STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255169	A. BUILDING _____ B. WING _____	C 04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS COUNTY NURSING CENTER	587 JOHN R JUNKIN DRIVE NATCHEZ, MS 39120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and Complaint Investigation (CI), MS#28189, at the facility from 4/21/25 through 4/24/25. The SA investigated MS #28189 for quality of care and falls and cited F689. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550, F576, F692, F695, F755, F761, F812, F867, and F880. The facility was licensed for 100 beds and had a census of 61.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and 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 must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		5/16/25

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

Electronically Signed | 05/14/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to honor a resident's preference related to smoking during the scheduled smoking times, in accordance with the facility's designated smoking schedule, for one (1) of eighteen (18) residents reviewed for resident rights, Resident #15. Findings included: A review of the facility policy titled, "A Matter of RIGHTS," undated, revealed, "A Guide to Your Rights and Responsibilities as a Resident...Dignity and Respect ...You have the right to dignity and respect in the care you receive and the setting you live in. This right includes the right: to be treated as an individual...It also means you have a right to expect care and a residential setting...reflects your individual preferences..."	F 550	1. On 4/23/2025, The assigned certified nursing assistant took resident #15 to smoke immediately. All resident who smoke are now being given smoke breaks timely. 2. All residents who smoke have the potential to be affected. 3. On 4/28/2025, a notice was posted by the Activities Director regarding a special resident council meeting in resident common areas. On 5/1/2025, a special resident council meeting was held and conducted by the Activities director to discuss new smoking times that would accommodate both the residents and the facility. A new smoking schedule was agreed upon by the council and the new	

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F 550	Continued From page 2 A record review of the "Admission Record" revealed the facility admitted Resident #15 on 7/5/24 with diagnoses including Type 2 Diabetes Mellitus. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/12/25 revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of thirteen (13), which indicated he was cognitively intact. A record review of the facility's "Resident Smoking Schedule" revealed 12:30 PM as one of the designated times for resident smoking breaks. On 4/23/25 at 12:30 PM, an observation revealed Resident #15 was waiting to go outside for a smoke break. No staff was present to assist him. During an interview at this time, Resident #15 stated that staff were often late taking him out to smoke or sometimes he did not get to go at all during the scheduled time. He expressed that this was upsetting because he enjoyed both smoking and the opportunity to go outside for fresh air. He stated that the outdoor time helped him feel more relaxed and provided a sense of freedom. He added that since this is his home, he felt he and other residents should be treated with more consideration, stating staff should be more consistent in honoring the outdoor smoking schedule. On 4/23/25 at 12:45 PM, an observation revealed no staff had yet come to take Resident #15 or the other residents outside to smoke.	F 550	schedule was implemented on 5/2/2025.On 4/23/2025, The Director of Nursing (DON) in-serviced the Nurses and certified nursing assistants on the smoking policy and resident rights. On 5/2/25, the DON in-serviced nursing staff on the new smoking schedule and the importance of timeliness. 4. Beginning 4/23/2025, the Director of Nursing will interview two (2) residents per week times four (4) weeks then monthly times two (2) months to monitor compliance with smoke break schedule adherence and resident rights related to smoking. Smoke break times will be monitored by the Director of Nursing or Registered Nurse Supervisor three (3) times weekly for two (2) weeks, then monthly times two (2) months. The DON will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis times three (3) Months, for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for 5/14/25.	

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F 550	Continued From page 3 On 4/23/25 at 12:45 PM, during an interview with the Staff Development Licensed Practical Nurse #1 (LPN), she confirmed the "B Hall" staff was scheduled to take the residents out to smoke. When asked if a staff member was currently assigned, she responded that she would find the assigned Certified Nurse Aide (CNA). On 4/23/25 at 12:50 PM, in an interview with CNA #1, she explained she was originally assigned to take the residents out to smoke today, but stated it was not a good time because she needed to change two (2) residents. She further stated that smoking times were frequently delayed because staff were often busy during that time. On 4/23/25 at 3:37 PM, the Director of Nursing (DON) confirmed 12:30 PM was a scheduled smoke time for residents. She explained that the facility needed to adjust the smoking time because staff were usually busy during the 12:30 PM smoke break. The DON confirmed the residents had the right to be taken out for a smoke break by the facility staff at the scheduled times designated by the facility.	F 550		
F 576 SS=D	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with	F 576		5/16/25

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F 576	Continued From page 4 individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents receive mail on Saturdays, which affected one (1) of one (1) resident council members reviewed and had the potential to affect all 61 residents residing in the facility. Resident #26. Findings included:	F 576	1. On 4/24/2025, there was no mail to be delivered to residents. 2. All residents who receive mail have the potential to be affected. 3. On 4/25/2025, the Director of Nursing in-serviced the weekend RN supervisors about mail delivery to the residents on the	

