STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	03/26/2021

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

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification along with five (5) complaint investigations (CI), CI MS #17199, CI MS #17230, CI MS #17351, CI MS #17367, and CI MS #17594 from 3/23/21 to 3/26/21. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA did not substantiate CI #17199 for Abuse, Quality of Care and Resident assessment, CI #17230 for Misappropriation of Property, CI #17351 for poor quality of care and dietary services, CI #17367 for poor quality of care and /discharge and CI #17594 for refusing to release a resident's medical records due to lack of evidence with no citations related to the complaint. The SA also cited F561, F584, F608, F609, F677, F689, F759, F880 and F921 during the survey. The census at the time of the survey was 68 and the facility held a license for 109 beds.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		5/17/21

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

Electronically Signed | 05/19/2021

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F 561	Continued From page 1 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, policy review, dietary meal slips, and Resident Rights, the facility failed to honor resident choices related to food preferences for one (1) of 17 residents, Resident #46. Findings include: Review of the facility's Resident's Rights, not dated, revealed the resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. Review of the facility's "Meal Services policy for Alternate Foods for Food Preferences", not dated, revealed substitutes of similar nutritive value are offered to resident's who refuse food served. The procedure revealed that the dining service department prepares an alternate food choice to be offered to residents who refuse food at meals. The nursing assistant, on observing that a resident is refusing a food, offers the alternate food to the resident. The alternate food	F 561	1. On 3/24/2021 the Dietary Manager reviewed food preferences with Resident #46 to ensure that her likes and dislikes were noted and an alternate food would be offered or if refused by the resident at that time. A new meal ticket card and care plan was updated accordingly on 3/24/2021. 2. Residents that receive meal trays from the dietary department have the potential to be affected. 3. On 3/24/2021 the dietary staff to include cooks and dietary aides were in serviced by the dietary manager regarding the facility policy "Alternate foods and preferences" and the requirement to offer substitutes to residents that refusing food and not to serve documented dislikes to residents. On 3/31/2021 observations of meal trays and tickets were started by the dietary manager ensure that dislikes were	

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F 561	Continued From page 2 is delivered to the resident within 15 minutes of the request. Review of Resident #46's Care Plan, revealed on 8/26/2020, an intervention was initiated to honor Resident' #46's food preferences. Review of the Resident #46's daily meal tickets, dated 3/25/2021, revealed that grits were listed as a dislike for breakfast and macaroni and cheese was listed as a dislike for lunch and dinner. Record of the Admission Record revealed the facility admitted Resident #46 on 1/1/20 with the diagnoses which included End Stage Renal Disease, Congestive Heart Failure, Type II Diabetes, Essential Hypertension, Hemiplegia and Hemiparesis following a Cerebral Infarction. The Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 02/11/2021, revealed Resident #46 had a score of 15 on the Brief Interview for Mental Status (BIMS) indicating Resident #46 was cognitively intact. In an interview with Resident #46, on 03/23/2021 at 4:30 PM, revealed she was not happy with her meals. Resident #46 stated she gets foods that she does not like. On 03/24/2021 at 1:50 PM, in an interview with Resident #46 revealed that she did not enjoy her lunch. She stated that she had received macaroni and cheese and she does not like it. She stated she had told them she does not like macaroni and cheese, but they continue to serve it to her. On 03/24/2021, at 2:00 PM, in an interview with Dietary Employee #1/Dietary Manager regarding	F 561	not served to the residents. 3/31/2021. Residents that received a meal tray were interviewed by dietary manager on 3/24/2021 for food preferences and tray cards and care plans updated as needed. 4. On 5/14/2021 an in-service was provided by the Director of Nursing for nursing staff including certified nursing assistants instructing CNA's that when preparing to deliver the meal tray for residents to review the dislike section on the meal ticket. If a dislike has been served notify Dietary department and request an alternate. Documented Monitoring will be conducted by the dietary manager and nursing staff beginning 5/14/2021to include observation of the meal tray and not serving of dislikes foods to the resident. The monitoring tool for the dietary department will be documented on a form titled "Trayline Checklist" for twice weekly x four weeks then twice a month for one ; then monthly, starting on 3/31/2021. The monitoring for nursing will be documented on a form titles "Resident Food Preferences Likes/Dislikes daily for two weeks, then weekly x one month, then monthly for two months, then on a random basis to ensure continuing compliance, started on 5/14/2021. The results of the monitoring will be brought to the daily stand up meeting started on 5/14/21 weekly x 1 month, and then monthly x 1 to Quality Assurance Performance Improvement Committee for review and recommendations and ongoing basis as needed.	

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F 561	Continued From page 3	F 561		

resident food preferences, she stated that residents have the opportunity to provide information about their likes and dislikes of certain foods. She stated that these preferences are listed on the resident's dietary meal slips for the dietary servers to use as a guide for preparing the resident's plates.

On 03/24/2021 at 2:15 PM, in an interview with Certified Nursing Assistant (CNA) #1, she stated that she had served Resident #46's her lunch tray today. She confirmed that the resident's lunch tray included macaroni and cheese.

On 03/25/2021 at 8:15 AM, observed Resident #46 sitting in a wheelchair in room, while waiting to go to dialysis. The resident's breakfast was on the overbed table in front of her. Her grits were uneaten. The resident stated she did not like grits and had asked that she not receive grits for breakfast. The resident stated that when she tells the CNA's that she does not like a food that is served, she does not receive anything else.

On 03/25/2021 at 9:00 AM, in an interview the with Dietary Employee #1/Dietary Manager, she stated she was aware that Resident #46 had received the macaroni and cheese yesterday. She stated she was unaware that the resident had received grits this morning for breakfast. The Dietary Manager stated she realizes it is important to serve the residents foods that they like. She further stated that if resident's receive foods that they do not like, they will probably not eat, and this can lead to weight loss.

