STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255164	A. BUILDING _____ B. WING _____	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY NURSING HOME	910 MAIN STREET FAYETTE, MS 39069

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 5/12/2025 through 5/15/2025. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F644, F656, F684, and F690. The facility had a census of 43 and was licensed for 60 beds.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review, the facility failed to complete a significant change assessment and submit a required Level II Preadmission Screening and	F 644	1. Corrective Action Taken for Resident # 16 A Level II Pre Admission Screen (PASRR)	6/30/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/06/2025

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F 644	Continued From page 1 Resident Review (PASRR) for one (1) of two (2) residents reviewed for PASRR (Resident #16). Specifically, the facility failed to submit a PASRR Level II and complete a significant change assessment after Resident #16 was diagnosed with major mental illness, including bipolar disorder and Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms. Findings Include: A review of the facility's "Pre-Admission Screen" policy revealed: "Preadmission Screening and Resident Review (PASRR) aims to ensure individuals are not inappropriately placed in nursing homes for long-term care and to provide them with the services they need in those settings..." A record review of Resident #16's Pre-Admission Screen (PAS), dated 7/25/11, revealed no major mental illness at the time of screening. A record review of Resident #16's record revealed that a Level II PASRR was submitted on 4/1/22 related to an intellectual developmental disability. A record review of Resident #16's Admission Record revealed an admission date of 8/9/2011, with new diagnoses of bipolar disorder and Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms with an onset date of 7/17/23. Further record review of Resident #16's clinical record revealed that a Level II PASRR was not submitted in response to the new diagnoses of major mental illness, and a significant change assessment was not completed as required.	F 644	referral was completed on June 1, 2025, and submitted for Resident # 16 following the identification of new diagnoses of Bipolar Disorder and Major Depressive Disorder with psychotic features (diagnosed 7/17/2023). A modification of a Significant Change in Status Assessment (SCSA) that had a ARD date of April 24, 2024, and modification was completed to reflect the updated mental health conditions June 4, 2025. The comprehensive care plan was reviewed and revised May 19, 2025 by the interdisciplinary team (IDT) to address current behavioral health needs, Pre Admission Screen requirements, and ensure appropriate services and interventions are in place. Behavioral health services were consulted for evaluation and treatment recommendations May 19, 2025 with the Consultant Psychiatrist. 2. Identification of Other Residents Who May Have Been Affected A full audit of all current residents was conducted May 19-23, 2025 to identify any individuals with: * New diagnoses of serious mental illness (SMI) or intellectual/developmental disabilities (IDD) was completed. * Significant changes in status that were not followed by a Pre Admission Screen (PASRR) referral or SCSA. * For any resident meeting these criteria: A Level II PASRR was submitted if	

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F 644	Continued From page 2 On 05/13/25 at 9:42 AM, during an interview, Registered Nurse (RN) #1, charge nurse, confirmed that a significant change assessment was not completed for Resident #16 following the new diagnoses of bipolar disorder and Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms. She acknowledged that it should have been done. On 05/13/25 at 3:43 PM, during an interview, the Social Services staff member stated that Resident #16 had the above mental health diagnoses and acknowledged that a significant change should have been completed at that time. She stated that completing a significant change ensures the resident receives the appropriate services and that staff are informed of the resident's needs. A record review of Resident #16's Minimum Data Set (MDS) with Assessment Reference Date (ARD) 4/10/25 revealed the resident was severely cognitively impaired.	F 644	required. A Significant Change MDS was completed if indicated. Care plans were updated to reflect current needs. 3. Systemic Changes to Prevent Recurrence * The Pre-Admission Screening Policy was revised on May 28, 2025 to include: Mandatory reassessment of Pre Admission Screen (PASRR) status with any new diagnosis of SMI/IDD. Clear triggers for initiating a Level II Pre Admission Screen PASRR and Significant Changes MDS when new qualifying diagnoses are made. * A Pre Admission Screen and Significant Change Tracking Log May 21, 2025 was implemented to ensure timely follow-up on new diagnoses or changes in resident condition. * Education and training were provided by Outside RN to: MDS Coordinators, Social Services, and Nursing Staff that include the Medical Record Nurse, Staff Development Nurse, Director of Nursing and the Day Shift Supervisor Pre Admission Screen procedures, Level II referral requirements, and the criteria for significant change assessment findings with care planning and documentation on May 30, 3025. * Weekly interdisciplinary team meetings	

