STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255243	A. BUILDING _____ B. WING _____	06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BILLDORA SENIOR CARE	314 ENOCHS ST TYLERTOWN, MS 39667

(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 survey from 06/24/19 through 06/27/19. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements of participation. The SA cited deficiencies at F-554, F-623, F-645 and F-656, F-809 and F880. The facility was licensed for 68 beds and had a census of 52 at the time of survey.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, record review, and facility policy review, the facility failed to assess a resident for self-administration of eye drops, Resident #39, for one (1) of 24 residents observed during the initial pool process. Findings include A review of the facility policy titled, "Self-Administration of Medication Policy", dated April 2017, revealed the interdisciplinary team was to determine if the practice (self-administer medications) was safe and would assess the resident. The policy revealed the team would determine before the resident exercises this right. Review of the medical record revealed no	F 554	F554 Resident Self-Admin Meds - Clinically Appropriate CFR(s): 483.10(c) (7) 1. Licensed Practical Nurse (L.P.N.) #1 removed eye drops from Resident #39 room on 6/24/19. Licensed Practical Nurse (L.P.N.) #1 explained to the resident the importance of informing the nurses of any medications that are brought into their room on 6/24/19. Facility Resident #39 was assessed for self- administration of eye drops on 6/27/19 by the Interdisciplinary Team. The team determined that resident #39 was not a candidate for self-administration of eye drops due to her inability to administer them properly	8/23/19

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

Electronically Signed | 08/07/2019

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F 554	Continued From page 1 assessment for Resident #39 to self-administer medications. An observation, on 6/14/19 at 11:05 AM, revealed a small green bottle of "Refresh Eye Drops" on Resident #39's bedside table. The bottle of eye drops did not have a label or name on it. An interview at this time with Resident #9 revealed the Refresh eye drops were hers and given to her by the eye doctor. Resident #39 said the nurse at the facility did not give the eye drops to her and the nurses don't know about it. A review of Resident #39's "Admission Record" revealed the facility admitted the resident on 12/05/18. A review of Physician's Orders for Resident #39 revealed an order, dated 12/05/18, for Refresh Tears solution one (1) drop both eyes every eight (8) hours as needed for cataracts. The eye drops did not have an order to self-administer or leave at the bedside. A review of Resident #39's "Baseline Care Plan", dated 12/05/18, section D, "Self Administer Medications", was marked "yes". The baseline care plan was signed by the Director of Nursing (DON) on 12/05/18. A review of Resident #39's comprehensive care plan revealed no mention of eye drops or the resident self-administering medications. An interview, on 06/26/19 at 3:17 PM, with the DON, revealed she was aware of Resident #39 having eye drops in her room and said the assessments would have been done by the MDS nurse. Further interview on 06/26/19 at 4:09 PM, with the	F 554	because of her impaired vision. On 7/9/19, the Office Manager mailed letters to resident families requesting to refrain from sending any over the counter medicines or prescriptions to residents. The Staff Development Nurse conducted a one on one in-service that was held on 6/27/19 with LPN #1 emphasizing the importance of following the facility polices and ensuring that medications are not kept in resident s room. 2. All facility residents have the potential to be affected by this practice. The Director of Nursing, Administrator, and Staff Development Nurse made rounds on 7/1/19, 7/2/19, 7/3/19, 7/5/19, 7/8/19, 7/9/19, 7 /10/19 and no other medications were identified during the observation. 3. The Director of Nursing and Staff Development Nurse conducted an in-service on 6/28/19 with nursing staff emphasizing the importance of not having medications in resident' s rooms unless the resident is deemed safe to self-administer and notifying nurses and/or supervisor immediately if any medications are found. 4. The Director of Nursing and Staff Development Nurse will make visual observations of resident rooms two (2) times a week for six (6) weeks starting on 8/1/19, ensuring medications are not being kept in resident' s rooms. Any problems identified will be addressed, corrected, and reported by the Administrator and Director of Nursing to the Quality Assurance Performance Improvement Committee monthly to maintain substantial compliance and	