On 3/25/2021 at 9:10 AM, in an interview with Registered Nurse (RN) #1/Director of Nursing (DON), stated when residents receive the foods

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F 561	Continued From page 4 they do not like, it can lead to weight loss and when diabetic residents do not eat, it can cause their blood sugars to drop. The DON confirmed food choices are a part of the Resident's Rights. On 03/24/21 at 2:00 PM, in an interview with Dietary Employee #1/Dietary Manager regarding resident food preferences, she stated residents have the opportunity to provide information about their likes and dislikes of certain foods. She stated these preferences are listed on the resident's dietary meal slips for the dietary servers to use as a guide for preparing the resident's plates.	F 561		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		5/17/21

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F 585	Continued From page 5	F 585		

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being

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F 585	Continued From page 6 investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, record review, and facility policy review the facility failed to maintain safekeeping of resident's belongings for one (1) of 17 residents, Resident #29. Findings include:	F 585	1. On 3/23/21 at 1:30 p.m. the Director of Nursing located Resident #29 reported missing black coat in resident's closet. resident #29 verified that the coat found by the DON was the coat he reported as missing.	

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F 585	Continued From page 7 The facility's, "Social Services Standard Missing Item" policy, dated 08/2017 revealed the facility will take reasonable preventing measures to prevent loss or damage of resident's possessions. During an interview on 3/23/21 at 11:50 AM, Resident #29 stated his black leather coat came up missing in May 2020. Resident #29 stated he informed Social Services (SS) #2. Resident stated she told me she would check on it. Resident #29 stated that SS #2 did not get back with him. Resident #29 stated he spoke with SS #2 in May 2020. On 3/26/21 SS #2 at 11:00 AM, she stated Resident #29 did not report the missing leather jacket but confirmed she would check the log. We usually do a grievance and ask resident for a description. SS #2 stated this is my first-time hearing about Resident #29's black leather coat. SS #2 also stated, "if an item that is on their inventory sheet comes up missing , the facility will replace it". On 3/26/21 at 11:20 AM ,in an interview with SS #1 stated, Resident #29 reported the missing jacket to SS #2 and did not want to complete a grievance for it. On 3/26/21 at 11:25 AM, in an interview with SS #2, stated "I remembered that he did say something about a black missing jacket." SS #2 stated Resident #29 did not want to complete a grievance for the missing jacket. She stated she looked in his closet for the black jacket, but she did not document about the missing jacket. On 03/25/21at 02:49 PM, in an interview with	F 585	2.Residents with belongings have the potential to be affected. Residents were interviewed by social services on 3/23/2021 about any missing items. No missing items were reported. 3.On 5/14/2021 at 12:30 p.m. an in-service was initiated by the outside Registered Nurse, for the administrator, Director of Nursings, Social Service Director and social service staff on the facility policy ,"Grievance Concern Comment Standard" Grievances will be logged on a form "Grievance/Concern/Comments Log" Any grievances will be discussed in the daily stand up meeting on an as needed basis, weekly x 4 weeks, or until resolved. The Administrator will be notified immediately of any reports of allegations of misappropriation of resident property. 4. Monitoring will be conducted by the Social Services Director on an ongoing basis beginning 5/14/2021 to ensure that residents who have reported missing items will have a grievance form completed per facility policy with a follow up presented to the resident regarding the outcome of the investigation. Any grievances and the grievance log will be taken to the weekly high risk meeting x 4 weeks, then monthly to Quality Assurance Performance Improvement Committee meeting for review and recommendations, trending and tracking, until resolved beginning 5/14/21.	

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F 585	Continued From page 8 Resident # 29, he denied being asked if he wanted to complete a grievance for the missing jacket. He stated he was not informed if they looked for his jacket. He denied SS #2 ever returning to him room to inform him of his status of the black jacket. On 3/25/21at 4:15 PM, in an interview with the Administrator, she stated she was told about the missing jacket today. She stated therapy bought it for Resident #29 for Christmas and the last time he saw it was in May. The Administrator stated the facility will get his size and will replace the jacket. Usually, we do a report on missing items and if we cannot find it, we call the family and replace it. The Administrator confirmed the resident did have a black jacket with zippers on it. Record review of the Admission Record revealed the facility admitted Resident #29 on 5/19/15 with diagnoses that include Hemiplegia and Hemiparesis and Type 2 Diabetes. A review of Resident #29's Minimum Data Set (MDS) with and Assessment Reference Date (ARD) of 1/13/21, revealed Resident #29's Brief Interview of Mental Status (BIMS) Score was 14, indicating he was cognitively intact.	F 585		
F 608 SS=D	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include	F 608		5/17/21

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F 608	Continued From page 9 but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, record reviews, and facility policy review the facility failed to report an allegation of marijuana use in a timely manner to local police department and the Attorney General's Office for one (1) of 17 residents reviewed, Resident #25. Findings include: A review of the facility's, "Policy & Procedure for Reporting suspected crimes under the Federal Elder Justice Act" section revealed it is the policy of the facility to comply with the Elder Justice Act (EJA) about reporting a reasonable suspicion of a crime under section 1150B of the Social Security	F 608	1. The facility administrator started an investigation on 01/06/2021 when notified by hospital of positive results of drug screen for opiates and marijuana on resident #25. 2. Residents at the facility have the potential to be affected. 3. On 5/14/2021at 12:30 p.m. the facility administrator, Director of Nursing, Social services Director and Social services staff were in serviced by the outside registered nurse, who is retired state surveyor and nurse consultant, and certified Infection	