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F 644	Continued From page 3	F 644	now include a review of newly diagnosed conditions and Pre Admission Screen and Status Change Update compliance started on May 21, 2025. 4. Monitoring and Quality Assurance The Director of Nursing (DON) or Day Shift Supervisor will conduct weekly audits of 5 residents for 12 weeks to ensure starting May 21, 2025: New SMI/IDD diagnoses trigger appropriate Pre Admission Screen PASRR and MDS assessments. Care plans reflect all updated findings. * Audit results will be reviewed during monthly Quality Assurance Performance Improvement Committee meetings starting June 26, 2025 for oversight and follow-up. * If non-compliance is identified, corrective actions (including training or additional audits) will be implemented. * After 12 weeks of compliance, monitoring will continue monthly for 3 additional months. All finding will be forward to the Quality Assurance Performance Improvement Committee for review and recommendation at the monthly meeting starting June 26, 2025	
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	F 656		6/30/25

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F 656	Continued From page 4	F 656		

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 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

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F 656	Continued From page 5 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review, the facility failed to implement the comprehensive care plan as developed for one (1) of two (2) residents reviewed for skin conditions (Resident #34). Specifically, the facility failed to carry out weekly skin evaluations as required by the resident 's care plan and physician orders. Findings include: A record review of the facility's "Comprehensive Care Plan" policy with a revision date of 1/2025 revealed: "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and time frames to meet a resident's medical, nursing..." A record review of Resident #34's Comprehensive Care Plan initiated 4/22/25 revealed skin impairment related to moisture-acquired skin damage to the buttocks. The care plan directed staff to "Monitor and Document weekly." A record review of Resident #34's weekly skin evaluations revealed they were not completed during April 2025. A record review of Resident #34's electronic Treatment Administration Record (eTAR) revealed: "Weekly skin assessments every Wednesday" date initiated 10/1/24. Wednesday	F 656	F656: Deficiency Summary: The facility failed to implement the comprehensive care plan for Resident #34 by not completing weekly skin assessments as outlined in the resident's care plan and physician orders, placing the resident at risk for undetected changes in skin condition. 1. Corrective Action Taken for Resident #34 * A comprehensive skin assessment was completed immediately for Resident #34 on May 14, 2025 by the Treatment Nurse. * The resident's care plan and physician orders were reviewed and reconfirmed on May 14, 2025 for accuracy and completeness. * The missed documentation for April 2025, was addressed with the responsible nurses and followed up with counseling and education by the Director of Nurses on May 13, 2025. A directed in-service by and outside RN was conducted on May 30, 2025. * The Interdisciplinary Team IDT reviewed the resident's care plan May 19, 2025 to ensure that all interventions for skin integrity remain appropriate and are being consistently implemented. 2. Identification of Other Residents Who May Have Been Affected	

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F 656	Continued From page 6 4/16/25 was not initialed as completed. In an interview with the Director of Nursing (DON) on 5/13/25 at 4:03 PM, she stated that weekly skin evaluations should be completed and documented weekly. She stated the purpose of the skin evaluation is to help staff identify any new breakdowns and to evaluate and treat skin accordingly. She confirmed that Registered Nurse (RN) #1 did not follow the care plan. On 05/14/25 at 3:09 PM, during an interview, RN #1 (Charge Nurse) acknowledged it was her responsibility to complete the weekly skin evaluations and stated she did not follow the care plan. On 5/14/25 at 1:05 PM, in an interview, RN #2, the facility's Minimum Data Set (MDS) Nurse, stated the care plan is created to guide staff in delivering care. She confirmed RN #1 did not follow the care plan related to weekly skin evaluations. She stated Resident #34 cannot receive quality care if the care plan is not followed. A record review of Resident #34's Minimum Data Set (MDS) with Assessment Reference Date (ARD) 2/28/25 revealed the resident was severely cognitively impaired. A record review of Resident #34's weekly skin evaluation dated 5/7/25 noted moisture-associated skin damage to the buttocks, further supporting the need for ongoing evaluation and documentation as outlined in the care plan. A record review of Resident #34's Admission	F 656	* An audit of all residents with Skin impairment or at risk for pressure injuries was conducted May 14-23, 2025 to identify any missed or undocumented weekly skin assessments starting May 14, 2025. * For any missed documentation: A current skin assessment was completed. Documentation was brought up to date. Responsible staff were counseled and/or educated. * Residents found to have unaddressed skin issues were referred to the Wound Nurse or primary provider for further evaluation. 3. Systemic Changes to Prevent Recurrence Nursing staff were educated on May 30, 2025 by outside RN on the facility's policy regarding the implementation of care plan interventions, including on May 30, 2025 by outside RN: * The importance of adhering to scheduled skin assessments. * Accurate and timely documentation in the Electronic Treatment Administration Electronic Health Record (eTAR). * The Treatment Day Shift Supervisor will now verify completion of all scheduled weekly skin assessments every Friday for the current week. * A weekly Skin Assessment Compliance Report was implemented to monitor missed documentation or assessments on May 19-23, 2025.	