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F 576	Continued From page 5 A review of the facility's policy titled, "A Matter of RIGHTS," undated, revealed, "A Guide to Your Rights and Responsibilities as a Resident... Dignity and Respect, you have the right to dignity and respect in the care you receive and the setting you live in. This right includes the right: to be treated as an individual... It also means you have a right to expect care and a residential setting... that reflects your individual preferences..." On 4/23/25 at 10:30 AM, during a resident council meeting, Resident #26, the council president, reported that residents did not consistently receive mail on Saturdays. She stated that this concern had been brought up at every council meeting and confirmed that although some nurses would deliver the mail in the past, it was not received every Saturday. All residents in attendance confirmed they did not receive mail consistently on Saturdays and would like to receive it regularly. On 4/23/25 at 11:20 AM, during an interview with the Director of Nursing (DON), she explained that residents not receiving mail on Saturdays had been a concern. She stated that it was the Registered Nurse (RN) Supervisor's responsibility to ensure mail was distributed and reported that she had addressed the issue and had disciplined staff for failure to distribute mail. The DON stated it was important that residents receive their mail on Saturdays. On 4/23/25 at 2:47 PM, during an interview with the Activities Director, she stated that the mail issue had been ongoing and that she mentioned it during the morning meeting. She confirmed the residents should receive their mail on Saturdays	F 576	weekend and implemented a sign in sheet. The mail is delivered to the nurses station by the postal service. The RN supervisor will separate and deliver mail in a timely manner as evidenced by the sign in sheet beginning 4/26/2025. 4. The Director of Nursing (DON) will interview two (2) residents per week for four (4) weeks then monthly times 2 months to ensure mail is being delivered beginning 4/28/2025. The DON will also monitor the mail delivery sign in sheet weekly times three (3) months beginning 4/28/2025. The Residents will be asked by the Activities Director during the monthly resident council meeting if mail is being delivered on weekends beginning 5/1/2025. The Director of Nursing will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis times three (3) months, for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for 5/14/25.	

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F 576	Continued From page 6 and was unsure why the issue persisted. On 4/24/25 at 9:09 AM, in a follow-up interview with Resident #26, she stated that recently, residents had not been receiving their mail on Saturdays at all. A record review of the "Admission Record" revealed the facility admitted Resident #26 on 2/2/18 and she had current diagnoses including Iron Deficiency Anemia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/11/25 revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of fifteen (15), which indicated she was cognitively intact A record review of the Resident Council meeting minutes, dated 2/14/25, revealed residents had concerns of not consistently receiving mail on Saturdays.	F 576		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §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. This REQUIREMENT is not met as evidenced by: Resident #45 PASARR Final Version	F 646	1. On 4/22/2025, the Social Services Director immediately completed a Mississippi Preadmission Screening and Resident Review (PASRR) level II change	5/16/25

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F 646	Continued From page 7 Based on interview and record review the facility failed to update the Level II Preadmission Screening and Resident Review (PASSAR) to reflect recent mental health diagnoses for one (1) of 18 residents sampled. Resident #45 Findings include: A review of the facility policy, "Pre-admission Screening Application for Long Term Care (PASRR), 2/2024 revealed ... "A PASRR is required for every resident admission to long term care ...There should be a Change In Status Form completed if resident is sent to a psychiatric hospital or other significant change ..." A record review of the facility's "Admission Record" revealed the facility admitted Resident #45 on 10/13/22 with diagnoses including Unspecified Psychosis not due to a substance or known physiological condition (onset date 11/16/23) and Paranoid Schizophrenia (onset date 11/16/23). A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/23/25 revealed the staff's assessment of the residents' cognitive status was severely impaired. A record review revealed Resident #45 had no Level II PASSAR to address the most recent mental health diagnoses. On 04/22/25 at 08:40 AM, an interview with the Director of Nursing (DON) revealed she acknowledged the failure of the facility to ensure the resident's Level II PASARR was updated to	F 646	in status request on resident #45 and uploaded to Medicaid Long-term services and support (LTSS) System. 2. All residents who require a change in status have the potential to be affected. 3. On 04/23/2025, an audit was conducted by the Social Services Director to ensure accurate screening of mental illness prior to admission and with new psychiatric diagnosis and no other issues were identified. Medical records or Director of Nursing will review all new orders and ensure appropriate diagnoses and report to the Director of Nursing and Social Services Director in morning team meeting Monday thru Friday beginning on 4/24/2025 and ongoing. On 4/22/2025, the Social Services director was in-serviced by Director of Nursing on PASRR policy. 4. Starting on 04/22/2025, the Director of Nursing or Medical Records began monitoring all new diagnosis entered during the clinical morning meeting Monday- Friday and Saturday and Sunday will be reviewed on the following Monday. The Director of Nursing, Medical Records, and Social Services Director will review new behaviors and new diagnosis to ensure PASSR is accurate. The Director of Nursing will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis times three (3), for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for	

