray confirmed she had rice and mustard greens along with red beans, cornbread, pork chop, yogurt and banana pudding. She admitted that she had told them months ago that she didn't eat rice and greens, but they continued to put them on her plate. She also revealed that greens and rice were listed on her meal ticket under "dislikes". An observation of the resident's meal ticket confirmed that rice and greens were listed under "dislikes". An interview on 4/08/25 at 11:45 AM with	F 561	Improvement (QAPI) was held and Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 04/11/2025 and based on findings the facility failed to honor a residents choice related to food preferences to Resident #61. Resident #61 was assessed on 04/11/2025 by the Registered Nurse (RN) Supervisor to ensure no adverse effects to Resident #61 related to not honoring a residents choice related to food preferences. Resident # 61s food preferences were updated by the Food Services Director on 04/11/2025 related to honoring a residents choice related to food preferences. 2) Residents with food preferences have the potential to be affected by this deficient practice. 3) On 04/11/2025, an audit was conducted by the Food Services Director to ensure residents choices are honored related to food preferences. On 04/10/2025, the dietary staff were educated on Alternate Foods for Food Preferences policy by the Registered Nurse (RN) Staffing Director on ensuring residents choices are honored related to food preferences. Beginning on 04/09/2025, the licensed nurses and Certified Nurse Assistants (CNAs) were educated on Alternate Foods for Food Preferences policy by the RN Staffing Director on ensuring residents choices are honored related to food preferences and will be completed by 04/25/2025. Newly hired licensed nurses, CNAs, and	

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F 561	Continued From page 4 Registered Nurse (RN) #1 confirmed that there was a place on the meal ticket's that listed the resident's likes and dislikes, and the residents should not receive those foods. She revealed that staff assisted the residents to fill out their preferences and choices and that the Dietary Manager kept up with them. An interview on 4/08/25 at 1:04 PM with the Dietary Manager (DM) confirmed that Resident #61's Lunch Meal Ticket dated 4/07/25 had dislikes documented that included mustard greens and rice and that she should not have received those two food items. He confirmed that the lunch menu on 4/07/25 consisted of a pork chop, red beans and rice, greens, banana pudding, and cornbread. The Dietary Manager revealed that the kitchen staff were supposed to follow the meal tickets as the plates were being passed down the line and that the greens and rice must have been put on Resident #61's plate by mistake. He revealed that he evaluated residents when admitted, went over their likes, dislikes, and preferences and the dietary staff were supposed to prepare their meal trays accordingly. He confirmed that Resident #61's dislikes were not honored, and she should not have received the greens and rice. An interview on 4/09/25 at 12:50 PM with the Administrator confirmed that resident food likes, dislikes and preferences were assessed when admitted to the facility and that Resident #61 should not have been served foods that were on her dislike list, stating, "That's on us." The Administrator also revealed that the dietary staff should be reading and following those meal tickets when serving meals and admitted that residents had the right to make food choices.	F 561	dietary staff will be educated on Alternate Foods for Food Preferences policy upon hire and as needed on ensuring residents choices are honored related to food preferences. 4) Beginning on 04/14/2025, the Administrator and/or Food Service Director will conduct an audit to ensure residents choices are honored related to food preferences on 5 resident 5 times a week for 4 weeks and then 5 residents monthly for 3 months. Audits will be monitored, documented, and maintained by the Director of Nurses. Areas of concern will be reported to the QAPI Committee for review. The QAPI Committee will convene on 05/12/2025 to discuss further recommendations as needed and once a month for 3 months. Additional training and/or disciplinary action will be considered as warranted.	

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F 561	Continued From page 5 Record review of Resident #61's "Dietary Admission Interview Form" with admission date of 4/30/21 revealed that Rice, Mustard and Turnip Greens under "Food Preferences" were answered "No." Record review of Resident #61's "Dislike and Allergy Report" revealed that she disliked Rice, Turnip Greens, and Mustard Greens. Record review of Resident #61's Lunch Meal Ticket dated 4/07/25 revealed that her dislikes included Mustard Greens and Rice. Record review of Resident #61's "Admission Record" revealed an admission date of 4/29/21 and that she had diagnoses that included Type 2 Diabetes Mellitus, Unspecified Anemia, and Unspecified Anxiety Disorder. Record review of Resident #61's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/11/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	F 561		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an	F 645		5/13/25