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F 554	Continued From page 2 DON, revealed the only assessment completed related to self-administering medications was documented on Resident #39's form "Baseline Care Plan" on admission. On 06/27/19 at 9:11 AM, an interview with Licensed Practical Nurse (LPN) #2 revealed she had been Resident #39's nurse for about a year. LPN #2 said she did not know the resident had eye drops in her room that she was self-administering. LPN #2 also said she did not believe the resident to be capable of administering eye drops with proper use or technique. LPN #2 said if she had seen them she would have removed the medication, notified the family, and the charge nurse. On 06/27/19 at 10:37 AM, an interview with Registered Nurse (RN) #1/MDS Nurse, revealed she started working here in July of 2018 and said she was familiar with Resident #39. RN #1 said she had also completed Resident #39's last MDS assessment. She stated the resident was known to have eye drops, but the inter-disciplinary team (IDT) team did not complete an assessment and did not care plan Resident #39 using the eye drops by herself. RN #1 also stated that Resident #39 was very independent and when the staff would remove the eyedrops, the resident or her family would bring the eye drops back. RN #1 stated the care plan for Resident #39 would not address the issues of self-administering or Resident #39 continuing to bring more eye drops to her room. RN #1 then said the care plan should address Resident #39's continued self use of the eye drops and if an assessment determined that resident could self administer, there would need to be a care plan for that as well.	F 554	make changes to the plan of correction as necessary.	

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F 554	Continued From page 3 A review of Resident #39's admission Minimum Data Set (MDS), with an Assessment Reference Date of 12/12/18, revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated Resident 39 had a moderate cognitive impairment. A review of Resident #39's MDS, with an ARD date of 06/03/19, revealed a BIMS with a score of 15, which indicated no cognitive impairment.	F 554		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		8/23/19

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F 623	Continued From page 4 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	F 623		

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F 623	Continued From page 5 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review the facility failed to notify the family in writing and notify the ombudsmen of a transfer for an acute hospitalization stay for one (1) of three (3), hospitalizations reviewed, Resident #53. Findings Include:	F 623	F623 Notice Requirements before Transfer/Discharge CFR(s): 483.15 (c) (3)-(6) (8) 1. The Social Worker completed transfer/discharge letter for Resident #53 and a copy was given to Resident Representative on 6/29/19. The	

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F 623	Continued From page 6 Review of the Bed Hold/ Temporary Leave Policy revealed at the time of transfer for hospitalization or therapeutic leave, the facility will provide the resident and or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. Record review of the Minimum Data Set (MDS) revealed Resident #53 was sent to the hospital with anticipation to return on 04/27/2019, 05/06/2019, and 05/31/2019. There was no documented evidence of written notification to the family and Ombudsman of the transfers for Resident #53. During an interview, on 06/26/19 at 10:33 AM, the Social Worker revealed the facility had not notified the family in writing in a language they could understand, of the transfers for Resident #53. The Ombudsmen also was not notified in writing, of the resident going to the hospital. A review of the facility's Face Sheet revealed the facility admitted Resident #53, on 04/25/2019, with diagnoses, which included Major Depressive Disorder, Atrial Fibrillation and Hypertension. A review of Resident #53's Quarterly MDS, with an Assessment Reference Date (ARD) of 05/31/2019, revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident is cognitively intact.	F 623	Ombudsman was notified of the transfer of Resident #53 on 7/15/19 by the Social Worker. The Social Worker was in-serviced on 7/3/19, by the Administrator on ensuring transfer/discharge letters are provided for Resident/Resident Representative that are transferred or discharged from the facility and a copy of the transfer/discharge letters are sent to the Ombudsman. 2. All facility residents have the potential to be affected by this practice. The Social Worker performed audits of transfers to the hospital for the past 30 days on 7/5/19, to ensure that the transfer/discharge letter had been provided to the Resident/Resident Representative and that the Ombudsman had been notified. No other issues were identified during the audit. 3. The Administrator conducted an in-service on 7/3/19 with the Social Worker and the Medical Records Clerk which included emphasizing the importance of ensuring transfer/discharge letters are provided for all Residents/Resident Representative transferred/discharged from facility and upon transfer copies of the transfer/discharge log are sent to the Ombudsman. 4. The Administrator and the Social Worker will observe the facility' s transfer/discharges and perform audits one (1) time a week for six (6) weeks starting on 7/5/19, ensuring that transfer/discharge letters are provided for all Residents/Resident Representative being transferred/discharged and a copy	