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F 608	Continued From page 10 Act, as established by the patient protection and affordable care act (ACA). It is the policy of the facility to notify local law enforcements of any suspected crime that occurs at the facility. During an interview on 3/25/21 at 09:46 AM, with Resident #25, reported to the State Agency (SA) he was sent to the local hospital because he was nauseated and had tremors. The resident stated while at the hospital he tested positive for Marijuana and opioids. Resident #25 stated at first, he did not want to reveal where he got the drugs from. The facility assured him he would not get in trouble if he told the truth. The resident said Maintenance Man #3 sold him the Marijuana. Resident #25 said he paid $20.00 a cigarette. A review of the facility's investigation revealed Resident #25 stated Maintenance Man #3 came to his room while on Covid-19 isolation and let him know that he was selling Weed. Resident #25 states he began to buy the Marijuana from Maintenance Man #3 since that time. Resident #25 reported he spent $140.00 (1st time= 30.00, 2nd time =$30.00, 3rd time =$ 30.00, 4th time =$10.00, 5th time = $ 20.00, 6th time = $ 20.00) with Maintenance man #3 on Marijuana. Resident #25 said he has never purchased Marijuana from anyone but him. During an interview on 03/25/21 at 10:51 AM, with the Administrator revealed the local hospital called in the allegation on 1/6/21. The Administrator stated the hospital informed her Resident #25 tested positive for Opioids and Marijuana. The Administrator said the facility initiated an investigation done by the previous Director of Nurses (DON). The Administrator confirmed the facility failed to report this crime to	F 608	control nurse, on facility policies, "Freedom of Abuse Neglect and exploitation and reporting under the Elder Abuse Act. Any further incidents of suspected or alleged violations, and investigation will be initiated by the facility administrator and will be reported to the local police the state attorney general's office and other state agencies as required beginning 05/14/2021. 4. Violations will be logged on a form titled "Adverse Events" An emergency Quality Assurance Performance Improvement meeting will be held. The investigation of findings and adverse event log will be reported to the Quality Assurance Performance Improvement Committee on an ongoing basis for review and recommendations, as needed on an emergency basis. If violations occur the violations and form titled "Adverse Events" will be brought to daily stand up times 2 weeks, then weekly to High Risk meeting, then to monthly Quality Assurance Performance Meeting til investigation is complete starting on 05/14/2021.	

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F 608	Continued From page 11 the local police department or the Attorney General's office. In an interview with the maintenance Man #3 on 03/25/21 at 11:30 AM ,he stated he did not sell marijuana to Resident #25. Maintenance man #3 said Resident #25 could have received the marijuana from Resident #25's brother. Maintenance Man #3 also revealed the residents window was close to the street. Resident #25 brother came to his room window often. The Maintenance Man #3 said the facility drug tested him and he was negative. The Maintenance Man #3 also stated he did not talk to resident #25 often. The Maintenance Man #3 said he called the Corporate office and explained he felt the facility accused him of something that was not true. The Corporate Office Director informed the Administrator to allow him to come back to work because the allegation was not substantiated. Record review of the Face sheet revealed the facility admitted Resident #25 on 3/07/18, with diagnoses that included Unspecified Nephritic Syndrome with unspecified Morphologic. Intervertebral Disc Degeneration Lumbar region and Depressive disorder. Record review of the admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 01/18/21, revealed Resident#25 had a Brief Interview of Mental Status (BIMS) of 15 that indicated Resident #25 is cognitively intact.	F 608		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609		5/17/21

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F 609	Continued From page 12 must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, record reviews, and facility policy review the facility failed to report an allegation of marijuana use in a timely manner to the State Agency for one (1) of 17 residents, Resident #25. Findings include: Record review of the facility's, "Abuse, Neglect and Exploitation" policy, revised November 2017, revealed it is the policy of this facility to provide	F 609	1. The facility administrator started investigation on 1/06/2021 when notified by hospital of positive results of drug screen for opiates and marijuana on resident #25. 2. Residents at the facility have the potential to be affected. 3. On 5/14/2021, at 12:30 pm, the facility Administrator, Director of Nursing, Social Services Director, and Social Services	

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F 609	Continued From page 13 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 resident property. The facility will report all alleged violations to the administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframe's: immediately, but later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in seriously bodily injury or not later than 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within five (5) working days of the incident, as required by state agencies. Review of the State Agency (SA) call log revealed the state agency had not received any calls on the hotline of a marijuana allegation from the facility on 1/6/2021. The State Agency (SA) received a call on 1/15/21 at 1:25 PM reporting a Certified Nursing Assistant (CNA) issue of drug use and harassment of staff due to being terminated. In an interview on 03/25/21 at 10:51 AM, with the Administrator revealed the local hospital informed her Resident #25 tested positive for Opioids and Marijuana on 01/06/21. The Administrator stated the facility initiated an investigation completed by the previous Director of Nurses (DON). The Administrator also stated the previous DON called the allegation in to the SA on 1/06/21. The	F 609	Staff were inserviced by Retired State Surveyor, Certified Infection Control Registered Nurse consultant on the facility policies, "Freedom of Abuse, Neglect, and Exploitation" and reporting under the Elder Abuse Act. Any further incidents of suspected or alleged violations will warrant an investigation to be initiated by the facility Administrator, and will be reported to the local police department, the State Attorney General's office, and other state agencies as required. Violations will be logged on a form titled "Adverse Events" and and brought to an emergency Quality Assurance Performance Improvement meeting as needed. 4. Violations will be logged on a form titled "Adverse Events" An emergency Quality Assurance Performance Improvement meeting will be held. The investigation of findings and adverse event log will be reported to the Quality Assurance Performance Improvement Committee on an ongoing basis for review and recommendations, as needed on an emergency basis. If violations occur the violations and form titled "Adverse Events" will be brought to daily stand up times 2 weeks, then weekly to High Risk meeting, then to monthly Quality Assurance Performance Meeting til investigation is complete starting on 05/14/2021.	

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F 609	Continued From page 14	F 609		

Administrator confirmed she did not follow up to confirm the initial report was received, and she did not report the results of the investigation within five (5) working days of the incident. The Administrator also stated she failed to report the allegation to the local police and Attorney Generals (AG) Office. The Administrator stated the investigation is still in progress and the facility had not completed the investigation. Resident #25 was interviewed and refused to reveal the person's name he got the marijuana from. The Administrator stated she gave him three (3) different employees names before he said he was going to be honest. The Administrator stated Resident #25 said he was afraid Maintenance Man #3 would retaliate. The Administrator stated all the staff was tested that worked on Resident #25's unit. Only one (1) CNA tested positive and was terminated. Maintenance Man #3 was suspended until an investigation was completed. The Administrator stated the Maintenance Man #3 said he did not sell marijuana to Resident #25. Maintenance Man #3 did not test positive and was approved to return to work by the corporate office because the facility could not substantiate, he sold the Marijuana to Resident #25.