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F 645	Continued From page 6	F 645		

independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the

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F 645	Continued From page 7 condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to accurately submit a resident's information for Preadmission Screening and Resident Review (PASRR) for a Level II evaluation for one (1) of three (3) residents reviewed for PASRR. (Resident #43) Findings include: Review of the facility policy titled, "Pre-Admission Screening PAS/PASRR (MS Only)" last reviewed 8/24, revealed, "To enter a Long-Term Care program an eligible beneficiary must have a Pre-Admission Screening (PAS) application completed to determine clinical eligibility for individuals seeking admission to a Division of Medicaid certified nursing facility on all residents regardless of payor source... Process... Review the medical records and other relevant medical	F 645	1) On 04/11/2025, an initial Quality Assurance and Performance Improvement (QAPI) was held and Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 04/11/2025 and based on findings the Accounts Manager did not accurately submit a residents information for a Preadmission Screening and Resident Review (PASRR) for a Level II evaluation for Resident #43. The Accounts Manager was educated on 04/11/2025 by the Social Services Director to ensure how to accurately submit a residents information for a PASRR for a Level II evaluation. Resident #43 was assessed with no adverse effects on 04/11/2025 by the Registered Nurse (RN) Supervisor related to not accurately submitting a residents information for a PASRR for a Level II	

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F 645	Continued From page 8 documentation to verify major medical conditions and services..." Record review of the "Admission Record" revealed Resident #43 was admitted on 12/09/24, with diagnoses of Unspecified Psychosis, Major Depressive Disorder, and Psychotic Disorder with Delusions. Record review of Resident # 43's "Active Orders" as of 12/09/24 revealed, Citalopram hydrobromide 20 mg (milligram) one tablet by mouth one time a day related to Major Depressive disorder, Haloperidol 1 (one) mg tablet by mouth every 8 (eight) hours related to Unspecified Psychosis, and Trazodone 50 mg 1 (one) tablet orally at bedtime related to Psychotic disorder with delusions. Record review of Resident #43's intake information for PASRR dated 12/09/24 revealed, Section I: Medications: coded no medications specified...Section J: Disease Diagnoses: coded only the admitting diagnosis of Cerebral Infarction... Section L: Referral Questions: 31. Does Resident # 43 have any history of mental illness? answered No...32. Does Resident #43 take, or have a history of taking psychotropic medications? answered No. During an interview with the Accounts Manager on 4/8/25 at 10:30 AM, she revealed she completed the Pre-Admission Screening on admission for Resident #43. She confirmed that she did not list any diagnoses other than the admitting diagnosis of Cerebral Infarction. She stated she never adds any other diagnosis than the primary diagnosis. She also revealed that she was not familiar with all the psychiatric diagnoses	F 645	evaluation. The Social Services Director submitted a significant change in status form for a Level II to the appropriate agency on 04/09/2025 for Resident #43. 2) One resident of eighty-three residents has the potential to be affected by the deficient practice. 3) Beginning on 04/09/2025, the Director of Nurses (DON) and/or RN Staffing Director immediately initiated education with the social services staff and licensed nurses on policy titled Pre-Admission Screening PAS/PASRR (MS only) with a revision date of 08/2024, that included how to how to accurately submit a residents information for a PASRR for a Level II evaluation and will be completed by 04/25/2025. Newly hired social services staff and licensed nurses will be educated upon hire on policy titled Pre-Admission Screening PAS/PASRR (MS only) with a revision date of 08/2024, that included how to how to accurately submit a residents information for a PASRR for a Level II evaluation and as needed. 4) Beginning on 04/14/2025, the DON and/or RN Staff Director will monitor by review on form titled Pre-Admission Screening for accurately completed PASRR form on any new admits and any resident requiring a change for a PASRR for a Level II evaluation weekly for 4 weeks and then any new admits monthly for 3 months. Audits will be monitored, documented, and maintained by the DON.	