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F 623	Continued From page 7	F 623	of the log is provided to the Ombudsman. Any problems identified will be addressed, corrected, and reported by the Administrator and Social Worker to the Quality Assurance Performance Improvement Committee monthly to maintain substantial compliance and make changes to the plan of correction as necessary.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility;	F 645		8/23/19

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F 645	Continued From page 8 and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.	F 645		

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F 645	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and policy interview the facility failed to accurately complete the Pre-Admission Screening and Resident Review (PASRR) on one (1) of three (3), PASRRs reviewed, Resident #29. Findings Include: Record review of the Preadmission Screening and Resident Reviews (PASSR) program/policy revealed the PASSR level II is advocacy program mandated by the federal centers for Medicare and Medicaid Services (CMS) to ensure that nursing home applicants and residents with mental illness and intellectual/developmental disabilities are appropriately placed and receive necessary services to meet their needs. PASSR Level II guidelines require that nursing homes address behavioral health needs of residents, including residents with Mental Illness (MI), Intellectual disability (ID) and conditions related to intellectual disability (referred to in regulatory language as related conditions (RC). These are the target conditions for PASSR. Behavioral health needs, when present, must be identified through a comprehensive evaluation process referred to as Preadmission Screening and Resident Review evaluations assessment: whether the individual requires the level of care provided in an institutionally based setting and if so whether an NF is the appropriate institution. Once a person with a suspected or known diagnosis is identified through the Level I portion of the PAS application for LTC, a Level II evaluation must be performed to determine whether the individual has special treatment needs associated with the MI and or MR/RC. The	F 645	F645 PASARR Screening for MD and ID CFR(s): 483.20(k) (1) - (3) 1. On 6-28-19, the Social Worker requested for Level II screening to be completed on Resident #29. The Social Worker was in-serviced on 7/3/19, by the Administrator to ensure Level II screenings are being performed upon admission on residents with a psychiatric diagnosis and/or psychotropic medication usage, Level II screening should be done with changes in resident s condition and as part of the pre-admission screening process. 2. All facility residents have the potential to be affected by this practice. The Social Worker performed an audit on 7/15/19 for nine (9)out of 52 residents with psychiatric diagnosis and psychotropic medications to ensure that Level II screenings had been completed as necessary. No other issues were identified during the audit. 3. The Administrator conducted an in-service on 7/3/19, with the Social Worker which included emphasizing the importance of performing Level II screenings on residents upon admission and/or a change of condition with a supporting psychiatric diagnosis or psychotropic medication usage. The screening process will be done prior to admission to include review of psychiatric diagnosis and psychotropic medication usage. Changes in condition are reviewed in the daily stand up meetings with the Interdisciplinary Team. The	

