STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE FOREST HEALTH AND REHABILITATION	1116 FOREST AVENUE JACKSON, MS 39206

(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, as well as four (4) Complaint Investigations (CI MS #28868, CI MS #28989, CI MS #29026, and CI MS #29005), at the facility from 06/02/25 through 06/6/25. CI MS# 28868 was investigated for nursing services, resident not turned/repositioned timely, pressure sores, and resident left wet for extended periods. MS #28989 was investigated for pressure sores, nursing services, facility not clean, offensive odors, and quality of care/treatment. MS #29026 was investigated for infection control, resident not groomed adequately, services not performed per the plan of care, and linen in poor condition. There were no citations regarding MS #28868, MS #28989, and MS #29026. MS #29005 was investigated for falls, resident safety, and quality of care/treatment and F656 and F689 were cited. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F600, F656, F686, F689, F865 and F880. The SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 6/04/25 when Resident #211, who had eloped from the facility and made her way to a busy intersection among moving vehicles, placing her in danger of potential harm, injury, impairment or death. The IJ and SQC existed at: CFR §483.12 Freedom from Abuse, Neglect, and Exploitation - F600 - Scope/Severity "J" CFR §483.25(d)(2)- Accident/Hazards - F689 Scope/Severity "J"	F 000		

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

Electronically Signed | 06/30/2025

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 000	Continued From page 1 The facility Administrator was notified of the IJ and SQC on 06/4/25 at 11:40 AM. The facility provided an acceptable Removal Plan on 6/6/25, in which they alleged all corrective actions to remove the IJ were completed on 6/5/25 and the IJ removed on 6/6/25. The SA validated the Removal Plan on 6/6/25 and determined the IJ was removed on 6/6/25, prior to exit. Therefore, the scope and severity for CFR §483.12 Freedom from Abuse, Neglect, and Exploitation - F600 and CFR §483.25(d)(2)-Accident/Hazards - F689 Scope/Severity "J" was lowered to "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The census at the time of survey was 111, and the facility held a license for 120 beds.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		7/4/25

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F 600	Continued From page 2 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to protect the resident's rights to be free from neglect when the resident eloped from the facility unsupervised and unmonitored and made her way to the middle of a busy intersection for (1) of 24 residents sampled. Resident #211 The facility's failure to ensure that Resident #211 was unable to exit the facility unsupervised resulted in her running into the middle of a busy intersection located at an intersection near the facility, placing the resident in a situation that was likely to cause serious injury serious harm, serious impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), which began on 6/4/25, when Resident #211 exited the facility. The State Agency (SA) notified the Administrator of the IJ on 6/5/25 at 11:40 AM. The State Agency (SA) validated the Removal Plan on 6/6/2025 and determined that the IJ was removed on 6/5/25, prior to exit. Therefore, the scope and severity for CFR §483.12 Freedom from Abuse, Neglect, and Exploitation - F600 - Scope/Severity "J"was lowered to "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include:	F 600	1. On 06/04/2025, the facility failed to keep Resident #211 exited the building. Accident/Incident investigation initiated immediately by the Administrator. Upon returning to the facility, within 6 minutes and in visual range of staff, Resident #211 was assessed by Director of Nursing (DON) on 06/04/2025. The resident was found to be free of injuries. Resident wandering/elopement assessment completed by Assistant Director of Nursing (ADON) on 6/4/2025 and resident determined to be at risk for wandering/elopement. Color picture of Resident #211 taken and placed in wandering/elopement binder at each nurse station and reception desk by Social Services on 6/4/2025. Door codes changed on 6/4/2025 by Maintenance Director. 2. On 6/04/2025, the ADON assessed all residents and determined 12 residents were at risk for wandering/eloping. No issues identified. 3.The QAPI Committee (Administrator, DON, Medical Director, Infection Preventionist/RN Educator, ADON, Human Resources, MDS Coordinator, Treatment Nurse, Wound Care, Business Office, Rehab Manager, Medical Records, Social Services #1, Social Services #2,Environmental Services, Maintenance	

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F 600	Continued From page 3 A review of the facility's policy, "Freedom of Abuse, Neglect and Exploitation", November 2019, revealed, " ...This facility shall not condone any acts of resident ...neglect ..."Neglect" means failure of the facility, its employees, ...to provide ...services to a resident that are necessary to avoid physical harm ..." On 6/4/2025 at 3:15 PM, the State Agency (SA) observed several staff running across the parking lot. It was later determined that Resident #211 had eloped from the front door of the facility. The SA observed the resident had reached the intersection of two adjoining streets near the facility. The distance from the front door of the facility to the intersection is estimated to be 600 feet. Resident #211 was sitting on the back of a trailer that was attached to a pick-up truck that was stopped at the traffic light. Approximately seven (7) cars were observed to be in the street at the time Resident #211 sat in the intersection. Several staff were engaged in removing the resident from the truck's trailer and getting her back to the facility. The resident was initially carried by the staff, but a wheelchair was brought from the facility for the remainder of the trip back. The weather was 86 degrees and sunny. On 6/4/2025 at 3:27 PM an interview with Licensed Practical Nurse (LPN) #2 revealed she was starting her shift and was located at the nursing station, receiving information from the day shift nurse about another resident. LPN #2 stated at approximately 3:15 PM, she heard a Certified Nursing Assistant (CNA) yell, "The new lady is out". LPN #2 reported she proceeded to run after the resident with the other nurses. LPN #2 noted the resident was back in the facility at approximately 3:20 PM. LPN #2 denied seeing	F 600	Director, Activities Director, Staffing, RNA, Central Supply) met on 6/04/2025 to review Freedom of Abuse Standard and Wandering/Elopement Standard with no recommended changes to the standards. On 06/04/2025 facility staff educated on wandering/elopement process and procedures. On 06/04/2025 Social Services conducted 100% audit of wandering/elopement binders located at Unit A and Unit B nurse stations and front entrance to ensure completeness and accuracy. On 06/04/2025 armbands were applied by Social Services to all residents assessed and determined to be at risk for wandering/elopement. All new admissions will have a wandering/elopement risk assessment completed by licensed nurse upon admission to ensure residents at risk are appropriately identified, armbands applied and photo added to binders located at Unit A and Unit B nurse stations and the front entrance. 4. Beginning 6/4/2025, Nurse Educator, DON or ADON will conduct Wandering/Elopement Drills once on every shift for 2 weeks, then once a week on every shift for the next 2 weeks, then monthly for 2 months to ensure at risk residents are appropriately identified and the staff are knowledgeable of wandering/elopement processes and	

