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	255338	A. BUILDING _____ B. WING _____	05/16/2019

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LAMAR HEALTHCARE & REHABILITATION CENTER	6428 US HIGHWAY 11 LUMBERTON, MS 39455

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F 000	INITIAL COMMENTS ****Amended 2567*** After review with the Regional Office, and Administrative review, this survey was re-opened from 5/14/19-5/16/19, by Healthcare Management Solutions (HMS), on behalf of the MS State Department of Health. Based on further investigation, the following changes were made to the 2567: F550, F558, and F812 continued without changes. F640 was added. F688 was amended; scope/severity changed from an E to a D. F580, F685, F689, F692, F697, F710, and F790 were deleted. F636 moved to F641. F656 moved to F657; scope/severity changed from a D to an E. A Recertification survey was conducted 02/25/19 through 02/28/19, by Healthcare Management Solutions, LLC on behalf of the Mississippi State Department of Health. The facility was found to be not in substantial compliance with the Medicare and Medicaid Requirements for Participation. Deficiencies were cited at F550, F558, F580, F636, F656, F685, F688, F689, F692, F697, F710, F790, and F812. The facility census was 88 at the time of survey and the facilty held a license for 120 beds.	F 000		

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

Electronically Signed | 04/15/2019

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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F 000	Continued From page 1 The facility's census on May 14, 2019 was 85 residents, and the facility held a license for 120 residents.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F 550		6/18/19

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F 550	Continued From page 2 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and review of the "Quality of Life - Dignity" policy, the facility failed to routinely ensure resident dignity for one (1) of 18 sampled residents, when the urinary catheter bag was uncovered/not in a privacy bag for Resident (R) #71. Findings include: Review of facility policy, "Quality of Life - Dignity," revised August 2009, indicated: Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: Helping the resident to keep urinary catheter bags covered. Resident #71 was observed on 02/25/19 at 9:32 AM; he was resting in bed in his room. His urinary catheter drainage bag was hanging on the bedrail toward the hallway, uncovered, and visible to anyone in the hallway. Observation on 02/25/19 at 1:00 PM, showed Resident #71's urinary catheter drainage bag was hanging on the bedrail toward the hallway, uncovered, and visible to anyone in the hallway, including the resident's mother and sister, who were visiting. Observation on 02/26/19 at 9:40 AM, showed	F 550	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. Root Cause Analysis(RCA) was completed by the Quality Assurance and Performance Improvement Committee(QAPI) on 3/14/19 and again on 6/7/19. Based on findings the certified nursing assistant(CNA) failed to ensure resident #71 urinary drainage bag was covered on 2/25/19 and 2/26/19. Resident #71 urinary drainage bag was replaced with a fig leaf urinary drainage bag with a built in dignity cover on 3/1/19 per the Director of Nurses(DON). 2. All residents have the potential to be affected by this practice. 3. Education was initiated by the Director of Nurses on 3/12/19 for current clinical staff and was completed on 4/3/19	

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F 550	Continued From page 3 Resident #71 resting in bed in his room. His urinary catheter drainage bag was hanging on the bedrail toward the hallway, uncovered, and visible to anyone in the hallway. Observation on 02/26/19 at 10:55 AM, showed Resident #71 resting in bed in his room. His urinary catheter drainage bag was hanging on the bedrail toward the hallway, uncovered, and visible to anyone in the hallway. Review of the February 2019 "Physician Orders", for Resident #71, revealed to check placement, patency, and drainage to Foley catheter every shift and as needed.	F 550	regarding urinary drainage bags and dignity. Education was initiated with the clinical staff by the Staff Development Nurse on 6/11/19 and 6/13/19. Newly hired clinical staff will be educated by the Staff Development Nurse regarding dignity with urinary drainage bags during orientation. 4. Director of Nurses/Unit Manager to conduct a Quality Review of dignity with urinary drainage bags weekly x 4 weeks, then monthly x 3 months. Quality Review to be modified based on findings. The findings of the Quality Review to be reported in the monthly QAPI Committee Meeting and reviewed by the Interdisciplinary Team for any further recommendations for 90 days.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the "Repositioning" policy, the facility failed to reasonably accommodate one (1) of one (1) resident, included in the sample, with specialized positioning dining support needs, to achieve more independent functioning, dignity, and well-being out of 18 sampled residents, Resident (R) #41.	F 558	1. Root Cause Analysis was completed by the Quality Assurance and Performance Improvement Committee(QAPI) on 3/14/19 and again on 6/7/19. Based on findings the facility failed to ensure resident #41 was properly positioned during meal time on 2/25/19. No negative outcomes for Resident #41	6/18/19