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F 645	Continued From page 10 term PASSR is used interchangeably with the term Level II evaluation. The Level I is the initial screen which identifies persons who are subject to Level II evaluations. Record Review of the Preadmission Screen and Resident Review (PASSR) for Resident #29, documented upon admission (02/08/17) revealed the resident did not have a mental illness noted upon admission. Record Review of Resident #29's Admission physician's orders, dated 02/08/2017, revealed the resident was admitted on Seroquel 12.5 milligram (mg) daily at 3:00 PM for a diagnosis (DX) of Psychotic Disorder. Record Review of the physicians Orders Dated 06/26/19, revealed the resident was ordered Seroquel 25 mg twice a day and 50 mg at bedtime for Psychosis. During an interview, on 06/26/2019 at 3:30 PM, the Social Services Director confirmed The PASSR on admission was inaccurate. The Social Services Director confirmed Resident #29 was admitted with a psychiatric diagnosis and was ordered Seroquel for Psychosis. A review of the facility's Face Sheet revealed the facility admitted Resident #29 on 02/08/2017, with diagnoses, which included Psychosis, Anxiety and Atrial Fibrillation. A review of Resident #29's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/20/2019, revealed Resident #29 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident	F 645	Medical Records Nurse will notify the Social Worker of any new psychotropic medications or new psychiatric diagnosis that would require a Level II screening. The Medical Records Nurse was in-serviced on 7/3/19 by the Administrator with emphasis on notifying the Social Worker of any new psychotropic medications or new psychiatric diagnosis. 4. The Administrator and the Social Worker will observe Level II screenings and perform audits one (1) time a week for six (6) weeks starting on 8/2/19, to ensure that Level II screenings are requested for all residents being admitted and/or a change of status with a supporting psychiatric diagnosis. Any problems identified will be addressed, corrected, and reported by the Administrator and the Social Worker to the Quality Assurance Performance Improvement Committee monthly to maintain substantial compliance and make changes to the plan of correction as necessary.	

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F 645	Continued From page 11 had moderate cognitive impairment.	F 645		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 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	F 656		8/23/19

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	255243	A. BUILDING _____ B. WING _____	06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BILLDORA SENIOR CARE	314 ENOCHS ST TYLERTOWN, MS 39667

(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 656	Continued From page 12 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. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, record review, and facility policy review, the facility failed to develop a care plan related to self-administered eye drops for one (1) of 22 resident care plans reviewed, Resident #39. Findings include: A review of the facility policy titled, "Reviewing and Revising the Care Plan", revised 02/2017, revealed the Comprehensive Care Plan must be developed within seven (7) days after the completion of the comprehensive assessment, and that the care plan would be prepared by the inter-disciplinary team that had determined the resident's needs. A review of Resident #39's current Comprehensive Care Plan revealed no mention of eye drops, or the resident self-administering medications. A review of Resident #39's "Baseline Care Plan", dated 12/05/18, section D, "Self administer medications", was marked "Yes". The baseline care plan was signed by the Director of Nursing (DON) on 12/05/18. An observation and interview, on 06/24/19 at 11:05 AM, revealed a small green bottle of "Refresh" eye drops on Resident #39's bedside	F 656	F656 Develop/Implement Comprehensive Care Plan CFR (s): 483.21 (b) (1) 1. Licensed Practical Nurse (L.P.N.) #1 removed the eye drops on 6/24/19 from Resident #39 room. Licensed Practical Nurse (L.P.N) #1 explained to the resident the importance of informing the nurses of any medications that are brought into their room on 6/24/19. Facility Resident #39 was assessed for self- administration of eye drops on 6/27/19 by the Interdisciplinary Team and it was determined that Resident #39 was not a candidate for self-administration of eye drops due to her inability to administer them properly because of her impaired vision. The care plan was updated to reflect her impaired vision. No other resident's are able to self-administer. 2. All facility residents have the potential to be affected by this practice. The Director of Nursing, the Staff Development Nurse and the Administrator made rounds on 7/1/19, 7/2/19, 7/3/19, 7/5/19, 7/8/19, 7/9/19, 7/10/19 and no other medications were identified during the observation. 3. The Director of Nursing and the Staff Development Nurse conducted an	