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F 646	Continued From page 8 reflect the resident's two most recent mental health diagnoses. The DON stated it is the responsibility of the Social Services Director to make sure the Level II PASARR contains current information. The DON confirmed the importance of having the PASARR updated with the resident's current medical information is to assure the resident is appropriately placed. The DON noted she expected the Level II PASARRs to be done immediately as changes occur to a resident's condition. On 04/22/25 at 8:48 AM, an interview with the Social Services Director (SSD) revealed she affirmed that the resident's Level II PASARR did not reflect the resident's most recent mental health diagnoses. The SSD confirmed it is her responsibility to keep this record updated. The SSD noted that going forward she will make sure to have all Level II PASARRs up to date. On 04/22/25 at 9:27 AM, an interview with the Administrator confirmed the facility's failure to maintain an updated Level II PASARR to reflect the residents' most recent mental health diagnoses. The Administrator reported that the Social Services Director was responsible for maintaining updated Level II PASARRs. The Administrator acknowledged that the importance of having an updated Level II PASARR is to ensure appropriate placement for the residents. The Administrator stated the facility will provide training and in-service for the SSD to make sure she understands how to stay up to date with this record.	F 646	5/14/25.	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		5/16/25

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F 689	Continued From page 9 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review, the facility failed to investigate or determine root causes for Resident #38 for three (3) of seven (7) falls. (1/12/25, 2/13/25, and 2/25/25) Findings included: A review of the facility's "Responsibility for Accident/Incident Reports Policy," dated 07/2016, revealed, "It is the policy of this facility for all Incident and Accidents involving resident's to be investigated immediately upon knowledge of the incident. Procedure. Staff are to be trained how to investigate and document assessment of possible causes for the accident/incident. They are to obtain written statements from staff on duty and an possible witnesses to the incident. They are to document on the proper forms ..." A record review of the "Admission Record" revealed the facility initially admitted Resident #38 on 01/09/25 with diagnoses including Cardiac Arrest. A record review of the Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/7/25, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score	F 689	1.On 4/13/2025, the RN supervisor completed a fall assessment. Resident #38 remains a high risk for falls. 2.All residents with incidents have potential to be affected. 3.On 4/21/2025, the Director of Nursing immediately began in-servicing nursing staff on completion of incident reporting and implementing interventions. When a resident has a fall, the nurse will complete fall assessment, investigation as to root cause, interventions, and updating care plan. The Director of Nursing will review the incident report, nurses notes and complete an investigation beginning 4/22/2025 and ongoing. 4.On 4/22/2025, and ongoing, the Director of Nursing will begin reviewing all incident reports within 72 hours, ensure that fall assessments are completed if indicated, and interventions are implemented. The Director of Nursing will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis times three (3) months, for review, revisions or	

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F 689	Continued From page 10 of 12, which indicates moderate cognitive impairment. A record review of the "Progress Notes," for Resident #38, dated 1/12/2025 at 9:26 AM, revealed, " ...This nurse was called to resident room by unit CNA (Certified Nurse Aide) R/T (related to) witnessed fall without injury. CNA stated 'resident slid to the floor and sat down when trying to get on the stand lift ..." The author was LPN #4. A record review of the "Progress Notes," for Resident #38, dated 2/13/25 at 11:18 AM, revealed, " ...This nurse was called to Therapy, when entering the room noted resident laying on the floor on her left side ...immediately started c/o (complaining of) being dizzy ...Resident left the facility at approx (approximately) 10:10 AM ...Nurse called report to (Proper Name of Acute Care Hospital_..." A record review of the "Progress Notes," for Resident #38, dated 2/25/25 at 15:30 (3:30 PM), revealed, "This nurse was called to residents room by CNA upon entering the room resident was sitting on bed. Noted knot to left side of forehead noted bleeding ..." Another note dated 2/25/25 at 14:14 (2:14 PM) revealed, "This nurse assisted floor nurse ...with sending resident to ER (Emergency Room) DT (due to) unwitnessed fall with head injury ..." A record review of the medical record for Resident #38 revealed there was no facility fall investigation (Fall Evaluation Tool) completed related to the falls that occurred on 1/12/25, 2/13/25, and 2/25/25. There was a "Fall Evaluation Tool," for falls that occurred on	F 689	resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for 5/14/25.	