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F 558	Continued From page 4 Findings include: Review of the facility policy on "Repositioning," revised May 2013, under the section for "Repositioning the Resident in Bed" which documented the following instructions, "Check the care plan . . . to determine resident's specific positioning needs." On 02/25/19 at 12:05 PM, an observation was conducted of Resident #41, being served lunch in her room. The surveyor was positioned in the hallway adjacent to her bedroom, with an unobstructed view of Resident #41 and her side of the room. Certified Nursing Assistant (CNA) #15 carried a food tray into the room and placed it on the surface of the rolling bed table positioned across Resident #41's bed. Resident #41 was sleeping in her bed. CNA #15 said R #41's name and roused her. CNA #15 raised the head of the bed, removed lids from the plated foods, and placed dining utensils on the right side of the tray. CNA #15 did not adjust the height of the bed and did not adjust the height of the rolling bed table. The surface of the bed table was at the same height as Resident #41's face. CNA #15 asked, "You OK?" Resident #41 nodded her head "Yes". CNA #15 left the room, returned with Resident #41's roommates' food tray, and began assisted her with setting up her meal. CNA #15 then left the room and continued delivering food trays to other resident rooms. Resident #41 picked up her spoon and raised her right arm above the tray to scoop food from a bowl. As she did, her upper torso began slowly sliding to the right side of her bed. As she continued trying to scoop food from the containers on her tray, her upper torso continued to slide to the right until her face was	F 558	identified upon assessment by the Director of Nurses on 2/27/19. Resident #41 was screened for positioning by an Occupational Therapist on 2/27/19 and a wedge cushion was implemented for proper positioning while in bed on 2/27/19 by an Occupational Therapist. 10 additional residents with possible positioning problems were screened by a Certified Occupational Therapy Assistant on 3/9/19 and no further recommendations for these 10 residents were warranted at that time. All residents are screened by therapy quarterly and as needed to identify any declines in functional status. 2. All residents have the potential to be affected by this practice. 3. Education was initiated by the Director of Nurses on 3/12/19 regarding proper resident positioning for current clinical staff and was completed on 4/3/19. Education was initiated by the Staff Development Nurse for clinical staff on 6/11/19 and 6/13/19 regarding proper positioning of residents. All newly hired clinical staff will be educated during orientation by the Staff Development Nurse regarding proper positioning of residents. 4. Director of Nursing/Unit Manager to conduct a Quality Review of proper resident positioning weekly x 4 weeks and then monthly x 3 months. Quality Review to be modified based on findings. The findings of the Quality Review to be	

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F 558	Continued From page 5 resting on the bed mattress to the right of the pillows at the head of her bed. In this bent over position, Resident #41 continued attempting to dine, by reaching her left hand to the tray above her, and feeling the foods in the containers. Her hand and arm moved slowly and tremored. She gripped a small bowl that contained Tetrazzini and lowered it to the mattress near her face where she began finger feeding bits of the food into her mouth with her head still resting on the mattress. There was some spillage with food debris accumulating in Resident #41's bed near her face. As she could not see her plate with her head lower than the food tray, she used her left hand to feel around on her tray to try and acquire other food items. These attempts were not successful. During these observations no staff members checked on the progress of the meals underway in Resident #41's room. CNA #2, also delivering food trays to resident's rooms, looked at the surveyor standing in the hallway outside Resident #41's room. CNA #2 stopped delivering food trays, walked down the hall, and entered Resident #41's room. CNA #2 observed Resident #41's poor dining position, moved across the room to her, and said, "Let's get you sitting up, so you can eat better." CNA #2 moved the rolling bed tray away from the bed, lifted Resident #41's torso into an upright position in the center of her mattress, and picked up food debris from the bed where Resident #41 had moved her bowl. CNA #2 reclined the head of the bed and assisted Resident #41 into a midline and upright orientation to her food. She placed a rolled-up towel along Resident #41's right side, lowered the bed, and positioned the tray near Resident #41's lap by lowering the rolling table surface. CNA #2 asked Resident #41, "Is that	F 558	reported in the monthly QAPI Committee Meeting and reviewed by the Interdisciplinary Team for any further recommendations for 90 days.	