During an interview, on 3/25/21 at 11:00 AM, with Social Worker #2 revealed Resident #25 had not been out of the facility with anyone because of the COVID-19 restrictions. Social worker #2 stated Resident #25 received several outside supervised visits. Social Worker #2 also stated Resident #25 received a visit from his Brother-in-law on October 9 and 16. Resident #25 sister visited on October 7, and a visit from his brother on October 30. Social worker #2 said the visitors were not allowed to bring items and had to stay with 6 feet of each other. Social Worker

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F 609	Continued From page 15 #2 said the outside visits were allowed from October 2020 to December 2020. the facility canceled outside visits due to an increase in Covid-19 cases. The visits started back March 8, 2021. During an interview with the Maintenance man #3 on 03/25/21 at 11:30 AM, he stated he did not sell Resident #25 marijuana. Maintenance Man #3 stated Resident #25 probably got the marijuana from his brother. Maintenance man #3 said the resident's room was by the street. The residents brother came to his room often. Maintenance man #3 said the facility drug tested him and he was negative. The Maintenance Man #3 said he did not talk to Resident #25 often. Maintenance Man #3 stated he called the Cooperate office and explained he felt the facility accused him of something that was not true. The Corporate office told the Administrator that because they could not prove he sold the marijuana to the resident to allow him to come back to work. During an interview with the facility's Medical Director (MD), on 03/25/21 at 11:45 AM, revealed he was notified that Resident #25 tested positive for opioid and marijuana use. The MD said the use of marijuana and opioids did not cause any harm to the residents physically. The doctor said if the marijuana were laced with some other substance, it could cause harm. He does not recommend continued use.	F 609		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		5/17/21

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F 677	Continued From page 16 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, Resident' s Rights, and the Certified Nursing Assistant Job Description, the facility failed to provide Activities of Daily Living (ADL) care for two (2) of 17 residents observed for ADL care, Residents #46 and #55. Findings include: In a record review of a copy of the Resident's Rights provided by the facility (undated), section 483.15 Quality of Life, (b) Self-determination and participation. The resident has the right to (1) Choose activities, schedules, and health care consistent with his or her interest, assessments, and care plans of car..., (3) Make choices about aspects of his or her life in the facility that are significant to the resident. In a review of the facility's, "CNA Job Description", dated 2/2/2015, Job Summary revealed the primary purpose of the Certified Nursing Assistant (CNA) position is to provide each assigned resident with excellent daily nursing care and services in accordance with the resident's assessment and plan of care. "Personal Nursing Care Functions "revealed the CNAs should assist residents with hygiene needs to include bathing, nail care, and ensure personal care needs are being met in accordance with the resident wishes. Resident #46 In a record review on the facility's "Follow Up Question Report", dated 3/25/21 revealed Resident #46 was scheduled to receive showers on Monday, Wednesday, and Friday. Review of	F 677	1. On 3/24/2021 it was documented resident #46 received a shower by assigned Certified nursing assistant. On 3/25/2021 resident #35 fingernails were cleaned by certified Nursing Assistant.#4 All Residents nails were checked for cleanliness and showers were reviewed 3/25/21 by Unit Managers and director of nursing. Any further concerns were corrected without delay. 2. Residents have the potential to be affected by the deficient practice. 3. On 5/14/2021 an in-service was initiated by the director of nursing for all certified nursing assistants regarding residents nails are to be cleaned during scheduled showers or baths and if a resident refuses the unit nurse managers/assistant director of nursing will be notified. All residents were observed for clean nails and documented shower/bath by Unit Nurse Managers and Wound Care Nurse on 5/14/21 4. The observations and findings of showers will be documented on the form titled CNA Assignment Sheet and provided as completed to the Director of Nursing/Unit Nurse Managers for a review on a daily basis of five residents per day times two weeks, then two residents per day times two beginning 5/14/2021. The documents entitled "Resident Fingernail Checks and CNA assignment sheet will	

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F 677	Continued From page 17 the report for the last 30 days indicated Resident #46 had received either a complete or partial bed bath only a total of five (5) times in 30 days. Prior to 3/25/2021, the last partial bed bath was on 3/5/2021. No showers were given during the time reviewed. In a record review, Resident #46's Care Plan (CP) on 10/08/2019 noted Resident #46 CP for "ADL Self Care Performance" revealed a deficit related to immobility and is total assistance with most Activities of Daily Living (ADL's). Interventions noted Resident #46 is totally dependent on staff to provide a bath. It further indicated to provide Resident #46 with a sponge bath when a full bath or shower cannot be tolerated. In an interview on 03/23/2021 at 4:30 PM, Resident #46 stated she was not receiving showers on the days she was supposed to receive them. The Resident #46 stated "showers" are her preference. In an interview on 03/24/2021 at 1:50 PM, Resident #46 stated she is not receiving showers and has not questioned the staff about her showers or asked if she will receive one. The resident stated that she prefers to receive showers instead of a bed bath but has not received either in several days. In an interview on 03/24/2020 at 3:00 PM, with Registered Nurse (RN) #4/Assistant Director of Nursing, acknowledged Resident #46 has not received a bath since 03/5/2021. She stated the resident is scheduled to receive showers on Monday, Wednesday, and Friday of each week.	F 677	be reviewed weekly at the high risk meeting times four weeks and monthly at the quality assurance performance Improvement committee meeting for review and recommendations times one month. 5/14/2021. Will continue to monitor for one month.	

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On 03/25/2021 at 8:15 AM, observed Resident #46 dressed and sitting in wheelchair in the room, while waiting for transfer to dialysis. Resident #46 stated that she received a bed bath yesterday.