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F 689	Continued From page 11 1/17/2025, 1/25/25, 1/28/25, and 2/27/25. On 04/21/25 at 10:11 AM, during an observation and interview with Resident #38, she was sitting in her wheelchair at the bedside. Resident #38 stated that she had fallen three (3) different times. On 04/23/25 at 10:55 AM, during an interview with the facility's Director of Nursing (DON), she explained that an investigation should be completed each time a resident falls, even when a resident experiences more than one fall in the same day. The DON stated that each incident should be reviewed separately to determine the cause and to implement interventions to prevent recurrence. On 04/24/25 at 10:17 AM, during a follow up interview with the DON, she stated she was not aware that Resident #38 had experienced a fall on 01/12/25. She acknowledged there should have been an incident report completed for that fall, explaining that incident reports help identify the circumstances of a fall and guide the implementation of preventive interventions. The DON stated she was also unaware of the fall that occurred on 02/13/25. She confirmed she had knowledge of the fall on 02/25/25 but admitted she failed to complete the incident report, stating she became sidetracked and forgot. She confirmed that all falls should be documented and investigated.	F 689		
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,	F 692		5/16/25

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F 692	Continued From page 12 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 observation, interviews, record review, and facility policy review, the facility failed to follow the physician's order to provide a nutritional supplement with meals to support nutritional status for one (1) of eighteen (18) sampled residents, Resident #27. Findings included: A review of the facility's policy titled "Initiation of Order Changes and Discontinuation of Medications," dated 2/2012, revealed, "...Procedure ...The nurse will assure that the order is complete with date, time, drug, dose, route, and how often to be administered ..." A record review of the "Admission Record" revealed the facility admitted Resident #27 on	F 692	1.On 4/22/2025, resident #18 was immediately given boost supplement with her meal by dietary staff per physicians order. On 4/22/2025 an audit of all residents for supplement orders by the Director of Nursing and all residents with orders for supplements are receiving supplements. 2.All residents who have orders for supplements have the potential to be affected. 3.On 4/22/2025, nursing staff and dietary staff were in-serviced by the Dietary Supervisor and the Director of Nursing on following physicians orders for supplements and communication to the	

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F 692	Continued From page 13 12/22/21 and she had current diagnoses including Unspecified Dementia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/22/25 revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated her cognition was severely impaired. A record review of the "Order Summary Report" revealed Resident #27 had a Physician's Order, dated 8/29/24 for "Regular diet ...Add boast (Boost, a type of nutritional drink) supplement to all meals ..." A record review of the meal tray card, dated 4/22/25, for Resident #27 revealed there was no supplement listed under the "Diet" portion of the card to reflect the Physician's Order. On 4/21/25 at 11:46 AM, during a dining observation, Resident #27 was observed without a meal supplement beverage on her tray. On 4/22/25 at 12:00 PM, during a second dining observation, Resident #27 again was not served a meal supplement beverage on her tray. On 4/22/25 at 12:10 PM, during an interview with Resident #27, she stated that she only liked sweets and mashed potatoes with no gravy. She confirmed that she would drink a nutritional supplement shake if she had one. On 4/22/25 at 12:45 PM, during an interview with the Dietary Supervisor (DS), she stated that Resident #27 was not served a nutritional supplement with her meals because there was no	F 692	dietary staff by use of dietary communication forms. 4.Starting on 4/22/2025, The Dietary Supervisor will print an order listing report daily, during tour of duty, on an ongoing basis to check for new dietary orders. The Director of Nursing (DON) will review new orders during the clinical morning meeting Monday- Friday and Saturday and Sunday will be reviewed on the following Monday beginning 4/22/2025 times four (4) weeks then monthly times two (2) months. Beginning 4/22/2025 the DON or Registered Nurse (RN) Supervisor will observe three (3) resident trays to assure supplements are given on meal tray three (3) times weekly times four (4) weeks, then monthly times two (2) months. The DON will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis times three (3) months, for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for 5/14/25.	

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F 692	Continued From page 14 order written to provide supplements with meals. She added that the only additional nutrition the resident received was snacks delivered to the floor. On 4/23/25 at 7:33 AM, during an interview with the Director of Nursing (DON), she confirmed the resident had a physician's order dated 9/3/24 for a nutritional supplement shake with all meals. She explained that orders are reviewed during morning meetings and should have been communicated to the dietary department. She acknowledged the failure in communication and emphasized that physician orders are intended to direct resident care. On 4/23/25 at 7:44 AM, during an interview with the Administrator, she acknowledged that the facility failed to follow the physician's order dated 9/3/24 to provide a nutritional supplement with all meals for Resident #27. She emphasized the importance of staff following physician orders and stated the facility would ensure reviews are used to cross-check physician orders.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		5/16/25