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F 558	Continued From page 6 better?" and she stated said, "Yes." On 02/25/19 at 12:30 PM, an interview was initiated with CNA #2. She reported Resident #41 tended to lean to the right in her bed, so during meals staff usually used a rolled-up towel on her right side to prevent her from sliding to the right. She said she learned about this intervention by talking to other staff. She said she did not believe this intervention was included in Resident #41's Care Plan. She said it was standard practice for CNAs to make sure table tray surfaces were at the optimal height as part of setting up meals for residents who dined in their rooms. On 02/25/19 at 12:42 PM, an interview was initiated with CNA #15. She confirmed delivering Resident #41's lunch tray and setting up her meal. She reported being aware that Resident #41 tended to lean to her right in bed but didn't observe her doing so when she served her meal tray. CNA #15 confirmed she did not make sure Resident #41's bed table was lowered to the appropriate height after placing the tray on her bed table surface. She confirmed she did not take any action to support Resident #41's position in her bed in preparation for the meal. She said she was rushing trying to get the lunch trays to residents. She said she did not recall any instructions about the use of positioning support for Resident #41 during meals. On 2/26/2019 at 10:15 AM, an interview was initiated with the Director of Nursing. He verified this incident of positioning for Resident #41, did not represent accepted practice at the facility and described actions underway to improve accommodations and supports for the residents of the facility.	F 558		

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F 558	Continued From page 7 Review of the Resident #41's "Minimum Data Set" (MDS), dated 12/05/18, identified her relevant diagnoses as "Chronic Obstructive Airway Disease, Heart Disease, Atrial Fibrillation, and Gastroesophageal Reflux Disease." Resident #41's "Functional Status in Bed Mobility (how resident moves to and from lying position, turns side to side and positions body while in bed)" as "Total dependence - full staff performance" . . . requiring "one-person physical assist."	F 558		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		6/18/19

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F 640	Continued From page 8 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility's policy, the facility failed to complete the discharge Minimum Data Set (MDS) for two (2) of three (3) residents' MDS's reviewed after discharge to the hospital, Resident #46 and Resident #64. Findings include: Review of the MDS 3.0 manual "Obra Required MDS Assessments" indicated, " ...Discharge Assessments ...MDS no later than the discharge + 14 calendar days ..."	F 640	1. Root Cause Analysis(RCA) was completed by the Quality Assurance and Performance Committee(QAPI) on 6/7/19. Based on findings the Minimum Data Set(MDS) nurse failed to complete discharge MDS assessments for resident #46 and resident #64 no later than 14 days from discharge. Resident #46 discharge MDS completed on 3/8/19. Resident #64 MDS completed on 2/25/19. Additional discharge MDS audited by the Director of Nursing on 6/10/19 and all have been completed within the 14 days of discharge date.	

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F 640	Continued From page 9 Resident #46 Review of Resident #46's "Hospital records" revealed she was admitted to the hospital on 2/1/19, for Pneumonia; however, according to Section Z of Resident #46's discharge MDS, documented that the discharge MDS was not signed by the Registered Nurse (RN) as being completed until 3/8/19. Resident #64 Review of the facility's document titled, "Detail Admission/Discharge Report", dated 11/15/18 through 5/15/19, indicated that Resident #64 was discharged from the facility to the hospital on 2/8/19, however, according to Section Z of Resident #64's discharge MDS, documented that the discharge MDS was not signed by the RN as being completed until 2/25/19. In an interview on 5/15/19 at 3:15 PM, the MDS consultant confirmed that Resident #46 and Resident #64's discharge MDS's were not completed timely as instructed in the MDS 3.0 manual. She indicated that the discharge MDS was to be completed by the 14th day after discharge.	F 640	2. All residents have the potential to be affected by this practice. 3. Education regarding the completion of discharged resident assessments no later than 14 days was completed with the Interdisciplinary Team and the MDS nurse on 6/12/19 by the Corporate Nurse Consultant. 4. Director of Nursing/MDS Nurse to conduct a Quality Review of discharged residents MDS to ensure completion no later than 14 days weekly x 4 weeks, then monthly x 3 months. Quality Review to be modified based on findings. The findings of the Quality Review to be reported in the monthly QAPI Committee Meeting and reviewed by the Interdisciplinary Team(IDT) for any further recommendations for 90 days.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews and review of the Minimum Data Set (MDS) manual, the facility failed to ensure the accuracy of a comprehensive MDS assessment for three	F 641	1. Root Cause Analysis(RCA) was completed by the Quality Assurance and Performance Committee(QAPI) on 6/7/19. Based on findings the Minimum Data	6/18/19