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F 656	Continued From page 13 table. The bottle did not have a label or name on it. Resident #39 revealed the Refresh eye drops were hers, that were given to her by her eye doctor, and the nurse at the facility did not administer the eye drops to her. A review of Physician's Orders for Resident #39 revealed an order, dated 12/05/18, for Refresh tears solution one (1) drop both eyes every eight (8) hours as needed for cataracts. The eye drops did not have an order to self-administer or leave at bedside. In an interview, on 06/26/19 at 3:17 PM, the DON said she was aware of Resident #39 having eye drops in her room, and said the assessments would have been done by the Minimum Data Set (MDS) nurse. Upon further interview, on 06/26/19 at 4:09 PM, the DON stated the only assessment completed related to self-administering medications was documented on Resident #39's "Baseline Care Plan" on admission. On 06/27/19 at 10:37 AM, an interview with Registered Nurse RN #1/MDS Nurse, revealed she was familiar with Resident #39 and had completed Resident #39's last MDS assessment. She stated the resident was known to have eye drops, but the inter-disciplinary team (IDT) team did not complete an assessment and did not care plan Resident #39 using the eye drops by herself. RN #1 said the care plan should address Resident #39's continued self-use of the eye drops and if an assessment determined that resident could self- administer, there would need to be a care plan for that as well.	F 656	in-service on 6/28/19 with nursing staff emphasizing the importance of not having medications in resident 's room unless the resident is deemed safe to self-administer medication. 4. The Director of Nursing and the Staff Development Nurse will observe room rounds two (2) times a week for six (6) weeks starting on 8/1/19, ensuring medications are not being kept in resident s room. Any problems identified will be addressed, corrected, and reported by the Administrator and the Director of Nursing to the Quality Assurance Performance Improvement Committee monthly to maintain substantial compliance and make changes to the plan of correction as necessary.	
F 809	Frequency of Meals/Snacks at Bedtime	F 809		8/23/19

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F 809 SS=E	Continued From page 14 CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility statement review, the facility failed to obtain approval from the Resident Counsel related to timing of meals, evening meals to morning meals, and provide a substantial snack between those meal times. Based on two (2) of four (4) days observed, and 10 Resident Counsel members interviews. Findings Include: Review of the facility statement, concerning Meal times, revealed Breakfast started at 7:00 AM and dinner started at 4:00 PM. There is a 15 hour	F 809	F809 Frequency of Meals/Snacks at Bedtime CFR(s): 483.60 (f) (1)-(3) 1. The Dietary Manager, the Director of Nursing, and the Administrator held a meeting with Resident Council, on 6/26/19. The daily meal times were revised according to Resident Council request. Dietary staff was in-serviced on 6/28/19, by the Dietary Manager on new meal times 7:00 a.m., 11:00 a.m., and 5:00 p.m. Substantial Snacks will be provided between meals and bedtime by dietary and nursing starting on 8/5/19.	

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F 809	Continued From page 15 lapse in between dinner and breakfast, unless a substantial snack was served in between. During resident group meeting, on 06/25/2019 at 10:09 AM, the members of the Resident Council complained about supper time. The council said that there's too much time between supper and breakfast. The group said supper comes out at 4:00 PM, and breakfast is at 7:00 AM. Resident #12 said he talked to the Administrator and the Director of Nursing (DON) and asked them if the facility could provide the residents a large breakfast, small lunch and a large dinner to hold the residents until breakfast the next day. Resident #41, the Resident Council President, said she has been in other facilities and she had never eaten dinner that early. The residents also stated they did not eat dinner at 4:00 PM at home. Observation, on 06/25/19 at 3:40 PM, revealed the tray line temperatures were completed and the first trays to the rooms came out at 4:03 PM. During an interview, on 06/26/19 at 2:23 PM, the Dietary Manager confirmed the evening meal comes out at 4:00 PM and breakfast starts at 7:00 AM. The Dietary manager said the resident will get a snack in between meals if they ask for one. the Dietary manager confirmed the residents that did not ask for a snack did not get one. Observation, on 06/26/2019 at 4:00 PM, confirmed the supper meals came out on the floor to be served. During an interview, on 06/30/19 at 3:35 PM, the Administrator confirmed the evening meals started at 4:00 PM and breakfast at 7:00 AM. The	F 809	2. All facility residents who receive meals and snacks in dietary have the potential to be affected by this practice. The Dietary Manager made rounds on 7/1/19, 7/2/19, 7/3/19 and 7/5/19 during all three meals observing the times that meals were bought out to residents. No issues or concerns were identified or voiced during the observation. 3. The Dietary Manager conducted an in-service on 6-28-19, with dietary staff which included emphasizing the changes in meal serving times approved by Resident Council and reviewed importance of substantial snacks being provided. Nursing staff was in-serviced by Staff Development Nurse on 6/26/19, on the new meal times and substantial snacks. 4. The Dietary Manager, the Director of Nursing, and the Staff Development will observe meal times being served three (3) times a week for six (6) weeks starting on 8/5/19, to ensure meals are being served at the appropriate times as requested by Resident Council. Resident satisfaction of meal service will be reviewed monthly at Resident Council meeting and through random interviews with residents. Any problems identified will be addressed, corrected, and reported by the Administrator and Dietary Manager to the Quality Assurance Performance Improvement Committee monthly to maintain substantial compliance and make changes to the plan of correction as necessary.	