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F 695	Continued From page 15 Based on observation, interview, record review, and policy review, the facility failed to ensure oxygen-in-use signage was posted on the door for one (1) of one (1) resident reviewed for oxygen safety, Resident #39. Findings included: A review of the facility's policy, "Oxygen Safety" (undated), revealed: " ...General Guidelines ...5. 'No Smoking' signs must be clearly visible in areas where oxygen is stored or in use." On 4/21/25 at 11:00 AM, Resident #39 was observed lying in bed with oxygen flowing at three (3) liters per minute. There was no oxygen caution signage posted on the resident's door. On 4/21/25 at 1:42 PM, during an observation and interview with Licensed Practical Nurse (LPN) #2, she confirmed there was no oxygen caution signage on Resident #39's door. She stated there should be one since oxygen was in use. On 4/22/25 at 11:15 AM, during an interview with the Director of Nursing (DON), she stated, there had been signage on the doors and explained there is a resident who is a known wanderer and likely removed the signs. She stated they had run out of signage for a couple of days while searching for replacements. She confirmed signage should be posted on the door and acknowledged that its absence represented a safety hazard. A record review of the "Admission Record" revealed the facility admitted Resident #39 on 11/3/21 with diagnoses including Chronic	F 695	1. On 4/21/2025, the Staff Development nurse immediately posted Oxygen in Use signs for all residents who are currently using oxygen. 2. All residents who use oxygen have the potential to be affected. 3. On 4/21/2025, the Director of Nursing began conducting in-services regarding oxygen use and oxygen safety. 4. Starting 4/22/2025, the Director of Nursing will conduct an audit three (3) times weekly for thirty (30) days and then weekly times two (2) months with department head rounds to ensure that oxygen signs are in place. The Director of Nursing will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis times three (3) months, for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for 5/14/25.	

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F 695	Continued From page 16 Obstructive Pulmonary Disease. A record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/27/25 revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. A record review of the "Order Review History Report" revealed a physician's order dated 8/27/24 for "Oxygen at 3 L (liters) per nasal cannula continuously ..."	F 695		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to assess residents' ability to safely self-administer medications for two (2) of five (5) residents reviewed for medication administration, Resident #37 and Resident #50. Findings included: A review of the facility's policy titled, "Self Administration of Medications," revised 11/2000, revealed, "When a resident requests to self administer his/her medication, the resident will be assessed by the interdisciplinary team to determine if this practice is safe. This decision will be made by the interdisciplinary team before the resident exercises this right ...Determining	F 760	1. On 4/22/2025, medications were immediately removed from resident #37 and #50 room and placed on medication cart and nurses were in-serviced on medication storage by the Director of Nursing. 2. All residents have the potential to be affected. 3. On 4/23/2025, the Director of Nursing began in-servicing nursing staff on assessing residents for ability to self-administer medications safely. The interdisciplinary team will assess residents for capability of self-administration and a physicians order will be obtained if	5/16/25

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F 760	Continued From page 17 factors regarding residents' capabilities for self administration of medication discussed by the interdisplinary (sic) team are: 1) Mental ability: A resident must be fully oriented to time, place and person. Cognitive skills for decision must be consistent and reasonable ...3) Must be physically able to accept control of the medication ...5) Must have a physician's order ..." Resident #37 On 4/22/25 at 7:25 AM, during an observation and interview, Licensed Practical Nurse (LPN) #3 was observed giving Resident #37 an albuterol sulfate inhaler. LPN #3 retrieved the inhaler from the resident's bedside drawer, where it had been stored. Resident #37 then self-administered the inhaler. LPN #3 stated the resident always self-administers the inhaler and keeps it in the drawer in case she needs it. LPN #3 stated the medication should probably be kept locked up in the medication cart when not in use. A record review of the "Admission Record," revealed the facility admitted Resident #37 on 11/15/24 with current diagnoses including Chronic Obstructive Pulmonary Disease. A record review of Resident #37's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/13/25 revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident's cognition was moderately impaired. A record review of the "Order Review History Report" revealed Resident #37 had a Physician's Order, dated 11/15/24, for "Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base)	F 760	resident meet criteria. 4. On 4/23/2025, the facility department heads began to monitor all resident rooms weekly times four (4) weeks, then monthly times two (2) months to ensure there are no medications present with no new issues identified. The interdisciplinary team will assess residents for capability of self-administration as needed. If resident is identified as safe to administer their own medications, this will be noted, care planned and re-assessed quarterly for safety. The Director of Nursing will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis times three (3) months, for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for 5/14/25.	

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F 760	Continued From page 18	F 760		

MCG/ACT (Micrograms/Asthma Control Test) 2 puff inhale orally every 4 hours as needed ..."

Resident #50

On 4/22/25 at 7:41 AM, during an observation and interview, Resident #50 was given a budesonide nebulizer vial by LPN #3 that was left at the bedside. Resident #50 did not take the medication at that time. LPN #3 stated the resident self-administers medications and she leaves it with him each morning because he can give his own medications.

A record review of the "Admission Record," revealed the facility admitted Resident #50 on 5/12/23 with current diagnoses including Chronic Obstructive Pulmonary Disease.

A record review of Resident #50's MDS dated 3/6/25 revealed a BIMS score of 12, which indicated the resident's cognition was moderately impaired. Further review revealed he had impairment on one side of the upper extremity.

A record review of the "Order Review History Report" revealed Resident #50 had a Physician's Order, dated 3/525 for, "Budesonide Inhalation Suspension 0.5 MG/2ML (Milligrams/Milliliters) 1 vial orally two times a day ..."