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F 600	Continued From page 4 Resident #211 exit the building. On 6/4/2025 at 3:30 PM an interview with LPN #3 revealed she was at the nursing station providing information on another resident to the evening shift nurse. LPN #3 stated that at approximately 3:10 PM she heard yelling and some saying, "She's gone". LPN #3 reported seeing staff running out of the building and she ran behind them. LPN #3 noted she did not see Resident #211 leave the building. On 6/4/2025 at 3:37 PM an interview with the Director of Nursing (DON) revealed at approximately 3:00 PM she was in the Administrators office when she heard someone yell "The lady." The DON noted she ran outside with the other staff and went to the intersection to retrieve the resident and bring her back to the facility. The DON noted the resident refused to come with the staff and yelled and kicked them. The DON noted the staff had to physically pick up the resident and carry her while yelling for someone to bring a wheelchair for her. The DON reported that her assessment of the resident revealed no injuries. During the interview the Emergency Medical Transport (EMT) arrived. The DON noted the resident will be sent to a geri-psych unit. On 6/4/2025 at 3:49 PM, an interview with Assistant Director of Nursing (ADON) revealed she was in the Administrator's office when at approximately 3:15 PM she heard an inaudible yelling coming from the hallway. The ADON stated she walked out of the office and saw people running toward the door. The ADON noted she ran after them and noticed the resident at the intersection near the facility. The ADON	F 600	responses. Beginning 06/04/2025, monthly audits for 3 months by Social Services and MDS Coordinator to ensure all residents at risk for wandering/elopement are appropriately identified in the wandering/elopement binders, armbands applied and main door codes have been changed at least once in the last 30 days. Beginning 06/04/2025, for 3 months the Administrator will audit the compliance of changing the main entrance door codes at least once per month. Findings from the drills, audits and door codes will be reviewed monthly during QAPI for 3 months starting July 3, 2025. Administrator and Director of Nursing will be responsible for monitoring and compliance to ensure the solutions are sustained. Any issues identified by the QAPI Committee related to the cited deficiencies will be addressed immediately with an appropriate action plan for improvement implemented.	

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reported the Resident #211 was combative and held on tightly to the trailer on which she was sitting. The ADON noted the resident yelled that she did not live at the facility and that she wanted to go home. The ADON noted the resident was returned to the facility at approximately 3:25 PM.

On 6/4/2025 at 4:10 PM, an interview with the Administrator revealed she was in her office when at approximately 3:15 PM she was alerted by someone screaming, "The Lady" from the hallway. The Administrator stated she ran to the front door and then to the location of the resident. The Administrator stated the resident was found at the intersection near the facility, sitting the back of a trailer that was attached to a pickup truck in the middle of the street. The Administrator stated Resident #211 was combative and resistant to coming back to the facility with the staff. The Administrator stated the resident was yelling, "I want to go home", "Don't touch me." The Administrator confirmed the resident was initially carried by the staff but was later placed in a wheelchair to get her back to the facility. The Administrator affirmed the resident was back in the facility at approximately 3:21 PM. The Administrator stated Resident #211 will be going to a geri psych unit.

On 6/4/2025 at 4:17 PM an interview with CNA #1 revealed that at approximately 3:15 PM she was at the back door, near the laundry room, clocking out when she saw the resident walking and heard another staff member yell "She got out." CNA #1 stated she ran back to the front of the building yelling for help. CNA #1 reported she ran out of the front door and proceeded to go along with the other staff toward the resident. CNA #1 confirmed the resident was located at the

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intersection near the facility, in the middle of the street, sitting on the back of a truck trailer. CNA #1 noted Resident #211 hysterical and combative. CNA #1 affirmed the resident was back in the building by approximately 3:20 PM.

On 6/5/2025 at 8:32 AM an additional interview with the Administrator revealed she had reviewed the surveillance video and confirmed that the resident was able to exit the facility through the front door because the receptionist pushed the button that unlocks the door, allowing Resident #211 to walk out. The Administrator acknowledged that no other staff or visitors were surrounding the resident at the time she exited the facility.

On 6/5/2025 at 8:40 AM, an interview with the Receptionist acknowledged that on 6/4/25 she was located at the receptionist desk when Resident #211 approached the door. The Receptionist stated she then pushed the button that unlocked the door and Resident #211 was able to walk out. The Receptionist affirmed that she did not recognize the resident because she was admitted to the facility the previous day after she left work.

On 6/06/25 at 10:30 AM, an interview with the Family Nurse Practitioner (FNP) revealed she was made aware of the incident and ordered the resident sent to the hospital for physical and mental evaluation. The FNP noted she does not take part in the preadmission process.

On 06/05/25 at 09:56 AM an interview with the Admissions Coordinator (AC) revealed when she receives pre-admission information for a resident, she forwards the information to the DON, ADON,

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the Administrator, the Business office and the Director of Respiratory to review the information. The AC affirmed that no information in Resident #211's preadmission documents stood out to her as worthy of concern for the resident. The AC confirmed that the resident's daughter mentioned that the resident had become more difficult to have at home.

On 06/06/25 at 9:21 AM, during a phone interview with the Resident Representative (RR) revealed she was contacted by the facility staff regarding her mother's elopement from the facility on 6/4/25. The RR affirmed that the facility explained that the receptionist let her out, not knowing she was a resident. The RR stated it had only been 24 hours since her mother was admitted to the facility, and she wants her mother to be safe. The RR stated she has no other plan for her mother's care.

On 06/06/25 at 9:46 AM, an additional interview with The Receptionist revealed she recalled buzzing the resident out the front door at time between 3:00 PM and 4:00 PM. The Receptionist recalled it was during the shift change and the second shift had already arrived.

On 6/06/25 at 9:51 AM, an additional interview with the Administrator revealed when a resident is admitted to the facility it is the responsibility of the nurse assigned to that resident as well as the DON, ADON and the Nurse Supervisor to keep the resident safe until a care plan has been done. The Administrator confirmed that from the front door of the facility to the intersection where the resident was found was 250 steps approximately 600 feet.