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F 656	Continued From page 7 Record revealed an admission date of 3/16/22 with diagnoses including non-pressure chronic ulcer of other part of left foot with unspecified severity and atherosclerosis of native arteries of other extremities with ulceration.	F 656	* The MDS Coordinator and IDT will review care plans weekly to ensure interventions are properly followed and documented starting May 21, 2025. * Revised the skin care protocol to include secondary review by charge nurses each week on Friday to catch missed entries proactively starting May 23, 2025. 4. Monitoring and Quality Assurance * The DON or Medical Record Director will audit 5 residents weekly for 12 weeks starting May 23, 2025 then monthly for three months to ensure all care plan interventions for skin monitoring are being followed and documented accurately. * Results of audits will be reviewed in monthly QAPI meetings starting June 26, 2025, and corrective actions taken if trends of noncompliance are identified. After the initial 12-week period, monitoring will continue monthly for 3 months or until consistent compliance is sustained. * Staff not meeting expectations will receive one-on-one coaching and progressive disciplinary action if needed.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		6/30/25

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F 684	Continued From page 8 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy reviews, the facility failed to ensure that care and services were provided in accordance with professional standards of practice for one (1) of two (2) residents reviewed for skin conditions (Resident #34). Specifically, the facility failed to ensure that weekly skin assessments were completed and documented as ordered by the physician and in accordance with facility policy, resulting in a lack of monitoring for skin breakdown. Findings include: A record review of the facility's "Skin Assessment" policy dated 1/2025 revealed: "It is our policy to perform a full body skin assessment as part of our systemic approach to pressure injury, prevention and management." The policy includes the following procedural guidelines...: "A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission, re-admission, and weekly thereafter." A record review of Resident #34's weekly skin evaluations revealed that they were not completed during April 2025. A record review of Resident #34's weekly skin evaluation dated 5/7/25 revealed moisture-associated skin damage to the buttocks. A record review of the Weekly Skin Report dated 4/25/25 revealed Resident #34 was not listed as	F 684	F684: The facility failed to ensure that care and services were provided in accordance with professional standards of practice. Specifically, the facility failed to complete and document weekly skin assessments for Resident #34 as ordered by the physician and required by facility policy, which delayed identification and monitoring of skin breakdown 1. Corrective Action Taken for Resident #34 * A comprehensive skin assessment was performed on Resident #34 on May 7, 2025, which confirmed the presence of moisture-associated skin damage to the buttocks. * Treatment orders were reviewed and updated by the wound care nurse and physician to reflect current needs May 7, 2025. * The resident's care plan was reviewed and revised by the interdisciplinary Team IDT on May 19, 2025 to include targeted interventions for managing and preventing further skin breakdown. * The nurse responsible for missed documentation in April was counseled and educated on timely and complete assessment documentation by the Director of Nurses DON on May 13, 2025, and educated by outside RN on May 30, 2025.to include timely documentation of	