A review of the medical records for Resident #37 and Resident #50 revealed no documentation that an interdisciplinary team assessment had been completed to determine their ability to safely self-administer medications, nor were there any physician's orders authorizing self-administration.

On 4/22/25 at 7:55 AM, during an interview with

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F 760	Continued From page 19 the Director of Nursing (DON), she confirmed that neither Resident #37 nor Resident #50 had an assessment or physician order to self-administer medications. The DON explained that Resident #50 has contractures in his hands, making it difficult to operate the nebulizer vial, which could lead to missed doses and potential hospitalizations due to his lung disease. The DON stated it is her expectation that nurses follow physician orders and assess appropriateness of self-administration.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		5/16/25

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F 761	Continued From page 20 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medications were stored securely for two (2) of five (5) residents reviewed for medication storage and administration, Resident #37 and Resident #50. Findings included: A review of the facility's policy titled, "Medication Storage in the Facility," revised January 2018, revealed, " ...Medications and biologicals are stored safely, securely, and properly ...The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications ...Procedures ...B ...Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access ..." Resident #37 During an observation and interview on 4/22/25 at 7:25 AM, Licensed Practical Nurse (LPN) #3 retrieved an inhaler from Resident #37's bedside drawer, where it had been stored. LPN #3 stated the resident always kept it in the drawer in case she needed it and stated the medication should probably be kept locked up in the medication cart when not in use. A record review of the "Admission Record" revealed the facility admitted Resident #37 on 11/15/24 with diagnoses including Chronic Obstructive Pulmonary Disease.	F 761	1. On 4/22/2025, medications were immediately removed from resident #37 and #50 room and placed on medication cart and nurses were in-serviced on medication storage by the Director of Nursing. 2. All residents have the potential to be affected. 3. On 4/23/2025, the Director of Nursing began in-servicing nursing staff on medication storage. All rooms were checked by the facility nursing department heads for medications with no other issues identified. 4. On 4/23/2025, the facility department heads began to monitor all resident rooms weekly times four (4) weeks then monthly times two (2) months,to ensure there are no medications present with no new issues identified. The interdisciplinary team will assess residents for capability of self-administration as needed. If resident is identified as safe to administer their own medications, this will be noted, care planned and re-assessed quarterly for safety. The Director of Nursing will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis times three (3) months, for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for	

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F 761	Continued From page 21	F 761		

A record review of Resident #37's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/13/25 revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident's cognition was moderately impaired.

A record review of the "Order Review History Report" revealed Resident #37 had a Physician's Order dated 11/15/24 for "Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT, 2 puffs inhale orally every four (4) hours as needed."

Resident #50

During an observation and interview on 4/22/25 at 7:41 AM, Resident #50 was given a Budesonide nebulizer vial that was left at the bedside by LPN #3. LPN #3 stated she leaves it with him each morning.

A record review of the "Admission Record" revealed the facility admitted Resident #50 on 5/12/23 with diagnoses including Chronic Obstructive Pulmonary Disease.

A record review of Resident #50's MDS with an ARD of 3/6/25 revealed a BIMS score of 12, which indicated the resident's cognition was moderately impaired.

A record review of the "Order Review History Report" revealed Resident #50 had a Physician's Order dated 3/5/25 for "Budesonide Inhalation Suspension 0.5 milligrams (mg)/2 milliliters (ml), one (1) vial orally two (2) times a day."

On 4/22/25 at 7:55 AM, during an interview with

5/14/25.

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F 761	Continued From page 22 the Director of Nursing (DON), she stated that medications should not be left in resident rooms because there are wandering, confused residents in the building who could ingest the medications. She further stated another risk would be residents giving themselves the wrong dose. She confirmed her expectation is that nurses administer medications appropriately and ensure secure storage.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to store food in accordance with professional standards for food safety by not discarding expired items, failing to refrigerate opened perishable items, and	F 812	1. On 4/21/2025, the expired items were immediately disposed of by the Dietary Supervisor. The dietary supervisor was immediately in-serviced by the administrator on food storage and	5/16/25

