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	255092	A. BUILDING _____ B. WING _____	C 04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYINGTON HEALTH AND REHABILITATION	1530 BROAD AVE GULFPORT, MS 39501

(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 conducted an annual recertification along with five complaints (CI MS #17576, CI MS #17635, CI MS #17647, CI MS #17673, and CI MS #17682) from 04/20/21 to 04/23/21. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated CI MS #17576 for leaving residents soiled for extended period of time and cited F-600. The SA did not substantiate CI MS #17647 for misappropriation, CI MS #17682 for unqualified personnel, CI MS #17673 for failing to provide appropriate wound care, and CI MS #17635 for medical records and staffing with no citations related to the complaint. The SA also cited F-687, F-812, F-850, and F-880 during the survey.	F 000		
F 600 SS=D	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 involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		6/13/21

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

Electronically Signed | 06/13/2021

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F 600	Continued From page 1 Based on observation, interviews, record reviews, and facility policy review the facility failed to provide the residents who were unable to carry out Activities of Daily Living (ADL's) the necessary services to maintain good personal hygiene for four (4) of 103 residents observed. (Resident #17, Resident #101, Resident #16, and Resident #55). Resident #17 Findings Include: Review of the facility's "Abuse, Neglect and Exploitation Policy", dated 11/2019, revealed: It is the policy of this facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of residential property. The policy also revealed the definition of neglect as "Neglect means the failure of the center, its associates or service providers, to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress". Review of the facility's "Covid-19 Temporary Nurse Aide Skills Competency Checklist" dated 1/20/20 revealed Personal Care Attendant (PCA) #1 was in-serviced on providing Activities of Daily Living (ADL's). Review of the facility's Vulnerable Persons Act dated 01/22/2021 revealed PCA #1 was in-serviced on Abuse and Neglect. Review of the facility's In-service sign in sheet dated 3/26/21 revealed PCA #1 was in-serviced on Resident Rights and Abuse and Neglect.	F 600	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly This Plan of Correction is submitted to meet the requirements established by the State and Federal Law. 1. On April 20, 2021, Residents #17, #16 and #101 were provided incontinent care and Resident #55 was provided a bath on April 23, 2021. Director of Nursing educated Licensed Practical Nurse (LPN)#2 and LPN #4 on rounds, responsibility of nurse overseeing certified nursing assistants (CNA) and staff assignments on April 26, 2021. Director of Nursing educated Personal Care Assistant (PCA)#1 on Incontinent Care and making rounds on April 23, 2021. Director of Nursing educated CNA#6 and CNA#3 on resident showers and residents appearance on April 28, 2021. 2. On April 28, 2021, incontinent residents were observed for incontinent needs and addressed by LPN and Risk Manager Registered Nurse (RN)for any patients identified. 3. Staff Development RN and Risk Manager RN educated staff on Abuse Neglect, Following Resident Care Plan, Elder Justice Act, Incontinent Care and	

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F 600	Continued From page 2 Review of the facilities comprehensive care plan Resident #17 has a self-care deficit related to limited mobility, general weakness often declines to change her clothes and often wears same clothes multiple days. Resident #17 is high risk for infection as evidenced by history of urinary tract infection and neurogenic bladder, and high risk for impaired skin integrity related to decreased mobility. During an observation on 04/20/21 at 11:40 AM, revealed Resident # 17 lying on her back in her bed on two reusable incontinent pads with her eyes closed. The incontinent pads Resident # 17 was lying on and the sheets were visibly wet. Resident #17's gown was also saturated in urine. Observation revealed the incontinent pads Resident # 17 was lying on and the sheets had yellow circular stains with brown rings around the edges of the yellow circular stains. Resident # 17's room had a very strong urine odor. During an interview 04/20/21 at 11:40 AM, with Resident # 17 revealed she was confused and displayed difficulty answering questions. Resident #17 confirmed she had urinated and her clothes and linen were wet. Resident # 17 stated "it would be good to be dry". On 04/04/20/21 at 11:43 AM, the State Agency (SA) notified Licensed Practical Nurse (LPN)#2 that Resident # 17 was requesting assistance. LPN #2 went down the hall and spoke to the LPN #4. On 04/20/21 at 12:06 PM, observation of Resident # 17 sitting on the side of the bed wearing the same clothes with both incontinent	F 600	providing showers beginning April 23, 2021 and ending April 28, 2021. The Local Ombudsman educated facility staff on Residents' Rights, Abuse / Neglect on May 20, 2021. The Facility Administrator educated facility staff on Abuse / Neglect, Incontinent Care and bathing residents on May 20, 2021. On April 28, 2021, incontinent residents were observed for incontinent needs and addressed by Licensed Practical Nurse and Risk Manager, Registered Nurse for patients identified. 4. Director of Nursing, Administrator, Assistant Director of Nursing or Risk Manager will monitor incontinent care for providing timely and showers are provided timely, to include off hours visits weekly times three weeks then monthly times three months and quarterly thereafter. Monitoring began May 5, 2021. Adverse findings will be brought to the monthly Quality Assurance / Performance Improvement Committee by Director of Nursing for continued compliance quarterly. ADHOC Quality Assurance Meeting was held on April 30, 2021.	