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F 684	Continued From page 9 having a buttocks abrasion; however, it was listed on the 5/2/25 report. On 5/13/25 at 4:03 PM, in an interview with the Director of Nursing (DON), she stated the weekly skin evaluations should be completed and documented weekly. She stated she expects staff to perform and document them consistently. She explained that the purpose of the skin evaluations is for staff to identify any new skin breakdown and to evaluate and treat the skin accordingly. She stated that Registered Nurse (RN) #1 told her that she had completed the evaluations on a scratch sheet but forgot to enter them into the computer and could no longer locate the notes. The DON stated that if there is no documentation, it indicates the task was not completed. On 5/14/25 at 11:00 AM, an observation of wound care and a weekly skin evaluation was conducted by RN #1. Care was provided within standards of practice. During the skin evaluation, RN #1 assessed the buttocks area, which revealed four areas of healed pink skin and one open area. There were no signs of infection or drainage noted. On 5/14/25 at 3:09 PM, in an interview, RN #1 (Charge Nurse) stated it is her responsibility to complete the weekly skin evaluations. She stated she typically writes the results on the back of the report and enters them into the computer afterward. She acknowledged that the purpose of the evaluations is to identify any skin conditions, wound progression, or deterioration. She confirmed that although she performed the evaluations, she failed to enter them into the computer.	F 684	weekly skin assessment, risks of not completing skin assessment. 2. Identification of Other Residents Who May Have Been Affected * A facility-wide audit was conducted May 19-23, 2025 by the interdisciplinary Team IDT nurses Staff Development Nurse, Medical Record Nurse, Charge Nurse, M in iu m Data Set, Nurse and Director of Nurses for all residents with skin impairments or at risk for skin breakdown to determine if weekly skin assessments were being completed and Accurately documented in accordance with policy and physician orders. For any resident found to be missing assessments or documentation: A full skin assessment was completed. Orders and care plans were reviewed and revised if needed. staff were immediately educated by the Director of Nurses on May 23, 2025. 3. Systemic Changes to Prevent Recurrence The facility's Skin Assessment Policy was reviewed May 30, 2025 by outside RN nurse with all licensed nurses, with emphasis on: Weekly documentation requirements. Accurate reporting on the Weekly Skin Report. Timely communication of any new findings to the wound nurse and physician. The Weekly Skin Assessment Audit tool was revised May 19, 2025 to	

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F 684	Continued From page 10 A record review of Resident #34's Electronic Treatment Record (ETAR) revealed: "Weekly skin assessments every Wednesday and cleanse moisture acquired skin damage to buttocks with normal saline, pat dry, apply calazine cream, apply nonadherent gauze and cover with bordered gauze twice daily." This review revealed that care for the open area on the buttocks was initiated on 4/21/25. A record review of Resident #34's Progress Notes dated 4/21/25 revealed: "Cleanse open area to buttocks with normal saline, pat dry, apply calazine cream, apply nonadherent gauze and cover with bordered gauze twice daily and as needed until healed." A record review of Resident #34's Minimum Data Set (MDS) with Assessment Reference Date (ARD) 2/28/25 revealed the resident was severely cognitively impaired. A record review of Resident #34's Admission Record revealed an admission date of 3/16/22, with diagnoses including non-pressure chronic ulcer of other part of left foot with unspecified severity and atherosclerosis of native arteries of other extremities with ulceration.	F 684	include a checklist to ensure all residents at risk or with skin issues are reviewed weekly starting May 19, 2025 in the morning stand up meeting by the Interdisciplinary Team. The Director of Nurses and or Day Shift Supervisor/Treatment Nurse will verify completion of all weekly skin assessments every Friday starting May 23, 2025 . A Weekly Skin Assessment Compliance Tracker was implemented on May 19-23, 2025 to monitor and flag missed assessments in real-time. Documentation audits were added to morning clinical stand-up meetings for early detection of compliance issues on May 19, 2025. 4. Monitoring and Quality Assurance The Director of Nursing (DON) or Day Shift Supervisor will conduct audits of five residents weekly for 12 weeks then monthly for three months started May 19, 2025 to ensure: Weekly skin assessments are completed and documented per policy. Findings are reflected accurately in the Weekly Skin Report. Audit results will be presented at monthly Quality Assurance Performance Improvement Committee meeting on June 26, 2025, monthly for six months for corrective actions will be taken immediately if non-compliance is found. the nurses with repeated documentation issues will receive targeted follow-up, including one-on-one education or disciplinary action as necessary by the Director of	

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F 684	Continued From page 11	F 684	Nurses.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 690		6/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255164	A. BUILDING _____ B. WING _____	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON COUNTY NURSING HOME	910 MAIN STREET FAYETTE, MS 39069