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F 812	Continued From page 23 improperly storing dry goods, for one (1) of two (2) kitchen observations. Findings included: A review of the facility's policy, "Food Safety Requirements," dated 02/2023 revealed, "Policy ...Food will be stored... in accordance with professional standards for food service safety... Policy Explanation and Compliance Guidelines: 1. Food safety practices shall be followed throughout the facility's entire food handling process ...b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms... 3. Facility shall inspect all food ...for safe transport and quality upon delivery/receipt and ensure timely and proper storage ...c. Refrigerated storage - foods that require refrigeration shall be refrigerated immediately upon receipt or placed in freezer ...Practices to maintain safe refrigerated storage include ...iv. Labeling, dating, and monitoring refrigerated food... so it is used by its use-by date... or discarded..." On 4/21/25 at 10:27 AM, during an observation of the kitchen and interview with the Dietary Supervisor (DS), Refrigerator #1 contained one (1) opened bag of coleslaw mix with a manufacturer's use-by date of 3/7/25. The contents of the bag were grayish in appearance. An observation of the pantry revealed a scoop sitting inside the bin of sugar, two (2) opened 48-ounce bottles of lemon juice sitting on the shelf with instructions to refrigerate after opening, and three (3) soft potatoes with shriveled skin. The DS acknowledged the expired coleslaw, the improperly stored juice, the scoop left in the	F 812	expiration. 2. All residents have the potential to be affected. 3. On 4/22/2025, the dietary staff was in-serviced on food storage and expiration by the Dietary Supervisor. 4. Starting 4/22/2025, the Dietary Supervisor began monitoring expiration dates daily for two (2) weeks and then weekly for monthly for two (2) months. The Dietary Supervisor will submit and report findings to the Quality Assurance Performance Improvement (QAPI) committee on a monthly basis times three (3) months, for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for 5/14/25.	

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F 812	Continued From page 24 sugar, and the overly ripe potatoes. She stated she was new to the job but took responsibility for the deficiencies and intended to discard the expired items and bring the kitchen up to standard. She stated in-services are held weekly. On 4/21/25 at 10:45 AM, during an interview with the Cook, she stated that the previous supervisor checked expiration dates but that is no longer happening due to the new DS. She explained that if she notices expired or undated items in the refrigerator, she throws them away. She reported that staff are in-serviced monthly on food safety. On 4/24/25 at 8:37 AM, during an interview with the Corporate Nurse (CN), she acknowledged the outdated coleslaw mix, improperly stored lemon juice, scoop left in the sugar, and overly ripe produce. The CN stated the DS is responsible for ensuring food quality and hygiene and affirmed the expectation that the DS ensures food is dated, stored correctly, and discarded before expiration.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written 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	F 867		5/16/25

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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.

§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.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to

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determine underlying causes of problems impacting larger systems;
(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
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§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.

§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.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct 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

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F 867	Continued From page 27 described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §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: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (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. This REQUIREMENT is not met as evidenced by: 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 failed to ensure a resident's right to smoke within the facility's designated smoke times during an annual recertification survey on 9/21/2023 and was cited again for the same deficiency during the current survey, demonstrating that QAPI failed to sustain ongoing monitoring and oversight to prevent recurrence for one (1) of 11 deficiencies cited. (F550) Findings included: A review of the facility policy, "Quality Assurance	F 867	1. On 4/23/2025, the facility Administrator reviewed the previously cited deficiencies and current Quality Assurance and Performance Improvement (QAPI) policy and procedures. QAPI policies and procedures are now being followed. On 4/23/2025, The assigned certified nursing assistant took resident #15 to smoke immediately. 2. All residents have the potential to be affected. 3.On 4/28/2025, a notice was posted by the Activities Director regarding a special resident council meeting in resident common areas. On 5/1/2025, a special resident council meeting was held and	

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F 867	Continued From page 28 and Performance Improvement (QAPI) Plan of Action 2025," revealed, "Purpose Statement...Quality Assurance and Performance Improvement ...guides our organization's efforts to proactively provide the highest quality of care and services for residents, families, and staff ...Feedback, Data Systems, and Monitoring...Quality Assurance Program Tools...This facility's QAPI systems and processes are maintained with an ongoing program that is dynamically designed to monitor and evaluate the quality of resident care, pursue methods to improve quality care, and to resolve identified problems...." Record review of the "Provider History Profile," revealed the facility received a citation for F550 - Resident Rights/Exercise of Rights on the previous annual recertification survey dated 9/21/2023. 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 9/21/2023, revealed the facility received a citation for F550, " ...Based on observations, interviews, record review, and the facility policy review, the facility failed to honor a resident's right to smoke at the designated times to smoke per facility's policy ..." During the current recertification survey, the facility failed to honor a resident's preference related to smoking during the scheduled smoking times, in accordance with the facility's designated smoking schedule, for one (1) of eighteen (18) residents reviewed for resident rights.	F 867	conducted by the Activities director to discuss new smoking times that would accommodate both the residents and the facility. A new smoking schedule was agreed upon by the council and the new schedule was implemented on 5/2/2025. On 4/23/2025, The Director of Nursing (DON) in-serviced the Nurses and certified nursing assistants on the smoking policy and resident rights. On 5/2/25, the DON in-serviced nursing staff on the new smoking schedule and the importance of timeliness. On 5/1/2025 and 5/8/2025, the Administrator in Training/Administrator was in-serviced on QAPI process, performance improvement plans, and plan of correction and sustaining corrective actions to prevent reoccurrence of previously identified deficits with ongoing monitoring and oversight by corporate nursing staff and/or another facility Administrator. Administrator/Administrator in training will conduct a QAPI meeting monthly for three (3) months and then at least quarterly and will evaluate all cited deficiencies to ensure ongoing monitoring, oversight, and compliance. 4. Smoke break times will be monitored by the Director of Nursing or Registered Nurse Supervisor three (3) times weekly for two (2) weeks, then monthly times two (2) months. On 5/1/2025, a special resident council meeting was held and conducted by the Activities director to discuss new smoking times that would accommodate both the residents and the facility. A new smoking schedule was	