On 03/25/21 at 9:15 AM, in an interview with RN #1/Director of Nursing (DON), she stated Resident #46 is supposed to receive a shower on Monday, Wednesday, and Friday. She stated it is important for residents to receive routine baths to decrease the risk of infection. She stated she was hired in February and since then has had repeated conversations with the CNA's regarding the importance of assisting residents with the care they need to maintain good personal hygiene.

Resident #55
Record review of Resident #55's Face Sheet revealed the facility admitted Resident #55 on 07/23/2018 with the diagnoses of Alzheimer's Disease, Type 2 Diabetes Mellitus, Essential Hypertension and Cognitive Communication Deficit.

Record review of Resident 55's Quarterly Minimum Data Set (MDS), with the Assessment Reference Date (ARD) of 02/18/2021, Section C0500 revealed a Brief Interview for Mental Status (BIMS) score of 04 with indicated Resident #55 is cognitively impaired. Section B0110 revealed Resident #55 is totally dependent for personal hygiene. Section G0110 of the Quarterly MDS, with the ARD of 2/18/2021, for Resident #55, revealed Resident #55 is totally dependent with one (1) person assistance for personal hygiene.

A review of the Resident #55's Care Plan

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revealed Resident #55 needs total assistance with hygiene, dressing and bathing related to Alzheimer's Disease.

Review of Order Summary Report (Physician's Orders) for Resident #55 revealed an order, dated 8/12/2019, "Provide nail care weekly on Monday every day shift".

On 03/23/2021, at 11:18 AM, observed Resident #55 sitting in the dayroom watching staff and residents as they pass by. Resident #55's nails were noted to have black matter under her fingernails.

In an observation of Resident #55's nails on 03/24/2021 at 11:30 AM, observed dried, dark material located underneath her fingernails on both hands.

In an observation of Resident #55 nails on 03/25/2021 at 07:35 AM, revealed Resident #55's fingernails still had dried, dark material located underneath them on both hands.

On 03/25/2021 at 07:40 AM, in an interview with CNA #5, she stated the CNAs clean the resident's nails during their baths. She stated that Resident #55 scratches and "digs" inside her brief and when she cleans the resident's nails, the next time she checks them, they are dirty again.

On 03/25/2021,at 07:45 AM, in an interview with CNA #6, revealed she is assigned to Resident #55 today. CNA #6 stated Resident #55 scratches and puts her hands in her brief. She stated she cleans the resident's nails during baths and as needed, but it is difficult to keep the resident's nails clean.

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F 677	Continued From page 20 On 03/25/2021 at 09:10 AM, in an interview with RN #1/Director of Nursing (DON), she states the CNAs are supposed to provide nail care to resident's who are dependent upon staff for assisting with their Activities of Living (ADL's). She further stated it is important to keep the resident's nails clean and trimmed to prevent the resident's from scratching themselves and causing skin tears that can become infected. The DON stated they did not have a policy specific to ADL care, but the care should be provided, and the job description of the CNA's had information related to the provision of nail care and baths that the CNAs are responsible for providing to the residents. On 3/25/2021 at 10:00 AM, in an interview with RN #2 and RN #3, the MDS nurses, stated they were unaware of the problem with Resident #55's nails and the problem with nail hygiene related to her "scratching and digging." They stated they would speak to the staff and include the importance or hand and nail care to prevent the resident from scratching her skin with contaminated nails and causing an infection.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		5/17/21

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F 689	Continued From page 21 by: Based on staff interviews, record reviews, facility policy review, the facility failed to supervise residents, as evidenced by a resident testing positive for cannabis on 1/3/21 for one (1) of 17 residents, Resident #25. Findings include: Review of the facility's, "Accidents or incidents investigating and reporting" policy, revealed all accidents involving residents, employees, visitors, vendors, etc., occurring at our facilities must be investigated and reported to the administrator. The purpose of this policy is to ensure the safety of all residents, employees and visitors, investigation into the cause of any incident will be tracked in order to improve care and to prevent future occurrences. A Review of the local hospital Pathology report, dated 01/03/21, revealed Resident #25 tested positive for Cannabinoid screen (marijuana) and opioids. A review of the facilities Comprehensive Care Plan, dated 06/29/2019, revealed Resident #25 uses, anti- depressant medication related to Depression. Resident #25 also has a Care Plan dated 01/21/21, for safety concerns related to Resident #25's recent testing positive on a drug screen for Opiates and Marijuana use at the local hospital. During an interview on 03/25/21 at 09:46 AM, Resident #25, revealed he was sent to the local hospital in January 2021 because he was nauseated and had tremors. Resident #25 stated he tested positive for marijuana and opioids.	F 689	1. The facility Administrator started investigation on 1/6/2021 when positive results of drug screen for opiates and marijuana were reported by hospital on Resident #25. 2. Residents have the potential to be affected 3. On 01/06/2021, The facility administrator in-serviced staff upon the return of the resident #25, to include frequent staff rounding, supervised resident when outdoors, visitors to be monitored, increase activities to be provided, and social services visits to ensure resident safety needs were met. On 5/14/2021 at 12:30 p.m. the facility Administrator, Director of Nursing, Social services Director and social services staff were in-serviced by outside Registered Nurse who is a retired surveyor, nurse consultant, and infection Control Nurse. 4. Any allegation of abuse, neglect, exploitation or mistreatment will be reported to the Administrator immediately to initiate investigation. The state aagency will be notified no later than 2 hours per reporting protocol and facility policy. Violations will be logged on a form titled Adverse Events. Violations will be logged on a form titled "Adverse Events" An emergency Quality Assurance Performance Improvement meeting will be held. The investigation of findings and adverse event log will be reported to the Quality Assurance Performance Improvement Committee on an ongoing basis for review and recommendations, as needed on an	