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F 690	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record reviews, and facility policy reviews, the facility failed to ensure incontinent residents received appropriate care and services to prevent the possibility of a urinary tract infection for one (1) of two (2) residents observed for incontinent care (Resident #8). Specifically, the facility failed to provide timely incontinence care and maintain cleanliness, which placed the resident at risk for skin breakdown and urinary tract infection. Findings Include: A record review of the facility's "Perineal Care" policy with a revision date of 1/2025 revealed: "It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible and to prevent and assess for skin breakdown..." On 05/13/25 at 3:15 PM, an observation of peri-care being performed by Certified Nursing Assistant (CNA) #1, assisted by CNA #2, revealed CNA #1 removed Resident #8's brief, which was heavily soiled with amber-colored urine and emitted a strong urine odor. The resident's wheelchair and pants were also soaked in urine. On 05/13/25 at 3:32 PM, in an interview, CNA #1 confirmed the brief was heavily soiled with amber-colored urine. She confirmed the resident 's chair and pants were also heavily soiled. She stated she was assisting CNA #2 and did not know when the resident was last checked or	F 690	F690: The facility failed to ensure that appropriate and timely incontinence care was provided for Resident #8. CNA staff did not provide incontinence care in accordance with facility policy or professional standards, resulting in prolonged exposure to urine, soiled clothing and equipment, and increased risk of urinary tract infection and skin breakdown. 1. Corrective Action for Resident #8 * Resident #8 was immediately provided with complete incontinence care and hygiene, including clothing change and wheelchair cleaning May 13, 2025 by Certified Nurses Aide number one and two. A full skin assessment was completed to access for irritation or breakdown. on May 13, 2025 by the Treatment Nurse. The incident was reported to the Charge Nurse and Director of Nursing DON on May 13, 2025, and immediate documentation was completed. Certified Nursing Aide CNA # 1 and Certified Nursing Aide CNA #2 were immediately, counseled, and provided one-on-one education on proper perineal and incontinence care procedures by the Staff Development Nurse and educated by an outside RN on May 30, 2025. * Resident #8's care plan was reviewed and updated May 19, 2025 to reinforce incontinence care frequency and check reminders by the Minimum Data	

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F 690	Continued From page 13 changed. On 05/13/25 at 3:36 PM, CNA #2 confirmed in an interview that the chair, pants, and brief were heavily soiled with urine. She stated she changed Resident #8 around 10:30 AM, right before lunch. CNA #2 acknowledged she was supposed to check the resident every two hours but had not done so because she was busy. She confirmed that the resident had not received peri-care for over four and a half hours. CNA #2 stated she is expected to provide peri-care every two hours. She acknowledged the resident could develop a urinary tract infection and skin infection from the delay in care. On 05/14/25 at 11:50 AM, the Director of Nursing (DON) stated in an interview that Resident #8 should be checked and changed every two hours if soiled. She further stated that if a resident is a heavier wetter, they should be checked every hour. She confirmed that her expectation of CNAs is to check and change residents every two hours to ensure they remain dry and clean. The DON acknowledged that residents left soiled for extended periods are at risk for skin breakdown and skin infections. A record review of Resident #8's Admission Record revealed an original admission date of 08/22/06, with diagnoses including acute kidney failure and mild intellectual disabilities. A record review of the Minimum Data Set (MDS) for Resident #8, conducted 3/20/25, revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident was severely cognitively impaired and reliant on staff for care.	F 690	Set Nurse MDS. 2. Identification of Other Residents Who May Have Been Affected * The facility completed and audit of all incontinence residents on May 19, -23, 2025 to ensure timely and proper incontinence care was being provided, access for any signs of skin breakdown or infection risk. Any resident found to have issues with hygiene, documentation, or delayed care received: Immediate hygiene intervention, A nursing assessment, and Updated interventions in their care plans. 3. Systemic Changes to Prevent Recurrence All Certified Nursing Aide CNAs were in-serviced on the facility's Perineal and Incontinence Care on May 30, 2025 Policy including: Frequency of checks and care (per schedule and as needed), Proper technique for cleansing, drying, and redressing, Documentation and verbal reporting of soiled clothing or risk factors to nursing staff. The facility implemented scheduled incontinence rounds every one to two hours per the resident care plan during waking hours, with documentation logs monitoring by Charge Nurses on May 19, 2025, Spot check of incontinence care will be completed by Charge Nurses or Staff Development Nurse each shift starting	

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F 690	Continued From page 14	F 690	May 19, 2025. * Environmental services were instructed to check wheelchairs for cleanliness during room rounds and report any soiling to the charge nurse. starting May 19, 2025. Care plans of all incontinent residents were reviewed to ensure they reflect individualized toileting and hygiene needs Starting May 19, 2025 4. Monitoring and Quality Assurance * The Staff Development Nurse or Day Shift Supervisor will perform audits on five incontinent residents per week for 12 weeks, then monthly for three months checking starting May 19, 2025: * Timeliness and quality of incontinence care, * Cleanliness of resident clothing and mobility devices, * Documentation in Certified Nurse Aide flow sheets or POC logs. * Audit results will be reported monthly to the Quality Assurance Performance Improvement Committee for 6 months starting June 26, 2025 for evaluation and changes	