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F 641	Continued From page 10 (3) of three (3) sampled residents. Resident #25, for accidents and pain; Resident #46 for diet, and Resident #22 for hearing, use of a hearing aid, and loose-fitting dentures. Findings include: Review of the MDS manual 3.0, indicates for Section Z0400, " ...the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements ..." Resident #46 Review of Resident #46's quarterly "MDS" with an Assessment Reference Date (ARD) of 12/12/18, showed Resident #46 had diagnoses including Degeneration of Brain, Vascular Dementia and Chronic Obstructive Pulmonary Disease. Therapeutic diet was not marked on this MDS. Review of the "Physician Orders" showed active orders for Fortified foods to the lunch and dinner trays since 08/3/17, and a pureed diet with nectar thickened liquids since 10/28/17. This information was not included in the 12/12/18 MDS. During an interview with the MDS coordinator on 2/27/19 at 3:00 PM, she confirmed that there were accuracy problems with the MDS regarding the therapeutic diet and thickened liquids for Resident #46. Resident #25	F 641	Set(MDS) nurse failed to accurately code the MDS for resident #25 for accidents and pain, resident #46 for diet, and resident #22 for hearing, and use of a hearing aid, and loose fitting dentures. Resident #25 quarterly MDS dated 3/27/19 was coded for accidents and pain. Resident #46 quarterly MDS dated 2/28/19 was coded for a therapeutic diet. Resident #22 annual MDS dated 6/10/19 was coded for hearing aides but not loose fitting dentures due to resident #22 stated she has no problems with her dentures. 7 additional MDS were audited by the Director of Nurses on 6/14/19 with no further coding errors noted. 2. All residents have the potential to be affected by this practice. 3. Education was completed with the Interdisciplinary Team and the MDS nurse regarding the accurate coding of MDS assessments on 6/12/19 by the Corporate Nurse Consultant. 4. Director of Nursing/Unit Manager to conduct a Quality Review of MDS assessments for accuracy weekly x 4 weeks, then monthly x 3 months. Quality Review to be modified based on findings. The findings of the Quality Review to be reported in the monthly QAPI Committee Meeting and reviewed by the Interdisciplinary Team(IDT) for any further recommendations for 90 days.	

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F 641	Continued From page 11 Observation on 5/14/19 at 11:45 AM, revealed Resident #25 seated in the dining room in a regular chair with a small front-wheeled walker next to the resident. Observation of Resident #25's bedroom and bathroom on 5/14/19 at 11:50 AM, revealed non-skid strips on the floor of the resident's bedroom, and a silver grab bar located on the right side of the toilet in the bathroom. During a phone interview with Family Member #1, of Resident #25 on 5/14/19 at 4:30 PM, Family Member #1 stated, "She [referring to Resident #25] really hasn't had any falls for quite some time. The one (1) fall in January, they [referring to staff] were with her in the bathroom and she leaned forward and fell. They put a grab rail in the bathroom next to the toilet and strips on the floor in her bedroom and I like that. She got a very slight hairline fracture of the wrist, and they splinted it. It has now been discontinued." Family Member #1 then stated, with her second fall in February, I really can't say it was even a fall or not. I think she was just coming out of the dining room and leaned over to the right side. She may or may not even had her walker as she forgets to use it at times, and with her dementia, that's to be expected. When Family Member #1 was asked about any concerns with Resident #25 regarding pain, Family Member #1 stated, "No, she [referring to Resident #25] is doing quite well. She really doesn't have pain. They [referring to staff] haven't had to put her on anything new for pain. I think she gets something regularly for her arthritis that she has had for many years now ...." Review of Resident #25's undated "Face Sheet" found in the electronic medical record (EMR),	F 641		

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F 641	Continued From page 12	F 641		

indicated the facility admitted Resident #25 with diagnoses that included, "Dementia, Vitamin D Deficiency, Vascular Dementia, and Hyperlipidemia.