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F 689	Continued From page 22 Resident #25 stated the Maintenance man #3 charged him twenty dollars for each Marijuana cigarette. Resident #25 said he purchased three (3) cigarettes from him. A review of the facility's investigation revealed Resident #25 stated the Maintenance man #3 came to his room while he was on the COVID-19 isolation hall and let him know that he was selling weed. Resident #25 stated he began to buy the Marijuana from Maintenance Man #3 since that time. Resident #25 reported he spent $140.00 (1st time= 30.00, 2nd time =$30.00, 3rd time =$ 30.00, 4th time =$10.00, 5th time = $ 20.00, 6th time = $ 20.00) to the Maintenance Man #3 on Marijuana. Resident #25 stated he has never purchased Marijuana from anyone but him. During an interview on 03/25/21 at 10:51 AM, with the Administrator revealed the facility called in the allegation on 1/6/21. The Administrator stated the hospital called and informed her Resident #25 tested positive for Marijuana. The Administrator stated the facility initiated an investigation completed by the previous Director of Nursing (DON). The Administrator also confirmed the facility failed to report to the local police department or the Attorney General's office of the incident. The Administrator confirmed the facility failed to follow up with sending the completed investigation the State Agency (SA). The Administrator stated the investigation has not been finished and is still in progress. Resident #25 was interviewed and refused to reveal the person's name he got the marijuana from. The Administrator said he gave them three (3) different employees names before he said he was going to be honest. The Administrator stated Resident #25 said he was afraid Maintenance	F 689	emergency basis. If violations occur the violations and form titled "Adverse Events" will be brought to daily stand up times 2 weeks, then weekly to High Risk meeting, then to monthly Quality Assurance Performance Meeting until investigation is completed starting on 05/14/2021.	

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Man #3 would retaliate. The Administrator stated all the staff was tested that worked on Resident #25's unit. Only one (1) CNA tested positive and was terminated. Maintenance man #3 was suspended until an investigation was completed. The Administrator stated Maintenance man #3 said he did not sell marijuana to Resident #25. Maintenance man #3 did not test positive and was approved to return to work by the corporate office because the facility could not substantiate, he sold the Marijuana to Resident #25. Maintenance man #3 returned to work on 2/8/21. Resident #25 was informed Maintenance man #3 was returning to work because the facility could not substantiate the allegation. The Administrator stated the informed Resident #25 the Maintenance man #3 would not work on his hall and if he felt unsafe to notify the staff. Resident #25's family was also notified. The family understood the facility was unable to substantiate the complaint.

During an interview on 3/25/21 at 11:00 AM, with Social Worker #2, revealed Resident #25 had not been out of the facility with anyone because of the COVID-19 restrictions. Social worker #2 stated Resident #25 received several outside supervised visits. Social Worker #2 also stated Resident #25 received a visit from his Brother-in-law on October 9 and 16, 2020. Resident #25's sister visited on October 7, 2020, and a visit from his brother on October 30,2020. Social Worker #2 stated the visitors were not allowed to bring items and had to stay six (6) feet away from each other. Social Worker #2 stated the outside visits were not allowed from October 2020 to December 2020. The facility canceled outside visits due to an increase in COVID-19 cases. The visits started back March 8, 2021.

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During an interview with the Maintenance man #3 on 03/25/21 at 11:30 AM, he stated he did not sell Resident #25 marijuana. Maintenance man #3 stated Resident #25 probably got the marijuana from his brother. Maintenance man #3 stated the resident's room was by the street. The resident's brother came to his room often. Maintenance man #3 stated the facility drug tested him and he was negative. The Maintenance man stated he did not talk to Resident #25 often. Maintenance man #3 stated he called the corporate office and explained he felt the facility accused him of something that was not true. The corporate office told the Administrator that because they could not prove he sold the marijuana to Resident #25 to allow him to come back to work.

During an interview with the facility's Medical Director (MD) on 03/25/21 at 11:45 AM, revealed he was notified that Resident #25 tested positive for opioids and marijuana. The MD stated the use of marijuana and opioids did not cause any harm to the residents physically. The doctor said if the marijuana were laced with some other substance, it could cause harm. He does not recommend continued use.

Record review of the Face Sheet revealed the facility admitted Resident #25 on 3/07/18, with diagnoses that included Unspecified Nephritic Syndrome with unspecified Morphologic, Intervertebral Disc Degeneration Lumbar region and Depressive disorder. The admission Minimum Data Set (MDS), with the Assessment Reference Date (ARD) of 01/18/21, revealed Resident#25 had a Brief Interview for Mental Status (BIMS) of 15 that indicated Resident #25 is cognitively intact.

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F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to have a less than five (5) percent medication error rate by failure to administer respiratory inhalers per manufactures guidelines for two (2) of 25 medication administration observations resulting in a 8.8% medication rate for Residents #42 and #63. Findings include: Record review of the facility's, "Medication Administration Guidelines", with a revised date of July 2019, noted the policy's purpose is to allow for correct administration of oral inhalers to residents. The guideline indicated, "...Step 6. Rinse your mouth with water after breathing in medication. Spit out the water. Do not swallow." Record review of the prescribing information insert sheets for the two (2) inhalers observed, revealed both information sheets explained to rinse your mouth with water after breathing in the medication. Review of the Admission Record for Resident #42 revealed, the facility admitted Resident #42 to the facility on 6/4/21 with the diagnosis of Chronic Obstructive Pulmonary Disease with Acute Exacerbation, High Blood Pressure with	F 759	1. On 4/2/21 Licensed Practical Nurse #1 and Licensed Practical Nurse #2 were inserviced by the Nurse Educator on the facility policy "Medication Administration Guidelines to include that residents are to rinse their mouth with water after breathing the inhaler medication, spit out the water and do not swallow. On 3/24/2021 resident #42 and resident #63 were observed by the Licensed Practical Nurse for signs and symptoms of infection of the mouth, no adverse reactions reported. 2. Residents that receive medication per inhaler have the potential to be affected by the deficient practice. 3. On 4/14/2021 licensed nursing staff were inserviced by the nurse educator on the Medication Administration guidelines to include that after administration of a steroid inhaler to have the resident rinse the mouth to prevent the possible development of an oral infections. Physician orders were updated to include "rinsing after administration" on 4/16/21 for Resident #63. 4. Documented observations of licensed staff, registered nurses, and licensed practical nurses beginning 5/14/2021 providing a steroid inhaler will be	5/17/21