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F 645	Continued From page 9 or the psychotropic medications that may need to be included. She confirmed, after reviewing the active orders as of 12/09/24 (the day the PAS was completed), that the resident was admitted on psychotropic medications and had psychiatric diagnoses that should have been submitted to determine the need for a Level II PASRR referral. She acknowledged it was an oversight on her part. She then revealed a concern that incorrectly completing the PAS could result in a resident with psychiatric diagnoses not receiving the additional services they may need. An interview with the Director of Nursing on 4/9/25 at 10:40 AM revealed that she reviewed Resident #43's 12/9/24 PAS and confirmed that it was coded incorrectly. She confirmed that the resident was admitted with mental health diagnoses and on psychotropic medications. She stated that the purpose of the PAS is to identify the resident's needs to ensure the resident is appropriate for placement in the facility and to determine if the resident needs a referral for a Level II PASRR for any extra mental health services. An interview with the Social Worker on 4/8/25 at 11:00 AM confirmed, after review of the PAS completed on admission for Resident #43, that it was not completed correctly. She stated the resident was admitted with psychiatric diagnoses and on psychotropic medications and should have been referred for a Level II PASRR. She revealed that the accuracy of the PASRR is important to ensure the resident is appropriate for the facility and that the facility can meet the resident's mental health needs and provide any additional services required. She then stated that incorrectly completing the PAS could result in a	F 645	Areas of concern will be reported to the QAPI Committee for review. The QAPI Committee will convene on 05/12/2025 to discuss further recommendations as needed and once a month for 3 months. Additional training and/or disciplinary action will be considered as warranted.	

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F 645	Continued From page 10 resident not receiving needed care and services. A record review of Resident #43's Admission Minimum Data Set (MDS) dated 12/17/24, revealed Section N: Medications coded as taking antipsychotic and antidepressant medications.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required 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	F 656		5/13/25

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F 656	Continued From page 11 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to implement a care plan related to fluid restriction for one (1) of 17 resident care plans reviewed. (Resident #20). Findings include: Review of a facility policy titled, " Care Plan Process," last revised 12/24, revealed, "The comprehensive care plan is an interdisciplinary communication tool...The care plan must include measurable objectives and timeframes and must describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being..." Review of a care plan for Resident # 20 revealed, "Focus The resident is at risk for nutritional problems r/t (related to) ESRD (End Stage Renal Disease) with fluid restriction on Hemodialysis...	F 656	1) On 04/11/2025, an initial Quality Assurance and Performance Improvement (QAPI) was held and Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 04/11/2025 and based on findings the Minimum Data Set (MDS) Nurse did not implement the care plan related to fluid restriction for Resident #20 and licensed nurses did not accurately monitor and document fluid intake for Resident #20. One-on-one education with the MDS Nurses was conducted on 04/11/2025 by the Administrator to ensure to implement the care plan related to fluid restriction. MDS Nurse implemented the care plan related to fluid restriction for Resident #20 on 04/11/2025. Resident #20 was assessed with no adverse effects on 04/11/2025 by a Registered Nurse (RN) Supervisor related to not implementing the care plan related to fluid restriction	

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F 656	Continued From page 12 last revised 9/05/24.. Interventions:..1000 ml (milliliters) fluid restriction. Document fluid intake. Day shift not to exceed 450 ml. Evening shift not to exceed 450 ml. Night shift not to exceed 100 ml..." Record review of the Intake and Output (I&O) forms for Resident #20 from 3/30/25 through 4/7/25 revealed incomplete documentation. Daily 24-hour totals ranged from 240 ml to 400 ml. The (I&O) records lacked documentation necessary to determine if the resident's prescribed fluid restriction was being maintained. An interview on 4/08/25 at 3:25 PM, the Director of Nursing (DON) confirmed that staff were not consistently following the resident's care plan as it related to fluid restriction and intake documentation. During an interview conducted on 4/09/25 at 9:10 AM, the Minimum Data Set (MDS) Nurse reviewed Resident #20's care plan and stated that if staff were not documenting the total daily fluid intake, then the care plan was not being implemented. She stated the care plan serves to direct resident-specific care and failure to implement it could result in the residents receiving more fluids than ordered. Record review of the Admission Record revealed that Resident #20 was admitted to the facility on 10/11/22 with diagnoses that included Hypertensive Heart and Kidney Disease with Heart Failure and Stage 5 Chronic Kidney Disease (End-Stage Renal Disease).	F 656	and licensed nurses not accurately monitoring and documenting fluid intake for a resident on fluid restriction. 2) Residents who have a care plan related to fluid restriction have the potential to be affected by the deficient practice. 3) On 04/11/2025, an audit was conducted by the Director of Nurses (DON) to ensure the implementation of the care plan related to fluid restriction residents. Beginning on 04/11/2025, licensed nurses were educated by the DON and/or RN Staffing Director on Care Plan Process policy to ensure the implementation of the care plan related to fluid restriction residents and will be completed by 04/25/2025. Newly hired licensed nurses will be educated upon hire and as needed on Care Plan Process policy to ensure the implementation of the care plan related to fluid restriction residents. 4) Beginning on 04/14/2025, the DON and/or MDS Nurse will review care plans to ensure the implementation related to fluid restriction residents on 5 residents 5 times a week for 4 weeks and then 5 residents monthly for 3 months. Audits will be monitored, documented, and maintained by the DON. Areas of concern will be reported to the QAPI Committee for review. The QAPI Committee will convene on 05/12/2025 to discuss further recommendations as needed and once a month for 3 months.	

