

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255326	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/06/2025
NAME OF PROVIDER OR SUPPLIER PINE FOREST HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 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	F 656		7/4/25	

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F 656	Continued From page 2 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 implement a comprehensive care plan for two (2) of 24 residents reviewed. Resident # 41 and Resident #98. Findings include:	F 656	1. On 06/05/2025, Resident #98 did not receive incontinence care per the care plan. Bed linens for Resident #98 checked. Bed changed with fresh linen on 6/5/2025 by CNA. On 6/5/2025, Resident #98 assessed by DON. No negative outcomes identified.		

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F 656	Continued From page 3 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. 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	F 656	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 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		

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F 656	Continued From page 4 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. 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	F 656	(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 5 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.	F 656			
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 -	F 689		7/4/25	

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F 689	Continued From page 6 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to 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	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,		

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F 689	Continued From page 7 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 - 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,	F 689	Human Resources, MDS Coordinator, Treatment Nurse, Wound Care, Business Office, Rehab Manager, Medical Records, 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		

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F 689	Continued From page 8 MS on 06/04/25 at 3:15 PM documented a temperature of 86°F and clear skies. 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	F 689	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 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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F 689	Continued From page 9 hysterical and combative. During an interview on 06/05/25 at 8:32 AM, the 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	F 689			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255326	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/06/2025
NAME OF PROVIDER OR SUPPLIER PINE FOREST HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 1116 FOREST AVENUE JACKSON, MS 39206		
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F 689	Continued From page 10 evaluation. She confirmed she does not participate in preadmission screening. On 06/05/25 at 9:56 AM, the admissions Coordinator 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.	F 689			

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F 689	Continued From page 11 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 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.	F 689			

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F 689	Continued From page 12 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 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%	F 689			

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F 689	Continued From page 13 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 689			
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	F 690		7/4/25	

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F 690	Continued From page 14 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. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and facility policy review, the facility failed to provide incontinent care in an appropriate manner to related to bowel and bladder care for one (1) of 24 residents reviewed. Resident #98. Findings include: A record review of the facility's policy "Perineal Care" with a revision date of 12/20 revealed the purpose of the procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation..." On 06/04/25 at 11:20 AM, during an observation of perineal care provided by Certified Nursing Assistant (CNA) 2 and assisted by CNA #3 revealed the CNAs performed perineal care and applied a clean brief. The State Agency (SA) asked CNA #2 to remove the clean brief and recheck the resident for cleanliness. CNA #2	F 690	1. On 06/05/2025, Resident #98 did not receive incontinence care per the care plan. Bed linens for Resident #98 checked. 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. Facility assessed all residents on 6/4/2025 and determined 24 residents are incontinent and have the potential to be affected. 3. QAPI Committee met on 6/24/2025 to review cited regulation. 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		

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F 690	Continued From page 15 removed the clean brief and wiped the anus area a total of seven additional times. Each time, the peri wipe was smeared with a brown substance. On 6/4/25 at 11:33 AM, an interview with CNA #3 confirmed that CNA #2 did not provide proper care. She stated that CNA #2 should wipe until the peri cloth is clean. On 6/4/25 at 11:38 AM, an interview with CNA #2 confirmed that she did not clean Resident #98 thoroughly. She stated that she should keep wiping until the wipe is clean. She acknowledged that the resident could get a urinary tract infection, yeast infection, or skin breakdown. An observation of perineal care for Resident #98 on 6/5/25 at 10:25 AM, after wound care was completed, revealed CNA #2, assisted by CNA #4, removed Resident #98's heavily soiled brief, turn pad, and draw sheet. All were soaked and had a putrid odor with yellow and brown staining from urine. On 06/05/25 at 2:32 PM, an interview with CNA #2 revealed that Resident #98 was not her assigned resident that day. She stated that the resident sometimes requests her care because she is used to her performing it. She stated that CNA #4 was the resident's assigned CNA for the day. CNA #2 confirmed that the resident was heavily soiled with foul-smelling urine. On 6/5/25 at 2:36 PM, an interview with Resident #98's Licensed Practical Nurse (LPN) revealed she had never been told that Resident #98 refused care. She stated only the nurse can change room assignments and she did not make any changes to the CNA schedule that day.	F 690	incontinence were determined to be up to date with physician orders on 6/6/2025. On 06/04/2025, Nurse Educator began educating clinical staff regarding incontinence care, 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. 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. ADON or Nurse Educator will observe 5 incontinent residents Activities of Daily Livings (ADLs) to validate they receive incontinent care per the individualized care plan weekly for 4 weeks and monthly for 2 months. Audit findings will be reviewed weekly by the DON and the findings will be reviewed in the QAPI Committee Meeting for 3 months starting on July 3, 2025. DON will be responsible for monitoring and compliance to ensure the solutions are sustained.		

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F 690	Continued From page 16 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 infected from being soaked in urine. She said the resident prefers CNA #2 to provide care and that CNA #2 is sometimes exchanged as the resident's caregiver. She stated she had not provided perineal care on Resident #98 that day. On 06/06/25 at 3:02 PM, an interview with the Director of Nursing (DON) stated CNA #2 should have continued to wipe until the resident was clean and used a clean wipe each time. She stated that when a resident is left unclean and heavily soiled with urine, they are at risk of a possible infection. She further stated that perineal care should be performed every two hours. A record review of Resident #98's "Admission Record" revealed an admission date of 4/7/25 with a diagnosis of pressure ulcer of sacral region, stage 4. A record review of Resident #98's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 4/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 6, which indicates severely impaired cognition. Section GG revealed Resident #98 is dependent for hygiene toilet care.	F 690			