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On 6/06/25 10:53 AM, an interview with the DON revealed the facility's Wandering Risk Screen and Elopement Evaluation for resident #211 was completed by Registered Nurse (RN) #1. The DON noted all staff are responsible for monitoring newly admitted residents for safety until they have a care plan.

On 6/06/25 at 11:20 AM a phone interview RN #1 acknowledged that she is responsible for completing the Elopement Evaluation and the Wandering Risk Screen for Resident #211. RN #1 noted at the time of admission her impression of the resident came from the diagnoses of Altered Mental Status and Urinary Tract Infection (UTI). RN #1 stated she noticed the resident behaving in a confused state and even addressing her as if she were her daughter. RN #1 reported she believed Resident #211's confusion was due to the UTI. RN #1 affirmed that she did not have knowledge of the RR's statement regarding Resident #211 leaving home and wandering in the streets.

On 06/06/25 at 12:18 PM, during an interview the Social Services Director (SSD) #1 acknowledged that she is responsible for updating the book that contains residents who are prone to wander. SSD #1 confirmed that the book was not updated to include Resident #211 at the time of her elopement from the facility on 6/4/2025. SSD #1 stated that she adds residents who are prone to wander to the book based on the assessment from the nursing staff at the time of admission. SSD noted that at the time the resident was admitted on 6/3/25 she was off work and had planned to do the assessment the next day. SSD #1 reported she is not shown preadmission paperwork to assess prior to admission.

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On 06/06/25 at 1:10 PM, an additional Interview with SSD #1 revealed she updated the wandering binder and included color photographs on 6/4/25.

A record review of the "Admissions Record" revealed the facility admitted Resident #211 on 6/3/25 with diagnoses including Unspecified Dementia and Altered mental status.

Removal Plan:

Corrective Actions Implemented Immediately

Resident Assessment:
Upon re-entry, a comprehensive full-body assessment was completed. No injuries were noted. There were no signs of bruising, bumps, skin tears, or lacerations. When asked about any discomfort, Resident #211 reported that her feet felt "a little sore." The Director of Nursing (DON) removed the residents' socks and observed no redness or open areas. Acetaminophen (Tylenol) was administered in accordance with the physician's order. Vital signs were obtained and found to be within normal limits.

Resident #211 became tearful and expressed a strong desire to return home, stating that her daughter was not adequately caring for her grandchildren and that she needed to be there for them. The Nurse Practitioner was promptly notified and provided an order for the Resident #211 to be transferred to the Emergency Room for further evaluation at a higher level of care.

Resident #211's Responsible Party (RP) was contacted and informed of the situation and the new medical order. An emergency response was

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called, and the resident was transported by ambulance and taken to the local emergency department. Resident #211 departed the facility on a stretcher at approximately 4:15 PM.

At 5:40 PM, a follow-up call was placed to the emergency department, where it was confirmed that the Resident #211 had been admitted to the Geri psych unit for continued evaluation and treatment.

Implementation Date: 6/4/2025
o Official report called to the State Agency on June 4, 2025
o Emergency Quality Assurance and Performance Improvement (QAPI) meeting held on June 4, 2025, with leadership to review failures and prevention strategies. Staff in attendance were Administrator, DON, ADON, Infection Preventionist/RN Educator, Maintenance Director, Medical Director via telephone, Social Services #1, Social Services #2, MDS Coordinator, Wound Care, Wound Care Nurse, Rehab Manager, Environmental Services, Activities Director, RNA, Central Supply, Medical Records, Human Resources, Business Office, Staffing, Treatment Nurse

Nurse Educator will conduct in-service training for all staff on wandering and elopement (new admits at risk) protocols on June 4, 2025.

o Social Services will complete a 100% audit of the wandering binders to ensure all qualifying residents are included and that color photographs are added on June 4, 2025.

o Central Supply Clerk, will order neon green armbands to identify residents at risk of wandering or elopement on June 4, 2025

o Maintenance Department will change the front entrance/exit door codes to prevent

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F 600	Continued From page 11 unauthorized exits on June 4, 2025. o DON and ADON will conduct elopement drills on every shift once a week for four weeks, then monthly thereafter, beginning on June 4, 2025. o DON and ADON will complete a 100% audit of care plans for residents identified as elopement risks to ensure their accuracy and completeness on June 4, 2025. o DON and ADON will complete a 100% audit of all resident assessments to identify those who meet criteria for wandering risk on June 4, 2025. o ADON will complete a 100% audit of the total number of residents in the facility on June 4, 2025. *No employees will be permitted to work until the assigned in-services have been completed. Validation: The SA validated on 06/06/25 through interview and record review that all actions to remove the immediacy were completed on 06/05/25. The Immediate Jeopardy was removed on 06/05/25 prior to the SA exit.	F 600		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		7/4/25

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	255326	A. BUILDING _____ B. WING _____	06/06/2025

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F 656	Continued From page 12	F 656		

assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, record reviews and facility policy review the facility failed to

1. On 06/05/2025, Resident #98 did not receive incontinence care per the care

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F 656	Continued From page 13 implement a comprehensive care plan for two (2) of 24 residents reviewed. Resident # 41 and Resident #98. Findings include: A record review of the "Comprehensive Care Plan Policy," revised 4/2025, revealed "...Standard....It is the standard of this facility to develop and implement to a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment ..." Resident #98 Record review of the "Care Plan Report" revealed "Focus: The resident has bladder incontinence ...Interventions/Task ...Incontinent care q (every) 2 hours and prn (as needed); Keep skin clean and dry ..." Record review of the "Care Plan Report" revealed "Focus: The resident has an ADL (activities of daily living) Self-Care Performance Deficit ...Interventions/Task ...Incontinent care q 2 hours and prn with total assist ..." During an observation of peri care on 6/5/25 at 10:25 AM, after wound care by Certified Nursing Assistant (CNA) #2 and assisted by CNA #4 revealed Resident # 98 had on a heavily soiled brief, turn pad, and draw sheet. All were was soaked with putrid odor of yellow and brown stain of urine.	F 656	plan. Bed linens for Resident #98checked. Bed changed with fresh linen on 6/5/2025 by CNA. On 6/5/2025, Resident#98 assessed by DON. No negative outcomes identified. 2. ADON assessed all residents on 6/4/2025 and determined 24 residents are incontinent and have the potential to be affected. No further negative issues were identified. 3. QAPI Committee met on 6/24/2025 to review cited regulation. The QAPI Committee reviewed the Resident Centered Care Planning Standard and Incontinence Management Standards with no recommended changes to the policy. All 24 residents with incontinence have resident centered comprehensive care plan interventions for treatment of incontinence were determined to be up to date with physician orders on 6/6/2025. Beginning 06/06/2025, Nurse Educator trained clinical staff regarding incontinence care, individualized care service plans, perineal care, and suprapubic care. Nurse Educator(NE) conducted In-services on 6/18/2025 educating clinical staff on the location of the Individual Care Service Plan (ICSP) within Electronic Medical Record, Kardex and process of Charge Nurse to confirm that unit staff have reviewed Kardex at the beginning of each shift. Beginning 06/06/2025, Nurse Educator trained CNAs to document that they	