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F 656	Continued From page 13	F 656	Additional training and/or disciplinary action will be considered as warranted.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to ensure accurate monitoring and documentation of fluid intake for a resident on fluid restriction for one (1) of (4) four residents reviewed for fluid restrictions (Resident #20). Findings include: Review of the facility policy titled, "Fluid	F 692	1) On 04/11/2025, an initial Quality Assurance and Performance Improvement (QAPI) was held and Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 04/11/2025 and based on findings facility did not accurately monitor and document fluid intake for Resident #20 on fluid restriction. Resident #20 was assessed with no adverse effects on 04/11/2025 by	5/13/25

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F 692	Continued From page 14 Restriction," last reviewed February 2022, revealed the policy statement: "Fluids will be restricted for residents as directed by the physician orders... Procedure: 3. Nursing service will document intake..." Record review of the "Order Summary Report" for Resident #20 revealed an order dated 8/26/24 for a 1000 milliliter (ml) fluid restriction. The order directed that fluid intake must be documented and specified the following shift limits: day shift not to exceed 450 ml, evening shift not to exceed 450 ml, and night shift not to exceed 100 ml. Record review of the Intake and Output (I&O) forms for Resident #20 from 3/30/25 through 4/7/25 revealed incomplete documentation. Daily 24-hour totals ranged from 240 ml to 400 ml. The (I&O) records lacked documentation necessary to determine if the resident's prescribed fluid restriction was being maintained. During an interview with Certified Nurse Assistant (CNA) #2 on 4/8/25 at 3:11 PM, she stated she was aware that Resident #20 was on a fluid restriction. CNA #2 further stated that CNAs are expected to report the amount of fluids the resident consumes during meals to the nurse. She confirmed that she had not been reporting the resident's fluid intake to the nurse. During an interview with Licensed Practical Nurse (LPN) #3 on 4/8/25 at 3:15 PM, she revealed she was assigned to Resident #20 on the day shift. LPN #3 stated she was aware the resident was receiving dialysis but was not aware the resident was on a fluid restriction. She also confirmed that the CNAs do not notify her of how much fluid the resident consumes during meals.	F 692	a Registered Nurse (RN) Supervisor related to not accurately monitoring and documenting fluid intake for a resident on fluid restriction. 2) Residents who have fluid restrictions have the potential to be affected by the deficient practice. 3) On 04/11/2025, an audit was conducted by the Director of Nurses (DON) to ensure accurately monitoring and documenting fluid intake for residents on fluid restriction. Beginning on 04/11/2025, licensed nurses and Certified Nursing Assistants (CNAs) were educated on Fluid Restriction policy by the DON and/or RN Staffing Director on ensuring accurately monitoring and documenting fluid intake for residents on fluid restriction and will be completed by 04/25/2025. Newly hired licensed nurses and CNAs will be educated on Fluid Restriction policy upon hire and as needed on ensuring accurately monitoring and documenting fluid intake for a resident on fluid restriction. 4) Beginning on 04/14/2025, the DON and/or Minimum Data Set (MDS) Nurse will review documentation on fluid intake for residents on fluid restriction for 5 residents 5 times a week for 4 weeks and then 5 residents monthly for 3 months. Audits will be monitored, documented, and maintained by the DON. Areas of concern will be reported to the QAPI Committee for review. The QAPI Committee will convene on 05/12/2025 to	