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pads folded back. Both wet pads and both wet sheets remained on Resident #17's bed.

Observation on 04/20/21 at 12:15 PM, revealed Resident # 17 was sitting on the bed wearing the same clothes with both wet pads and both wet sheets still on the bed. Resident #17's lunch tray was set up in front of her. Resident #17 was eating lunch. The smell of urine continued to be very strong in Resident # 17's room. The odor was strong enough to be evident in the hallway.

On 04/20/21 at 12:20 PM, an observation revealed Certified Nursing Assistant (CNA) #5 entered Resident # 17's room with linens in a clear plastic bag. CNA #5 closed the door to Resident # 17's room.

On 04/20/21 at 12:25 PM, observation revealed CNA #5 exited Resident # 17's room with the full clear plastic bag. Resident # 17 was sitting on the bed eating lunch wearing the same saturated clothes. The linens on the bed were clean and the bed was clean and neat.

On 04/20/21 at 12:30 PM, during an interview Resident #17 confirmed she was still wearing wet, urine-soaked clothes and saturated disposable brief. When asked if the CNA had left the same dress on but changed the brief, the resident pushed the lunch tray aside, stood up, pulled her dress up and stated "No she didn't" revealing a disposable brief which sagged down between Resident # 17's thighs almost to the resident's knees. The brief was saturated with urine.

On 04/20/21 at 12:40 PM, an observation revealed LPN #4 entered Resident # 17's room

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and removed the lunch tray while Resident # 17 sat on the bed wearing the wet dress and saturated brief. The strong odor of urine remained in the room.

On 04/21/21 at 02:47 PM, an observation of Resident #17 sitting on the side of the bed. Resident #17's brief and gown was saturated in urine. The urine had a strong odor. Resident #17 had three pink incontinent pads with dark brown stains.

During an interview on 04/21/21 at 02:47PM, with Resident #17 confirmed her brief was saturated in urine. Resident #17 said she does normally call the staff when she needs assistance. Resident#17 said the staff will stick their head in the room sooner or later. Resident #17 said "I know I stink but it's ok." Resident #17 said I do not get around like I used too. Resident #17 confirmed her incontinent pads had not been changed for several hours. Resident #17 said she did not want to bother the staff.

During an observation on 04/22/21 at 05:35 AM, with PCA #1 revealed Resident #17 lying in bed. Resident #17's gown and pink incontinent pad was saturated in brown urine. Resident #17 removed her brief and threw it in the garbage can. The room had a strong urine odor.

During an interview on 04/22/21 at 05:45PM, with PCA #1 confirmed Resident #17's pad was saturated with urine and dried brown stains. PCA #1 said the resident is a heavy wetter. PCA #1 said the resident took herself to the bathroom and removed her brief sometimes during the night. PCA #1 said she did not know the resident had removed her brief and laid down on the saturated

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pads.