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F 656	Continued From page 14 On 06/05/25 at 2:32 PM an interview with CNA #2 stated that Resident # 98 was not her resident today. She stated that the resident sometimes requests her care, because she is used to her doing her care. She stated CNA #4 was the resident CNA for today. She confirmed that the resident was heavily soiled with foul smelling urine. She confirmed the care plan was not followed. On 6/5/25 at 2:40 PM an interview with CNA #4 confirmed that Resident # 98 was heavily soiled in urine. She stated the wound could get infection from being soaked in urine. She stated the resident prefers CNA #2 to give care. She stated that her CNA #2 is sometimes exchange resident. She stated she had not done peri care today on Resident #98. She confirmed the care plan was not followed. On 06/06/25 at 3:02 PM, during an interview the Director of Nursing (DON) stated that when a resident is left unclean and heavily soiled with urine, they are at risk of a possible infection. She stated peri care should be done every two hours. Resident #41 A record review of the "Care Plan Report" with initiated date of 1/22/24 revealed "Focus: The resident has an ADL (activities of daily living) Self Care Performance Deficit ...Interventions ... The resident requires 2 staff participation to reposition and turn in bed ...." At 11:33 AM on 6/3/25 PM, in an interview with CNA #2, explained that Resident #41 asked her to turn her over on her side before leaving her room. She replied yes and proceeded to do so.	F 656	reviewed the Individual Care Service Plan(ICSP)/Kardex prior to providing care to every resident. In addition, licensed nurses were also in-serviced on the location of Individual Care Service Plan (ICSP)/Kardex. Charge nurses are responsible for making sure the Kardex is updated daily. 4. Beginning 06/05/2025 Minimum Data Set (MDS) Nurse will audit the resident care plan and Kardex of 5 incontinent residents to ensure they are current and resident specific weekly for 4 weeks and monthly for 2 months. The care plan audit findings will be reviewed weekly by the DON and any issues identified will be addressed immediately. Findings will be reviewed monthly in the QAPI Committee Meeting for 3 months starting on July 3, 2025. Director of Nursing and MDS Nurse will be responsible for monitoring and compliance to ensure the solutions are sustained.	

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F 656	Continued From page 15	F 656		

She said she got on the side of the resident and grabbed the pad up under her to pull, helping assist the resident with repositioning on her side. When the resident was all the way over to her side, the resident began to scream indicating the mattress up under her was sliding, she then looked and saw too that it was sliding off onto the floor. She said she immediately grabbed the resident upper body, to help brace the fall as much as possible but her low body hit the floor with her landing on her buttock. She says the care plan they look at shows that the resident requires two people when turning or repositioning her and that it was her fault the resident fell because she should have gone to get help instead of doing it alone.

A record review of the "Admission Record" revealed the facility admitted Resident #41 on 1/22/24 with diagnosis including Guillain-Barre Syndrome, Paraplegia, Restlessness and Agitation, Lack of Coordination and Muscle Weakness.

A record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/27/25 revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating the resident was cognitively intact..

On 6/5/25 at 9:15 AM an interview with the Licensed Practical Nurse (LPN) who works as the Minimum Data Set (MDS) Nurse revealed the purpose of the care plan is for staff to determine the needs of the residents therefore, it should be followed by everyone. She says not following the care plan would not turn out good for the residents and maybe even the staff.

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F 686	Continued From page 16	F 686		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to provide wound care in a manner to promote healing and prevent infection for one (1) of three (3) residents reviewed for wound care. Resident #98. Findings Include: A record review of the facility's policy titled Skin Management Standards, revised April 2021, revealed "Bacteria are present on all skin surfaces. When the primary defense provided by intact skin is lost, bacteria will reside on the wound surface. Follow infection control policies to prevent self-contamination and cross-contamination in individuals with pressure ulcers." Record review of the facility policy "Skin Management Standards "dated 04/2021 revealed	F 686	1. On 06/05/2025, the facility failed to provide Resident #98 with incontinence care to resident per the care plan. All bed linens for Resident #98 checked. Bed linens found soiled; bed changed with fresh linen. A full wound assessment for the resident was completed on 6/3/2025 by the Wound Care Nurse and reviewed by the Director of Nursing (DON). The resident's care plan was updated to reflect a specific peri-care protocol prior to all wound care procedures. A care conference was held 6/25/25 with the residents responsible party to discuss the incident and corrective actions being taken.	7/4/25