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F 809	Continued From page 16 Administrator said the residents had never complained about not having enough food to last through the night. Members that were present at Resident Group Meeting was Resident #3, #11, #12, #19, #23, #30, #39,#41, #45, and #52.	F 809		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable 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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		8/23/19

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F 880	Continued From page 17 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, staff interview, record review, and facility policy review, the facility failed to prevent the possible spread of infection while	F 880	F880 Infection Prevention and Control CFR(s): 483.80 (a) (1) (2) (4) (e) (f)	

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F 880	Continued From page 18 delivering ice to resident rooms for one (1) of three (3) observations for one (1) of four (4) days of survey. Findings include: Review of the facility policy titled, "Ice machines and Ice Storage Chests", dated 07/17, revealed to help prevent contamination of ice machines, staff shall follow these precautions that included to keep the access doors or storage container tops closed when not in use and keep the ice scoop in a covered container when not in use. An observation, on 06/24/19 at 2:54 PM, revealed Certified Nursing Assistant (CNA) #1 was passing ice to resident rooms using an ice chest and scoop. CNA #1 opened the ice chest and reached inside the chest for the ice scoop. She scooped the ice into the cup and set the ice scoop back in the ice chest with the ice, left the ice chest open, and walked into a resident's room. CNA #1 came back to the cart and picked up the scoop out of the ice chest, placed the scoop in a bag, and closed the lid. An interview at this time with CNA #1 confirmed she left the ice chest open with the ice scoop in the ice. CNA #1 said the facility policy was to place the scoop in the bag separate from the ice when not using it. Review of the "Employee Inservice Attendance Sheet" for CNA #1 revealed she attended the meetings on infection control on 04/10/19, and 01/21/19. On 06/26/19 at 3:39 PM, an interview with the Director of Nursing (DON) revealed the staff have regular inservices on infection control and the ice	F 880	1. On 6/24/19, Certified Nursing Assistant (CNA)#1 was in-serviced by the Staff Development Nurse on the importance of ensuring the ice hydration lid is closed between each use and that the scoop is placed in a bag separate from the ice when not in use. The Dietary Manager ordered a new scoop and guardian system on 7/10/19 which is for placement of the ice scoop when not in use. 2. All facility residents have the potential to be affected by this practice. The Staff Development Nurse made rounds on 6/28/19, 7/1/19, 7/2/19, 7/3/19 and 7/4/19 to verify that staff was following the correct policy and procedures while passing ice and hydration. No issues were identified during the observation. 3. The Director of Nursing and the Staff Development Nurse conducted an in-service on 6/28/19, 7/1/19 with nursing staff emphasizing the importance of following the company polices, ensuring that ice hydration cart lid is closed and scoop is in appropriate bag at all times when not in use. 4. The Director of Nursing and the Staff Development Nurse will observe two (2) times a week for six (6) weeks starting on 8/5/19, to ensure employees using the hydration cart and to ensure the above proper procedures are being followed. Any problems identified will be addressed, corrected, and reported by the Administrator and Director of Nursing to the Quality Assurance Performance Improvement Committee monthly to	

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F 880	Continued From page 19 scoop being left in the ice chest would be an infection control concern. On 06/27/19 at 9:48 AM, an interview with the Staff Development Nurse confirmed CNA #1 attended inservices when infection control education was covered.	F 880	maintain substantial compliance and make changes to the plan of correction as necessary.	

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	255243	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/27/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70 (a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 08/05/2019

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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E 000	Initial Comments ********** Survey conducted on 06/27/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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