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F 867	Continued From page 29 On 4/23/25 at 3:37 PM, during an interview with the Director of Nursing (DON), she confirmed the facility was cited for the same deficient practice during their last recertification. She also confirmed 12:30 PM as one of the scheduled smoking times designated by the facility. She explained the deficiency was repeated due to the need to adjust the smoking time, as staff are usually busy during the 12:30 PM smoke break. She acknowledged that despite this, residents still have the right to expect to go out at the scheduled time. On 4/24/25 at 11:37 AM, during an interview with the Interim Administrator, she explained that since the 12:30 PM smoke break falls during the lunch period, the facility either needs to adjust the scheduled time or specifically assign staff to that task. The Interim Administrator agreed that residents have the right to expect to go out at the designated smoking time.	F 867	agreed upon by the council and the new schedule was implemented on 5/2/2025. On 4/23/2025, The Director of Nursing a (DON) in-serviced the Nurses and certified nursing assistants on the smoking policy and resident rights. On 5/2/25, the DON in-serviced nursing staff on the new smoking schedule and the importance of timeliness. 4. Beginning 4/23/2025, the Director of Nursing will interview two (2) residents per week times four (4) weeks then monthly times two (2) months to monitor compliance with smoke break schedule adherence and resident rights related to smoking. The DON will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis ties three (3) Months, for review, revisions or resolution of plan. Corporate nurse or other facility administrator will attend facility QAPI meeting 3 times beginning on 5/14/2025 to ensure ongoing compliance of previous cited deficiencies. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for 5/14/25.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		5/16/25

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diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility

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F 880	Continued From page 31 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to follow infection prevention practices by not ensuring respiratory equipment was properly stored when not in use for one (1) of two (2) residents reviewed for respiratory services. (Resident #37) Findings Included: A review of the facility's "Nebulizer and Oxygen Tubing Storage Policy," dated April 2007, revealed, " ...It is the policy of this facility to decrease the risk of potential and/or direct exposure to infectious disease, air contaminants and bacterial exposure. We will provide our residents with the proper storage and cleaning of respiratory equipment. Procedure ...These	F 880	1. On 4/22/2025, the Director of Nursing immediately replaced resident #37 oxygen tubing and nebulizer tubing in labeled bags. 2. All residents who use respiratory equipment have the potential to be affected. 3. On 4/22/2025, the Director of Nursing in-serviced nursing staff on the appropriate storage and labeling of respiratory tubing. All nebulizer and oxygen tubing was replaced in labeled bags and secured to side of oxygen concentrator with tape on 4/22/2025 4. On 4/22/2025, the Director of Nursing	

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F 880	Continued From page 32 tubings will be ...stored in a dated plastic bag when not in use ..." On 4/22/25 at 7:37 AM, during an observation, Resident #37's oxygen and nebulizer tubing were observed unbagged, lying on each piece of equipment. No clean storage method was in place. A record review of the "Admission Record" revealed the facility admitted Resident #37 on 11/15/24 with diagnoses including Chronic Obstructive Pulmonary Disease. A record review of Resident #37's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/13/25 revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident's cognition was moderately impaired. On 4/22/25 at 8:00 AM, during an interview with the Director of Nursing (DON) at Resident #37's bedside, she confirmed the oxygen cannula and nebulizer tubing/masks were not bagged and stated they should be kept in a bag when not in use to prevent the spread of respiratory infection. She explained that it is the Sunday night cart nurse's responsibility to bag and change out tubing for each resident. On 4/23/25 at 2:47 PM, during an interview with Licensed Practical Nurse (LPN) #1, the Infection Preventionist (IP) Nurse, she stated that nasal cannula, oxygen, nebulizer tubing, and masks should be kept in a bag to prevent respiratory infections. She further stated they should be changed weekly by the Sunday night nursing staff and confirmed that this task appears on the	F 880	began checking the appropriate storage and labeling of all respiratory tubing twice weekly for two (2 weeks) monthly for two (2) months. The Director of Nursing will submit and report findings to the Quality Assurance Performance Improvement (QAPI) Committee on a monthly basis times three (3) months, for review, revisions or resolution of plan. The QAPI committee review of the plan occurred 4/29/25 the next review is scheduled for 5/14/25.	

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F 880	Continued From page 33 Medication Administration Record (MAR).	F 880		