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F 686	Continued From page 17 " ...Protocol ...3. Change dressing as ordered per physician ..." An observation and interview on 06/05/25 at 9:45 AM, revealed Licensed Practical Nurse (LPN) #1, assisted by LPN #6, providing wound care for Resident #98. LPN #6 removed the resident's bed linens and brief, which were heavily soiled with yellow and brown urine. LPN #1 removed the wound vacuum and dressing, which was saturated with urine and completed the wound care as ordered. Following the procedure, LPN #1 stated he had not noticed the soiled brief and linens until after completing care. He acknowledged that peri-care should have been performed prior to wound care and that failure to do so could result in infection, deterioration of the wound bed, and delayed healing. He further stated that the urine appeared to have been present for a prolonged period, indicating the resident had not been changed recently. On 06/05/25 at 2:30 PM, Resident #98 stated she was typically changed only once at night and could not recall when she was last changed. She stated that staff do not check on her during the night, and she remains wet for long periods. On 06/05/25 at 2:50 PM, an interview with LPN #6 (wound care nurse) revealed she did not check the resident's brief prior to the procedure. She stated that wound care was initiated despite the resident being visibly soiled and confirmed that care is typically performed with CNA assistance to provide peri-care beforehand. She acknowledged that proceeding with wound care prior to hygiene could result in infection. On 06/06/25 at 3:09 PM, the Director of Nursing	F 686	2. On 6/5/2025, Wound Care Supervisor assessed all residents and determined 24 residents have wound care orders and have the potential to be affected. No further negative issues were identified. On 6/6/2025, an air mattress audit was conducted and determined all residents are on the appropriate mattress setting. No negative issues were identified. 3. On 6/24/2025, QAPI Committee met and reviewed the Skin Management Standard with no recommended changes to the policy. On 6/14/2025, all nursing staff including Licensed Practical Nurse #1 and Licensed Practical Nurse #6 were in serviced by Nurse Educator on proper wound care protocols, infection prevention, and the importance of peri-care prior to wound dressing changes. On 06/14/2025, Nurse Educator conducted in service for licensed nursing staff on Proper wound care protocols per facility policy, Infection control standards related to wound care, Importance of peri-care prior to wound dressing changes, Resident dignity and continence care. The "Skin Management Standards" policy was reviewed on 6/14/25and reinforced during training. Staff were required to sign an acknowledgment form after training. A communication protocol was established on 6/14/25 requiring nurses to verify with CNAs that peri-care has been completed prior to wound care procedures. Wound Care Consultant	

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F 686	Continued From page 18 (DON) confirmed that peri-care should have been completed before wound care and that failure to do so could lead to contamination and further skin breakdown. She stated that all wound care should be provided per facility policy. Record review of the "Order Summary Report" with active orders as of 6/3/25 revealed an order dated 4/07/25 for wound vacuum application to the sacral ulcer with normal saline cleansing, pat dry, and dressing changes twice weekly and PRN (as needed) for dislodgement. Documentation of wound vac output was to be recorded each shift. A record review of the "Admission Record" for Resident #98 revealed an admission date of 04/07/25 with diagnoses including a stage 4 pressure ulcer to the sacral region. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment.	F 686	Nurse provided education to licensed nurses on 6/22/2025 and 06/27/2025 regarding appropriate documentation which included transcription and entering of treatment orders on the physicians order sheet in the Electronic Medical Record and the residents Treatment Administration Record. 4. Beginning 06/05/2025, the Wound Care Supervisor began observing wound care performed by Registered Nurse (RN) or Licensed Practical Nurse (LPN) for 5 incontinent residents with wounds weekly for 4 weeks and then monthly for 2 months to ensure wound care and incontinence care are provided according to the individualized care plan and the standards of practice. Any issues with non-compliance will be immediately corrected and addressed by the DON or Nurse Educator for additional staff education. The findings of the observations will be reviewed in the QAPI Committee Meeting for 3 months starting with the QAPI Committee conducted July 3, 2025. DON and Wound Care Supervisor will be responsible for monitoring and compliance to ensure the solutions are sustained.	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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	F 689		7/4/25

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F 689	Continued From page 19 §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 provide adequate supervision, monitoring, and preadmission risk assessment to prevent a resident from exiting the facility unsupervised and without staff awareness or intervention for one (1) of twenty-four (24) sampled residents. (Resident #211). This failure resulted in Resident #211 eloping from the building on 6/4/25, for an estimated 600 feet, and being found seated on the back of a trailer in a public intersection surrounded by traffic, thereby placing the resident in Immediate Jeopardy (IJ) for serious injury, harm, impairment, or death. This situation was determined to be IJ and Substandard Quality of Care (SQC), which began on 06/04/25 when Resident #211 eloped from the facility. The State Agency (SA) notified the Administrator of the Immediate Jeopardy on 06/05/25 at 11:40 AM and provided an IJ template. The facility provided an acceptable Removal Plan on 06/05/25, in which they alleged all corrective actions to remove the IJ were completed on 06/05/2025 and the IJ removed on 06/05/2025. The SA validated Removal Plan on 06/06/25, and determined that the IJ was removed on 06/05/25, prior to SA exit. Therefore, the scope and severity for CFR 483.25(d)(1)(2) Accidents/Hazards -	F 689	1. On 06/04/2025, the facility failed to keep Resident #211 exited the building. Accident/Incident investigation initiated immediately by the Administrator. Upon returning to the facility, within 6 minutes and in visual range of staff, Resident #211 was assessed by Director of Nursing (DON) on 06/04/2025. The resident was found to be free of injuries. Resident wandering/elopement assessment completed by Assistant Director of Nursing (ADON) on 6/4/2025 and resident determined to be at risk for wandering/elopement. Color picture of Resident #211 taken and placed in wandering/elopement binder at each nurse station and reception desk by Social Services on 6/4/2025. Door codes changed on 6/4/2025 by Maintenance Director. 2. On 6/04/2025, the ADON assessed all residents and determined 12 residents were at risk for wandering/eloping. No issues identified. 3. The QAPI Committee (Administrator, DON, Medical Director, Infection Preventionist/RN Educator, ADON, Human Resources, MDS Coordinator, Treatment Nurse, Wound Care, Business Office, Rehab Manager, Medical Records,	