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F 759	Continued From page 26 Heart Failure and Unilateral Pulmonary Emphysema. In a review of Resident #42's Order Summary Report with an order and start date of 12/14/20, revealed the order for two (2) inhaled medications for Chronic Obstruction Pulmonary Disease. The order also instructed to have the resident rinse the mouth out after each inhaled use. Review of the Quarterly Minimum Data Set (MDS), with the Assessment Reference Date (ARD) of 2/3/21, for Resident # 42, revealed for Section C Resident #42 had a Brief Interview for Mental status (BIMS) score of 15, which indicated he was cognitively intact. On 03/24/21 at 4:00 PM, during an observation of medication pass for Resident #42 revealed Licensed Practical Nurse (LPN) # 1 failed to have Resident #42 rinse his mouth out after using the respiratory inhaled medication. At 5:00 PM on 03/24/21, in an interview with LPN #1, when asked what he should have done after administering the inhaler, he explained that he should have the resident rinse his mouth. He further explained that he usually does have the resident rinse but just got busy and nervous. When asked why it is important to rinse the mouth after the use of a steroid inhaler, he explained it could cause a yeast infection if the resident does not rinse his mouth out. On 3/24/21 at 5:10 PM, in an interview with Resident #42, he explained that sometimes the nurses do ask him to rinse his mouth out and sometimes they do not. He further explained the nurses have explained to him that if he does not	F 759	conducted by the Unit Nurse Manager/Charge Nurse and Assistant Director of Nursing times two residents per day times one week, then one resident per week x 2 weeks, then monthly times one month, then randomly on an ongoing basis, to ensure that the resident rinses their mouth after the administration of the inhaler medication. Observations and findings will be documented on a form titled "Observation of administration of steroid inhaler. Any negative findings will be brought to the Quality Assurance Performance Improvement Committee Meeting on 5/14/2021, where documented findings were discussed.	

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F 759	Continued From page 27	F 759		

rinse it could "cause an infection in my mouth." Resident #42 denied ever having any infections in the mouth.

In a review of Resident #63's Admission Record revealed the facility admitted Resident #63 on 02/25/21 with the diagnoses of Peripheral Vascular Disease, COVID-19, Type 2 Diabetes Mellitus with Diabetic Polyneurophy, and Multiple Subsegmental Pulmonary Emboli without Acute Corpumonale.

Record review of Resident #63's Physician Orders revealed the resident has an order for a respiratory inhaler for Multiple Subsegmental Pulmonary Emboli but did not include a specific order to rinse mouth after each use.

Review of the admission MDS for Resident #63, with the ARD of 3/4/21, noted in Section C Resident #63 had a BIMS score of 11, which indicated he was moderately cognitively impaired.

On 3/24/21 at 4:30 PM, LPN #2 failed to have Resident #63 rinse her mouth out after using the respiratory inhaled medication.

On 3/24/21 at 5:20 PM, in an interview, LPN #2 was asked what he should have done after administering the steroid inhaler. He explained that he should have had resident rinse mouth after use to avoid a fungal infection. When asked does he normally have resident to rinse, he further explained that he cannot honestly say that he does it every time but knows as a nurse that it should be done.

On 3/24/21 at 5:30 PM, in an interview with Resident #63, she explained that she has never

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F 759	Continued From page 28 been told or ask to rinse mouth after using the inhaler. She explained that she started the inhaler about six (6) months ago related to shortness of breath with use of the mask. She further explained that she has not had any mouth infections since using the inhaler. On 3/24/21 at 5:40 PM, in an interview with the Director of Nursing (DON), she explained after using an inhaler the nurses should have the resident rinse their mouth with water and spit because if not it could cause the resident to have a yeast infection in the mouth. She further explained this should be included on each Physician order for any steroid inhaler. . An attempted phone call to the Pharmacy Consultant for the facility was made on 3/26/21, at 10:00 AM, but no answer and a message was left to return a call to the State Agency (SA).	F 759		
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,	F 880		5/17/21

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F 880	Continued From page 29	F 880		

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 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

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F 880	Continued From page 30 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 for one (1) of four (4) incontinent care observations, Resident #44. Findings include: The facility's, "Infection Control (Hand Hygiene) policy", revised on 9/2020, noted staff in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. The facility's," Hand Hygiene Table" policy, revised on 9/2020, noted the staff will conduct hand hygiene before performing resident care procedures and during resident care. On 03/25/21 at 12:40 PM in an observation of incontinence care by Certified Nursing Assistant (CNA) #7, revealed CNA #7 did not wash her hands or sanitize them before starting care. CNA #7 removed a soiled brief from Resident #44 and did not wash her hands or sanitize her hands before applying a clean brief.	F 880	F880 1. On 3/23/21 Certified Nursing Assistant #7 (seven) was in serviced by Assistant Director of Nursing regarding perineal care and hand hygiene with emphasis on hand washing prior to caring for a resident and changing gloves and washing hands after removing a soiled brief and the placement of a clean brief on the Resident. 2. Residents that require perineal care have the potential to be affected by the deficient practice. 3. On 04/06/21 the Nurse Educator conducted observation check offs of Perineal Care for Certified Nursing Assistants. Check offs on perineal care will continue, starting with two certified nursing assistants per shift x 2 weeks, then one per shift, x 2 weeks, then on an random basis as needed. On 5/13/21 beginning at 10:30 am a directed in service was conducted by retired State Surveyor, certified Infection Control RN consultant who is not affiliated with the facility. The in services included, Principles of Transmission Based	