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F 692	Continued From page 15 During an interview with LPN #4 on 4/8/25 at 3:20 PM, she stated she provided care for Resident #20 during the evening shift. LPN #4 confirmed she was aware the resident was on a fluid restriction but was unsure of the prescribed fluid restriction amount. She also confirmed that the CNAs do not report the resident's fluid intake to her during the shift. She stated she only documented the fluids she directly gave to the resident. During an interview with the Director of Nursing (DON) on 4/8/25 at 3:25 PM, she confirmed that upon review of the I&O forms from 3/30/25 to 4/7/25, staff were not accurately documenting the total amounts of fluid consumed by Resident #20. She stated that CNAs are responsible for informing nurses of the amount of fluids the resident drinks during meals, and nurses are expected to ensure the intake is documented correctly and that the resident's prescribed fluid restriction is followed. She acknowledged that the current documentation was inaccurate and incomplete, and therefore staff had no way to accurately assess how much fluid the resident was consuming. The DON expressed that concerns from this deficient practice could result in the residents consuming too much or too little fluid, potentially leading to fluid overload or dehydration. Record review of the Admission Record revealed Resident #20 was admitted to the facility on 10/11/22 with diagnoses including Hypertensive Heart and Kidney Disease with Heart Failure and Stage 5 Chronic KidneyDisease and End-Stage Renal Disease.	F 692	discuss further recommendations as needed and once a month for 3 months. Additional training and/or disciplinary action will be considered as warranted.	

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F 692	Continued From page 16 Record review of Resident #20's Quarterly Minimum Data Set (MDS) dated 2/11/25, Section O, revealed the resident was receiving dialysis while in the facility.	F 692		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must 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. 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 follow a physician 's order for a referral to a pain management clinic for Resident #23, this was for one (1) of three (3) residents reviewed for pain. Findings Include: Review of the facility policy titled "Pain Screen and Management" with a revision date of 12/23 revealed, "All residents who experience routine pain receive a comprehensive pain screening and a treatment plan until an acceptable level of relief of pain is achieved. All residents have the right to treatment for pain." On 4/07/25 at 11:15 AM, an observation and interview with Resident #23 revealed he was lying in bed and verbalized he was hurting in his lower abdomen (kidney area) and his lower ribs (lung area). The resident revealed he was unsure if he had taken something for the pain.	F 697	1) On 04/11/2025, an initial Quality Assurance and Performance Improvement (QAPI) was held and Root Cause Analysis was conducted by the Interdisciplinary Team (IDT) on 04/11/2025 and based on findings the facility failed to follow a physicians order for a referral to a pain management clinic for Resident #23. Resident #23 was assessed on 04/11/2025 by the Registered Nurse (RN) Supervisor with no adverse findings related to not following a physicians order for a referral to a pain management clinic. Resident #23 received a physicians order for a referral to a pain management clinic on 04/09/2025, and the pain management clinic called the facility with an appointment set for 05/19/2025. Resident #23 received a physicians order for a referral to hospice and was admitted hospice on 04/10/2025.	5/13/25

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F 697	Continued From page 17 An observation and interview of Resident #23 on 4/08/25 at 9:40 AM revealed he was lying in bed and the resident stated that he was hurting all over. The resident revealed that he had had a log truck accident in the past with injuries, including a skull fracture, a broken collarbone, and a broken hip, which required a hip replacement. He reported shoulder and hip pain radiating up his spine, described his pain as throbbing, and rated it 8 out of 10 on a pain scale. He added that he had just taken a "bunch of pills" and thought the nurse had given him something. During an interview with Licensed Practical Nurse (LPN) #3 on 4/08/25 at 9:50 AM, she confirmed that she gave the resident a PRN (as needed) a Methocarbamol (muscle relaxant) at 8:40 AM after he told her he was hurting in his shoulders and sides. She added the resident took Gabapentin scheduled three times a day for nerve pain and chronic pain and took Robaxin every 6 hours as needed for muscle spasm. According to LPN #3, the resident reported that Neurontin and the muscle relaxer provided relief. She stated that she knew the doctor had made a referral to the pain clinic several months ago, but she was unsure what happened, but he did not go. Record review of Resident #23's "Order Details" revealed a physician order dated 1/07/25, "Refer resident to pain management due to left shoulder and left hip pain." Record review of Resident #23's Medication Administration Record (MAR) revealed, an order dated 7/01/24 "Gabapentin (nerve pain/chronic pain) Oral Capsule 300 MG (milligrams) give 1	F 697	2) Residents who have a physicians order for a referral to a pain management clinic have the potential to be affected by this deficient practice. 3) On 04/11/2025, an audit was conducted by the Director of Nurses (DON) to ensure physicians order for a referral to a pain management clinic are followed. Beginning on 04/11/2025, the licensed nurses and social services staff were educated by the RN Staff Director on Physicians Order policy on ensuring physicians order for a referral to a pain management clinic are followed and will be completed by 04/25/2025. Newly hired licensed nurses and social services staff will be educated upon hire and as needed on Physicians Order policy on ensuring physicians order for a referral to a pain management clinic are followed. 4) Beginning on 04/14/2025, the DON and/or Medical Records Nurses will audit to ensure physicians order for a referral to a pain management clinic are followed on 5 residents 5 times a week for 4 weeks and then 5 residents monthly for 3 months. Beginning on 04/14/2025, the DON and/or Medical Records Nurses will audit physician orders Monday through Friday during Daily Stand-up Meeting related to ensuring physician orders are followed. Audits will be monitored, documented, and maintained by the DON. Areas of concern will be reported to the QAPI Committee for review. The QAPI Committee will convene on 05/12/2025 to discuss further recommendations as	