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F 689	Continued From page 20 F689 was lowered from a "J" to a "D" while the facility develops a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings Include: A review of the facility's policy titled "Wandering/Elopement Risk" (Revised November 2017) revealed "It is the standard of this facility to identify those residents at risk for wandering/elopement and to take the appropriate steps to minimize the risk of elopement. All residents are assessed for the potential to wander prior to or upon admission." A record review of the "Admission Record" for Resident #211 revealed an admission date of 06/03/25 with diagnoses including Unspecified Dementia and Altered Mental Status. During an observation on 06/04/25 at approximately 3:15 PM, the SA observed several staff running through the facility parking lot. It was later confirmed that Resident #211 exited the facility through the front door after the receptionist pushed the door release button. The resident was found seated on the back of a trailer at the intersection near the facility, an estimated 600 feet from the front entrance of the facility. The resident was combative, yelling, "I want to go home," and had to be carried by staff until a wheelchair arrived. Record review of weather records from Jackson, MS on 06/04/25 at 3:15 PM documented a temperature of 86°F and clear skies.	F 689	Social Services #1, Social Services #2,Environmental Services, Maintenance Director, Activities Director, Staffing, RNA, Central Supply) met on 6/04/2025 to review Freedom of Abuse Standard and Wandering/Elopement Standard with no recommended changes to the standards. On 06/04/2025 facility staff educated on wandering/elopement process and procedures. On 06/04/2025 Social Services conducted 100% audit of wandering/elopement binders located at Unit A and Unit B nurse stations and front entrance to ensure completeness and accuracy. On 06/04/2025 armbands were applied by Social Services to all residents assessed and determined to be at risk for wandering/elopement. All new admissions will have a wandering/elopement risk assessment completed by licensed nurse upon admission to ensure residents at risk are appropriately identified, armbands applied and photo added to binders located at Unit A and Unit B nurse stations and the front entrance. 4. Beginning 6/4/2025, Nurse Educator, DON or ADON will conduct Wandering/Elopement Drills once on every shift for 2 weeks, then once a week on every shift for the next 2 weeks, then monthly for 2 months to ensure at risk residents are appropriately identified and	

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F 689	Continued From page 21 During an interview on 06/04/25 at 3:27 PM, Licensed Practical Nurse (LPN) #2 stated she was at the nurses' station receiving report when she heard a Certified Nursing Assistant (CNA) yell, "The new lady is out." She ran outside with other staff and saw the resident being retrieved, but did not witness the elopement. On 06/04/25 at 3:30 PM, LPN #3 stated she heard shouting and followed staff outside, confirming the resident was found at the intersection but she did not witness her leaving the building. On 06/04/25 at 3:37 PM, the Director of Nursing (DON) stated she was in the Administrator's office when she heard yelling. She ran outside and saw the resident sitting on the trailer in traffic. The DON confirmed the resident was combative, refused to return, and had to be physically carried while another staff retrieved a wheelchair. During an interview on 06/04/25 at 4:10 PM, the Administrator stated she heard someone yelling "The lady" and ran to the front door. She saw the resident sitting in the middle of the street on a trailer attached to a pickup truck. The resident was yelling, "I want to go home," and "Don't touch me." The Administrator confirmed the resident was carried until a wheelchair was brought. She stated the resident would be transferred to a geriatric psychiatric unit. During an interview on 06/04/25 at 4:17 PM, Certified Nursing Assistant (CNA) # 1 stated she was clocking out by the laundry area when she heard yelling. She ran to the front and joined other staff in retrieving the resident from the intersection. She described the resident as hysterical and combative. During an inteview on 06/05/25 at 8:32 AM, the	F 689	the staff are knowledgeable of wandering/elopement processes and responses. Beginning 06/04/2025, monthly audits for 3 months by Social Services and MDS Coordinator to ensure all residents at risk for wandering/elopement are appropriately identified in the wandering/elopement binders, armbands applied and main door codes have been changed at least once in the last 30 days. Beginning 06/04/2025, for 3 months the Administrator will audit the compliance of changing the main entrance door codes at least once per month. Findings from the drills, audits and door codes will be reviewed monthly during QAPI for 3 months starting July 3, 2025. Administrator and Director of Nursing will be responsible for monitoring and compliance to ensure the solutions are sustained. Any issues identified by the QAPI Committee related to the cited deficiencies will be addressed immediately with an appropriate action plan for improvement implemented.	

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	255326	A. BUILDING _____ B. WING _____	06/06/2025

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Administrator confirmed that video surveillance showed the receptionist unlocking the door, allowing the resident to exit without being accompanied by staff.

During an interview on 06/05/25 at 8:40 AM, the Receptionist stated she pushed the release button for the front door when Resident #211 approached, and she did not recognize the resident because she had been admitted the previous evening after the receptionist's shift.

On 06/06/25 at 9:21 AM, the Resident Representative stated she was notified of the elopement and told the receptionist to let the resident out, not realizing she was a new admission. She stated it had only been 24 hours since her mother's admission and she wanted to ensure her mother's safety.

During an interview on 06/06/25 at 9:46 AM, the Receptionist recalled unlocking the door for the resident between 3:00 PM and 4:00 PM during shift change.

During an interview on 06/06/25 at 9:51 AM, the Administrator stated that when a new resident is admitted, the assigned nurse, DON, Assistant Director of Nurses (ADON), and Nurse Supervisor are responsible for safety monitoring until a care plan is developed.

During an interview on 06/06/25 at 10:30 AM, the Family Nurse Practitioner (FNP) stated she was notified of the elopement and ordered the resident to be transferred to a local hospital for evaluation. She confirmed she does not participate in preadmission screening. On 06/05/25 at 9:56 AM, the admissions Coordinator

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stated she forwarded the resident's preadmission information to the DON, ADON, Administrator, Business Office, and Respiratory Director. She did not identify any concerning information at the time, although she recalled that the daughter mentioned the resident had become difficult to manage at home.

During an interview on 06/06/25 at 10:53 AM, the DON stated that the facility's Wandering Risk Screen and Elopement Evaluation were completed by RN #1. She stated that all staff are responsible for monitoring newly admitted residents until a care plan is in place.

During an interview on 06/06/25 at 11:20 AM, RN #1 stated she assessed the resident as confused but attributed it to a Urinary Tract Infection (UTI). She acknowledged the resident addressed her as if she were her daughter but denied knowing about the history of wandering reported by the family.

During an interview on 06/06/25 at 12:18 PM, the Social Services Director (SSD) #1 stated that she is responsible for updating the facility's wandering book based on nursing assessments. She confirmed that Resident #211 had not yet been added because she was off work at the time of admission.

During an interview on 06/06/25 at 1:10 PM, the SSD #1 confirmed that she added Resident #211 to the wandering binder on 06/04/25 with a photograph.

Removal Plan:

Corrective Actions Implemented Immediately

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Resident Assessment:
Upon re-entry, a comprehensive full-body assessment was completed. No injuries were noted. There were no signs of bruising, bumps, skin tears, or lacerations. When asked about any discomfort, Resident #211 reported that her feet felt "a little sore." The Director of Nursing (DON) removed the residents' socks and observed no redness or open areas. Acetaminophen (Tylenol) was administered in accordance with the physician's order. Vital signs were obtained and found to be within normal limits.