During an interview on 04/22/21 at 10:24 AM, with LPN #2 revealed she made the CNA assignments for the 11-7 shift CNA's/PCA's. LPN #2 said PCA #1 was assigned to the front of the hall. LPN #2 said she worked on that hall earlier that night on the medication cart. she thought PCA #1 was making rounds. LPN #2 said another nurse came in at 11:00 PM. LPN #2 went to the 200 hall until 1:00 AM. LPN #2 said it is her responsibility to make sure the PCA's and CNA's provide ADL care to the residents. LPN #2 said she has been on the medication cart for the last three weeks and is unable to monitor the staff. LPN #2 confirmed the residents could develop pressure ulcers, UTI's and other complications for laying in urine for a long period of time. LPN #2 also confirmed the residents' incontinent briefs and incontinent pads should not have brown stains on them.

During an interview on 04/22/21 at 11:40 AM, with the Director of Nurses (DON) confirmed the resident's incontinent briefs and pads should not be saturated in brown tea colored urine. The DON said the resident could develop pressure ulcers, UTI's and other complications from laying in urine for several hours. The DON said this is unacceptable and will not be tolerated. The DON said the staff were educated to provide ADL care every 2 hours and as needed.

Record review of the Face Sheet revealed the facility admitted Resident #17 on 1/08/18 with the diagnoses that included Major Depressive Disorder, Neuromuscular Dysfunction of bladder and Congestive Heart Failure. The admission Minimum Data Set (MDS) with an Assessment

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Reference Date (ARD) of 02/14/21 revealed Resident#17 had a Brief Interview for Mental Status (BIMS) of 15 that indicated Resident #17 is cognitively intact.

Resident #16
Findings Include:

Review of the facility's Comprehensive Care Plan revealed Resident #16 has an increased risk for infection as evidenced by recent history of urinary tract infection, high risk for impaired skin integrity related to bowel and bladder incontinence and limited mobility. Resident #16 is also at risk for incontinence of bowel and bladder related to confusion, dementia, and impaired mobility.

During an Observation with PCA#1 on 04/22/21 at 05:37 AM, revealed Resident #16 was lying in bed with a saturated tea colored brief and incontinent pad. The room had a strong urine odor.

In an Interview with PCA #1 04/22/21 at 05:38 AM, confirmed the brief and pad was saturated in urine with dried brown stains on the brief and pads. PCA #1 said the resident is a heavy wetter. The PCA said Resident #16 was changed 2 hours ago.

In an interview on 04/22/21 at 10:24 AM, with LPN #2 revealed she made the CNA assignments for the 11-7 shift CNA's/PCA's. LPN #2 said the PCA #1 was assigned to the front of the hall. LPN #2 said she worked on that hall earlier that night on the medication cart.She thought the PCA was checking on the residents. LPN #2 said it is her responsibility to make sure the PCA's and CNA's provide ADL care to the residents. LPN #2 said

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she has been on the medication cart for the last three weeks and is unable to monitor the staff. LPN #2 confirmed the residents could develop pressure ulcers, UTI's and other complications for laying in urine for a long period of time. LPN #2 also confirmed the residents' incontinent briefs and incontinent pads should not have brown stains on them.

Record review of the Face Sheet revealed the facility admitted Resident #16 on 1/29/2010 with diagnoses that included Mixed incontinence, Benign prostatic hyperplasia, and Dementia. The admission MDS with an (ARD) of 01/14/21, revealed Resident#16 had a BIMS score of 6 which indicated Resident #16 is cognitively impaired.

Resident #101
Findings Include:

Review of the facility's comprehensive care plan revealed Resident #101 has increased risk for infection as evidenced by recent history of Pseudomonal urinary tract infection, benign Prostatic Hyperplasia with lower urinary tract symptoms, Urinary Retention and Impaired skin integrity related to bowel and bladder incontinence.

On 04/22/21 at 05:40 AM, an observation revealed Resident #101 lying in bed with head of the bed elevated. Resident #101 was non- verbal and confused and unable to make needs known. PCA #1 and SA observed Resident #101 lying in bed with a saturated brief. The brief and incontinent pads were saturated with tea colored urine and brown stains.

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In an interview on 04/22/21 at 05:41 AM, with PCA #1 said Resident #101 is a heavy wetter. PCA #1 said she tries to get to them as soon as she can. PCA #1 said the resident hit her in the mouth a few days ago so she did not provide care for him. "That's on me, I'll take that one."