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F 880	Continued From page 31 On 03/25/21 at 12:47 PM in an interview with CNA #7, she stated she should have washed my hands or sanitize them when she entered the room. CNA #7 also confirmed she should have sanitized or washed her hands after removing the soiled brief. She stated that her actions could cause the resident to get an infection. She stated her actions can spread infection. On 03/25/21 at 1:30 PM in an interview with the Director of Nursing (DON), she stated CNA #7's actions can cause cross contamination and was unsanitary. She stated CNA #7 should have washed her hands, regardless of who was watching, before and after removing soiled brief. On 3/25/21 at 1:40 PM, in an interview with Registered Nurse (RN)/Infection Control Nurse #5 stated, "The staff know they need to wash their hands. We have had monthly in-services and we remind staff to wash their hands. She stated CNA #7, should have washed her hands to prevent the spread of infection". Record review of Resident #44's Face Sheet revealed an admission date of 8/12/16 with diagnoses which included Parkinson's and Lewy Body Dementia. A review of the Significant Change Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 2/9/21 revealed a Brief Interview for Mental Status (BIMS) score of 00 which indicated Resident #44 had severe cognitive impairment. Section H revealed Resident #44 is always incontinent of bowel and bladder. A review of the Comprehensive Care Plan dated 3/15/19 revealed, Resident #44 has bladder	F 880	Precautions and Hand Hygiene, for all staff including Registered Nurse (RN), Licensed Practical Nurse (LPN), Certified Nursing Assistant (CNA), Dietary Staff, Therapy Staff, Housekeeping Staff, Maintenance Staff, Social Services Staff, Activities Staff and Administrative staff . A video from the Centers for Disease Control titled What You Need To Know About Hand Washing was viewed by all in service attendees. An in service titled Core Concepts for Hand Hygiene: Clean Hands for Healthcare Personnel was provided a post test was taken by all attendees, and step by step hand washing before and after perineal care was completed. The in services were continued until completion of all staff on 05/15/21 (with exception of one nurse who is out of town to be in serviced by Director of Nursing before returning to work.) 4. Documented observations and audits beginning5/14/2021 were conducted by Director of Nursing/Assistant Director of Nursing/Minimum Data Set Coordinator for two licensed staff per shift times two weeks, then one per shift times one week, then randomly to ensure compliance. The observations/audits will be documented on the Validation Checklist Perineal Care. The results of the observation/audits will be taken monthly to the facility Quality Assurance Performance Improvement Committee for review and recommendation. The Quality Assurance Performance Improvement Meeting was held on 5/14/2021, where perineal check offs and infection control were discussed.	

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F 880	Continued From page 32 incontinence and is at risk for complications. Resident has an Activities of Daily Living Self Care Performance Deficit related to Parkinson's with decreased mobility, dated 3/15/19.	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review the facility failed to ensure equipment was maintained in a safe manner for one (1) of 17 room observations, Resident #40. Findings include: The facility's, "Work Order" policy, dated 5/2015, revealed it shall be the standard of this facility to process work orders timely in order to provide a safe and functional environment. On 3/23/21 at 11:00 AM, an observation and interview with Resident #40 revealed the closet door was not on the tracks and leaning over into the closet. Resident #40's room door to the hallway would not close due to incorrect alignment of door facing with the door itself. Resident #40 stated she was not sure how long the closet door was broken. She stated someone had tried to fix it but could not. On 3/24/21 at 10:30 AM, in an observation of Resident #40's closet door was not on tracks and	F 921	1. On 3/25/2021 the Plant Operations Manager repaired the door to the closet in resident#40 bedroom so that it was in the tracks and not leaning backwards. Hallway door of Resident # 40 was repaired to ensure that hinges were in working order. 2. Residents with closets in the bedrooms and hallway doors have the potential to be affected. 3. Residents closet doors and hallway doors were assessed by the Plant Operations Director Manager/assistant Plants Operation Manager. On 5/14/21 and in-service was initiated by the retired state surveyor, Infection Control RN that is not affiliated with the facility. for housekeeping, registered nurses, licensed practical nurses and certified nursing assistants to fill out a work order or to notify staff to fill out a work order or to notify staff to fill out a work order and provide to Plant Operations Manager for	5/17/21

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F 921	Continued From page 33 leaning over into the closet and the room door to hallway was not closing. On 03/25/21 at 11:10 AM, in an interview and observation with Maintenance Staff (MS) #1, stated he was not aware there was a resident with a closet door broken. An observation of the door by MS #1 and State Agency (SA) revealed closet door and room door was still not fixed. MS #1 stated, "The room door is off because the building shifts". MS#1 stated, "The resident can't be harmed because the door has come off the railing and is leaning to the inside of the closet. If it is on the inside, the resident cannot be hurt, even if the resident is digging around in the closet and said the staff would not be hurt by a door, but it needs to be repaired". MS #1 stated the procedure for fixing equipment or building repairs is the staff completes a work order and it is sent to MS #1. He stated he usually has a same day turnaround, but he has not seen a work order for this. He stated he makes rounds monthly from room to room once a month but confirmed he has not been in Resident #40's room this month. Record review of Resident #40's Admission Record revealed Resident #40 was admitted to the facility on 12/3/19 with a diagnosis of "History of Falling." A review of the quarterly Minimum Data Set (MDS) with and Assessment Reference Date (ARD) of 2/8/21 revealed Resident #40 had a Brief Interview of the Mental Status (BIMS) score of eight (8) which indicated moderate cognitive impairment. A review of the Comprehensive Care Plan revealed, Resident #40 has impaired cognition	F 921	correction of concern identified. On 3/26/21 department managers were in serviced and assigned rooms rounds by the director of nursing. 4. Resident Room Rounds will be conducted by the department managers two times a week times one month then 1 time a week times 1 month then monthly ongoing. Room rounds will be made by the department managers to ensure residents are provided a safe, functional, and comfortable environment Beginning on 5/14/2021 the plant operationsmanager will assess doors weekly times one month and on an ongoing basis during routine maintenance rounds to ensure that the resident's closet doors are not off track and are not leaning and hallway doors are closing properly. The findings will be recorded on the form titled "Room Door Inspection which will be presented to Quality Assurance Committee for review and recommendations, as needed. 5/14/2021 .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255326	A. BUILDING _____ B. WING _____	03/26/2021

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

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F 921	Continued From page 34 with moderately impaired decision-making skills, related to forgetfulness, dated 3/10/20.	F 921		