Resident #211 became tearful and expressed a strong desire to return home, stating that her daughter was not adequately caring for her grandchildren and that she needed to be there for them. The Nurse Practitioner was promptly notified and provided an order for the Resident #211 to be transferred to the Emergency Room for further evaluation at a higher level of care.

Resident #211's Responsible Party (RP) was contacted and informed of the situation and the new medical order. An emergency response was called, and the resident was transported by ambulance and taken to the local emergency department. Resident #211 departed the facility on a stretcher at approximately 4:15 PM.

At 5:40 PM, a follow-up call was placed to the emergency department, where it was confirmed that the Resident #211 had been admitted to the Geri psych unit for continued evaluation and treatment.

Implementation Date: 6/4/2025
o Official report called to the State Agency on

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June 4, 2025

o Emergency Quality Assurance and Performance Improvement (QAPI) meeting held on June 4, 2025, with leadership to review failures and prevention strategies. Staff in attendance were Administrator, DON, ADON, Infection Preventionist/RN Educator, Maintenance Director, Medical Director via telephone, Social Services #1, Social Services #2, MDS Coordinator, Wound Care, Wound Care Nurse, Rehab Manager, Environmental Services, Activities Director, RNA, Central Supply, Medical Records, Human Resources, Business Office, Staffing, Treatment Nurse

Nurse Educator will conduct in-service training for all staff on wandering and elopement (new admits at risk) protocols on June 4, 2025.

o Social Services will complete a 100% audit of the wandering binders to ensure all qualifying residents are included and that color photographs are added on June 4, 2025.

o Central Supply Clerk, will order neon green armbands to identify residents at risk of wandering or elopement on June 4, 2025

o Maintenance Department will change the front entrance/exit door codes to prevent unauthorized exits on June 4, 2025.

o DON and ADON will conduct elopement drills on every shift once a week for four weeks, then monthly thereafter, beginning on June 4, 2025.

o DON and ADON will complete a 100% audit of care plans for residents identified as elopement risks to ensure their accuracy and completeness on June 4, 2025.

o DON and ADON will complete a 100% audit of all resident assessments to identify those who meet criteria for wandering risk on June 4, 2025.

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F 689	Continued From page 26 o ADON will complete a 100% audit of the total number of residents in the facility on June 4, 2025. *No employees will be permitted to work until the assigned in-services have been completed. Validation: The SA validated on 06/06/25 through interview and record review that all actions to remove the immediacy were completed on 06/05/25. The Immediate Jeopardy was removed on 06/05/25 prior to the SA exit.	F 689		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the	F 865		7/4/25

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promulgation of this regulation;

§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership

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(or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;
§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

§483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and

§483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect.

§483.75(h) Disclosure of information.
A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.

§483.75(i) Sanctions.
Good faith attempts by the committee to identify and correct quality deficiencies will not be used as

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F 865	Continued From page 29 a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place in December 2023. This was for two (2) recited deficiencies originally cited in December 2023 on an annual recertification survey. The deficiencies were in the area of the care plan not being followed and infection control. The continued failure during two surveys shows a pattern of the facility's inability to sustain an effective QAPI Committee for two (2) of seven (7) deficient practice citations. Findings Include: Record review of the facility's policy, "Quality Assessment and Performance Improvement", September 2019, revealed, " ...It is the standard of this facility to ...c. Develop and implement appropriate plans of action to correct identified quality deficiencies ..." F656: Based on interviews, record reviews, and a review of facility policy, the facility failed to ensure a Certified Nursing Assistant followed the comprehensive care plan when repositioning one (1) of 24 sampled residents Resident #41 F880 Based on observation, interview, record reviews, and facility policy review, the facility failed to prevent the possibility of the spread of infection during Percutaneous Endoscopic Gastrostomy	F 865	1. On 06/06/2025, it was determined that the facilitys Quality Assurance Performance Improvement (QAPI) Committee did not maintain implemented procedures and monitor the interventions the committee put into place in December 2023. During two surveys shows a pattern of the facility's did not sustain an effective QAPI Committee for two (2) deficient practice citations for care plan not being followed and infection control. On 06/05/2025, Resident #98 did not receive incontinence care per the care plan. Bed linens for Resident #98checked. Bed changed with fresh linen on6/5/2025 by CNA. On 6/5/2025, Resident#98 assessed by DON. No negative outcomes identified. On 06/04/2025, the facility staff failed to follow standards of care while donning Personal Protective Equipment (PPE) and performing perineal care while providing suprapubic catheter care. On 6/4/2025 Licensed Practical Nurse #4 was in serviced by Nurse Educator regarding donning and doffing PPE. On 6/4/2025 Licensed Practical Nurse #5 was in-serviced by Nurse Educator regarding suprapubic catheter care. 2. On 6/5/2025, Wound Care Supervisor	

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F 865	Continued From page 30 (PEG) care for Resident #14 and during suprapubic catheter care for Resident #62 for two (2) of five (5) care observations. Record review of the Statement of Deficiencies and Plan of Correction (Form 2567) from the previous annual survey in December 2023, revealed F656 was cited due failure to implement a care plan directive and F880 was cited regarding improper catheter care. On 06/06/25 at 3:04 PM, an interview with the Administrator revealed she affirmed that deficiencies from the previous annual survey were found during this survey. The Administrator stated there will be a plan of correction to address the deficiencies and her expectation is to maintain improvement and increase quality of care.	F 865	assessed all residents and determined 24 residents have wound care orders and have the potential to be affected. No further negative issues were identified. On 06/04/2025, DON assessed all residents and determined 24 residents are incontinent and have the potential to be affected. No further negative issues were identified. 3. On 6/05/2025, QAPI Committee met and reviewed the QAPI Plan with no recommended changes to the policy or process. Repeated deficient practices related to care plan and infection control cited from 2023 were reviewed by the QAPI Committee to identify where the system for monitoring failed. On 06/05/2025, Chief Operations Officer educated QAPI Committee on the QAPI process and techniques for monitoring and sustaining improvement solutions. On 06/05/2025 the QAPI Committee established a baseline action plan for education and monitoring to ensure compliance with deficient practices. 4. The plan of correction monitoring findings from the deficient practices identified on the CMS 2567 statement of deficiency from the Annual Recertification Survey, as well as 1 substantiated Complaint Survey date 06/06/2025 will be reviewed in the QAPI Committee for 3 months starting with the QAPI Committee conducted July 3, 2025. QAPI Committee	