During an interview on 04/22/21 at 05:46 AM, with Resident #101's roomate (Resident #85) confirmed the staff did not come in the room during the night to provide ADL care. Residents #85's last quarterly MDS dated 3/17/21, revealed a BIMS score of 15 indicating Resident #85 is cognitively intact. Resident #85 reported Resident #101 does not get ADL care often. Resident #85 stated Resident # 101 is unable to make his needs known. Resident #85 said he calls the staff often to clean Resident #101 and to assist with his meals. Resident #85 is the Resident council President for this facility.

In an interview on 04/22/21 at 10:24 AM,during an interview with the LPN#2 revealed she made the CNA assignments for the 11-7 shift CNA's/PCA's. The UM said the PCA #1 assigned to the front of the hall. LPN #2 said she worked on the 100 hall earlier that night on the medication cart. she thought the PCA's were making rounds. LPN #2 said another nurse came in at 11:00 PM. LPN #2 went to the 200 hall until 1:00 AM. LPN #2 said it is her responsibility to make sure the PCA's and CNA's provide ADL care to the residents. LPN #2 said she has been on the medication cart for the last three weeks and is unable to monitor the staff. LPN #2 confirmed the residents could develop pressure ulcers, UTI's and other complications for laying in urine for a long period of time. LPN#2 also confirmed the residents' incontinent briefs and incontinent pads should not

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have brown stains on them.

During an interview on 04/22/21 at 11:40 AM, the DON confirmed the resident's incontinent briefs and pads should not be saturated in brown tea colored urine. The DON said the residents could develop pressure ulcers, UTI's and other complications from lying in urine for several hours. The DON also said this is unacceptable and will not be tolerated. The DON said the staff were educated to provide ADL care every 2hrs and as needed.

Record review of the Face Sheet revealed the facility admitted Resident #101 on 4/25/17, with diagnoses that included Pseudomonal Urinary Tract Infection, Benign Prostatic Hyperplasia with lower urinary tract symptoms, Urinary Retention, and Impaired Skin Integrity. The admission MDS with an ARD of 3/25/19 revealed Resident#101 had a BIMS of 3 indicating Resident #101 is cognitively impaired.

Resident #55
Findings Include:

A record review of the MDS with ARD dated 2/25/21 section G revealed resident requires extensive assistance with ADL's.

A record review of Resident #55's Admission Record revealed diagnoses of Contracture right hip and Abnormal posture.

On 4/23/21 at 10:00 AM, in an interview and observation with Resident #55 revealed Resident #55 initially stated that staff had not given him a bath in 2 months. Resident #55 then stated that he had a bed bath last week by a night time CNA.

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A record review of the resident bath schedule revealed resident should get a bath on Monday, Wednesday and Friday. A record review of residents bath task shows resident did not get a bath in the last 7 days.

On 04/23/21 02:14 PM, in an interview with Resident #55 stated he did not get a bath before going to the hospital for surgery on 4/22/21.

On 04/23/21 02:40 PM, in an interview with CNA #2, stated that she helped CNA #6 get resident ready to go to the hospital. She stated she did not give resident bath that she help change resident brief and dress resident. She denied knowing if CNA#6 gave a bath to Resident #55.

On 04/23/21 02:48 PM, the SA phoned CNA #6 and did not get an answer. The SA was unable to leave a message.

On 4/23/21 at 3:07 PM, in an interview with LPN #2 stated the the nurses are supposed to check behind the CNA's and sign off behind the CNA's. She stated CNA#6 was supposed to give Resident # 55 a bath Wednesday morning. She looked at the sheet and confirmed there was no documentation of Resident #55 receiving a bath. She stated the nurses are responsible for checking behind the CNA's.

On 4/23/21 at 3:10 PM, in an interview with CNA #6 stated that she did not give Resident #55 a shower or bed bath. She stated Resident #55 refused a shower. She stated she just wiped his bottom, face, and under the arms. She stated she did not document in the computer because she got locked out of the system and was unable to

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F 600	Continued From page 11 chart. She stated she tried to notify the the nurse but was unable to. On 04/23/21 04:10 PM, in an interview with the DON stated residents should get a bath. He stated it is very important for residents to get a bath. He stated it can cause skin breakdown or infection. He stated CNA #6 did not come to him about being locked out of the system to chart.	F 600		