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F 697	Continued From page 18 capsule by mouth three times a day related to pain." Also revealed and order dated 1/27/25, "Methocarbamol (muscle relaxant) Oral Tablet 500 MG (milligram) give 1 tablet by mouth every 6 hours as needed for pain related to other muscle spasm." The MAR revealed the resident received Methocarbamol on the following dates and times: 4/01/24 at 6:00 AM 4/02/24 at 12:15 AM 4/03/25 at 12:23 AM and 9:22 AM 4/04/25 at 12:02 AM and 9:34 AM 4/05/25 at 12:18 AM, 9:16 AM, and 11:30 PM 4/07/25 at 6:04 AM and 11:31 PM 4/08/25 at 8:45 AM An interview with the Nurse Practitioner (NP) on 4/08/25 at 11:39 AM revealed Resident #23 has a history of mental illness and drug abuse. She explained that he has multiple allergies to pain medications and commented, "Basically there's nothing we can give him." She revealed therapy and lidocaine patches had been tried previously, and x-rays and tests had not revealed any specific injury. The NP revealed the resident says the muscle relaxant was effective. She confirmed the resident's physician made a referral to pain management but was unsure why he never went. An interview with the Director of Nursing (DON) on 4/08/25 at 3:02 PM confirmed that Resident #23's pain management referral was never made and acknowledged that this could result in a delay	F 697	needed and once a month for 3 months. Additional training and/or disciplinary action will be considered as warranted.	

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in the residents receiving appropriate care and pain relief.

An interview with the Medical Record's (MR) Nurse on 4/08/25 at 3:15 PM revealed Social Services would have been responsible for making Resident #23's pain appointment. However, the appointment was never scheduled, and the order was discontinued after 90 days.

An interview with Social Services (SS) on 4/08/25 at 3:20 PM revealed that she never received a copy of Resident #23's physician's order and was therefore unaware of the pain management referral.

During a telephone interview on 4/09/25 at 9:21 AM, with Resident #23's Medical Doctor (MD), he revealed the resident's pain had evolved over time. He described a complex history, including multiple geriatric psychiatry admissions and medication management regimen. He revealed the resident required high doses of medication to manage paranoia, which also lowered his blood pressure and had contributed to nighttime falls. The MD explained that the resident had end-stage chronic obstructive pulmonary disease (COPD) and a history of traumatic injuries. He stated that he believed the resident's pain was neuropathic and that Methocarbamol and Gabapentin may provide some relief with pain brought on by those type of injuries. He confirmed that he made a referral to pain management for the resident's shoulder and hip pain and felt the resident would still benefit from seeing a pain specialist. The MD also noted that during a recent visit on 4/07/25, the resident complained of abdominal pain caused by constipation related to immobility and was started on Simethicone for

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gas relief. He emphasized that the resident's pain should be addressed and acknowledged that his case was complex due to underlying mental illness and COPD.

Record review of Resident #23's "Progress Note" dated 1/07/25 revealed under, "Assessment and Plan: ... Chronic pain syndrome-Continue Gabapentin (nerve pain) 300 mg (milligrams) TID (three times daily)-refer to pain management."

Record review of the MDS with an Assessment Reference Date (ARD) of 3/14/25 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #23 was cognitively intact.

Record review of the "Admission Record" revealed the facility admitted Resident #23 on 8/22/24 with a medical diagnosis that included Chronic Obstructive Pulmonary Disease and Pain, Unspecified.