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F 865	Continued From page 31	F 865	will be responsible for monitoring and compliance to ensure the solutions are sustained. Any issues identified by the QAPI Committee related to the cited deficiencies will be addressed immediately with an appropriate action plan for improvement implemented.	
F 880 SS=E	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 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	F 880		7/4/25

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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 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, interview, record review, and facility policy review, the facility failed to

1. On 06/04/2025, the facility staff failed to follow standards of care while donning

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F 880	Continued From page 33 prevent the possibility of the spread of infection during Percutaneous Endoscopic Gastrostomy (PEG) care for Resident #14 and during suprapubic catheter care for Resident #62 for two (2) of five (5) care observations. Findings include: A record review of the facility's policy "Incontinence Management Suprapubic Catheter Care" with a revision date of 1/2020 revealed "Objective To promote hygiene, comfort, and reduce migration of infectious organisms to the bladder ...Procedure: 8. Clean around the area where the catheter enters the abdomen in a circular motion, moving in a bullseye pattern out to 2-3 inches beyond where catheter enters abdomen ..." A record review of the facility policy "Infection Control Enhanced Barrier Precautions" dated 2024 revealed" ...The Centers for Disease control and Prevention (CDC) recommends using Enhanced Barrier Precautions (EBP) with residents, regardless of Multidrug-resistant Organisms (MDRO) status, who have ... an indwelling medical device such as a feeding tube ...Post signs outside of residents 'rooms that state the required precautions and Personal Protective Equipment (PPE) and the resident care activities that need a gown and gloves ..." Resident #14	F 880	Personal Protective Equipment (PPE) and performing perineal care while providing suprapubic catheter care. On 6/4/2025 Licensed Practical Nurse #4 was in serviced by Nurse Educator regarding donning and doffing PPE. On 6/4/2025 Licensed Practical Nurse #5was in-serviced by Nurse Educator regarding suprapubic catheter care. 2. Residents that require Enhanced Barrier Precautions (EBP) and perineal care have the potential to be affected by the deficient practice. 3. On 6/24/2025, the QAPI Committee met to review the Infection Control Standard and Incontinence Management Perineal Care Standard with no recommended changes to the policy. On 06/04/2025, Nurse Educator in serviced facility staff and skill check offs conducted on donning and doffing PPE. Licensed staff in-serviced and skill checkoffs on donning and doffing PPE and suprapubic catheter care. On 6/9/2025 the Nurse Educator began conducting observation check offs of Perineal Care for nursing staff. 4. On 06/04/2025, Nurse Educator, Director of Nursing (DON) or Assistant Director of Nursing (ADON) began monitoring donning and doffing of PPE on 5 staff members per shift per week for 2 weeks, then 3 staff members per shift per	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	06/06/2025

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F 880	Continued From page 34 On 6/4/25 at 12:08 PM, during an observation Licensed Practical Nurse (LPN) #4, administered medications to Resident #14 via the PEG tube. LPN #4 did not don (put on) a gown as indicated on EBP prior to medication administration. On 6/4/25 at 12:22 PM, an interview with LPN #4 confirmed that she did not put on a gown before giving medication via PEG tube. She stated she was supposed to put on a gown prior to giving medication. She stated the reason for the gown is to protect the residents from her. She confirmed she had been trained on EBP and forgot to apply the gown. On 6/6/25 at 2:25 PM, during an interview with Registered Nurse #2 (RN)/Infection Preventionist (IP), she stated LPN #4 should have put on a gown prior to giving medication via PEG tube. She stated that by not wearing a gown, the nurse becomes a host and can transmit all types of infection from herself to other residents. On 6/6/25 at 3:24 PM, during an interview with the Director of Nursing (DON), she stated it was an infection control issue. She confirmed that LPN #4 should have worn a gown prior to beginning PEG tube care. She stated the gown prevents possible spread of infection and expects all staff to follow infection control guidelines. A record review of Resident # 14's "Admission Record" revealed an admission date of 4/6/22 with diagnoses of dysphagia following unspecified cerebrovascular disease.	F 880	week for 2 weeks, then 5 staff members 2 times monthly for 2 months. The findings will be reviewed in the QAPI Committee Meeting for 3 months starting on July 3,2025. Director of Nursing and Infection Preventionist are responsible for monitoring and compliance to ensure solutions are sustained. Any issues will be corrected immediately with additional education conducted as needed.	

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A record review of Resident #14's MDS with an ARD of 3/15/25 revealed a BIMS score of 99, which indicated the resident was unable to complete the interview.

Resident #62

On 6/4/25 at 10:38 AM, during an observation of LPN #5 providing catheter care for Resident #62 revealed LPN #5 began care using a wet soaped washcloth and cleaned the area at the entrance of the suprapubic catheter in a circular motion. She went around the site three times, flipped the cloth, and continued to clean in a circular motion two more times. She flipped the towel again and continued cleaning the site.

On 6/4/25 at 10:53 AM, an interview with LPN #5 confirmed that she used the cloth in a circular motion several times before flipping to a clean section. She stated that performing care in this manner could transfer bacteria back into the clean area and increase risk of urinary tract or bladder infection. She stated she had been trained in catheter care.

On 6/6/25 at 2:24 PM, during an interview with RN #2/IP nurse, she stated LPN #5 should have wiped once in a circular motion, then folded the washcloth to a clean section for each wipe. She

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stated that the technique used by LPN #5 could increase the chance of Resident #62 developing an infection, fever, or chills.

On 6/6/25 at 3:18 PM, during an interview with the DON, she stated LPN #5 should have flipped the washcloth with each wipe. She confirmed that the method used placed the resident at increased risk for infection.

A record review of Resident #62's "Admission Record" revealed an initial admission date of 7/15/22 with diagnoses including neuromuscular dysfunction of bladder.

A record review of Resident # 62's "Medication Review Report" dated 6/6/25 revealed an order dated 7/24/2023 "Suprapubic Cath (catheter) care - Clean with soap and H20 (water) every shift."

A record review of Resident # 62's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident is cognitively intact.