Review of a "Resident Incident Report" dated 1/27/19, indicated, "Resident was trying to sit on toilet and loss [sic] her balance. Resident fell on right side and landed on the floor. Certified Nursing Assistant (CNA) tried to catch her before she fell but couldn't."

Review of a "Resident Incident Report", dated 2/6/19, indicated, "Resident was ambulating in hallway when she fell into the wall with the right side of her body. A loud bang was heard, and nurses could see the resident through the surveillance window leaning on the wall with her bottom on the floor ...Resident could not give an accurate statement of how she fell. Walker was nearby."

Review of the January 2019, February 2019, and March 2019, Medication Administration Record (MAR), indicated Resident #25 received Aspirin (a non-steroidal anti-inflammatory medication) 81 milligrams (mg) one (1) by mouth daily and Naproxen (a non-steroidal anti-inflammatory medication) 250 mg tablets daily.

Review of Resident #25's quarterly "MDS," with an ARD of 3/27/19, specified the resident had a BIMS score of 5 out of 15, which indicated Resident #25 had severe cognitive impairment. Further review of the MDS indicated the question, "At any time in the last 5 days, has the resident: Received scheduled pain medication regimen?" Was marked: "No." Further review of the MDS indicated the question, "Has the resident had any

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F 641	Continued From page 13 falls since admission/entry or reentry?" Was marked: "No." During an interview on 5/15/19 at 3:52 PM, the Director of Nursing (DON) stated, "From looking at the MARs, she [referring to Resident #25] received the Naproxen and Aspirin." The DON then stated, the nurse who completed the 3/27/19, quarterly MDS Assessment should have indicated that on the MDS, that she was getting the Aspirin and Naproxen and the falls should have been noted too." During an interview on 5/15/19 at 3:54 PM, regarding the inaccurate coding on the quarterly MDS, the MDS Consultant stated, "We should have had that coded correctly on the MDS [referring to the section regarding receiving scheduled pain medications and the two falls] and that was an error on her [referring to the previous nurse] part. I see on the MAR that she [referring to Resident #25] was getting the Naproxen regularly. She [referring to the previous nurse who completed the MDS] did not do a thorough review and it should have been coded correctly." Resident #22 Review of Resident #22's quarterly "MDS", with an ARD date of 3/7/19, indicated for the category hearing "Moderate difficulty ... Hearing aid, yes" and for the category "loose fitting dentures" was marked unchecked." Review of Resident #22's quarterly "MDS" with an ARD date of 12/7/18, indicated for the category "hearing, "moderate difficulty ...Hearing aid, yes" and for the category "loose fitting dentures" was documented "unchecked."	F 641		

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F 641	Continued From page 14 Review of Resident #22's annual "MDS" with an ARD date of 6/15/19, indicated for hearing, "Adequate" and for the use of a hearing aide, "No." For the category "loose fitting dentures" the category was unchecked. Review of the document titled, "Miracle Ear" indicated Resident #22 was seen at the office on 2/27/19, and "pt (patient) wanted aids that was purchased in 2008 repaired." Further, review of the document indicated that Resident #22 was see by Miracle Ear on 2/15/11, for the annual hearing test and the hearing aids were delivered 2/22/11. In an interview on 5/16/19 at 12:00 PM, Resident #22 indicated that she has worn a hearing aid for many years and that recently her hearing aid was broken and taped together with tape. Resident #22 stated that her daughter took her a few months ago to Miracle Ear so that she could get her hearing aid fixed. Observation of Resident #22 at this time, revealed a hearing aid in the right ear and no hearing aid in the left ear. Resident #22 stated that her son takes her to the dentist usually, but a while ago her daughter took her to the dentist to have her loose dentures relined. Whatever they did, it took them a long time to get the upper dentures to fit right. Resident #22 showed the surveyor that she could raise her lower dentures with her tongue. Resident #22 stated that she has to glue the dentures in every day, but she still can raise the lower dentures with her tongue. Observation of Resident #22 revealed that when she talked, her upper dentures did not appear to move, however, Resident #22's lower dentures were raised when resident used her tongue to lift the lower dentures.	F 641		

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F 641	Continued From page 15 During an interview on 5/15/19 at 3:54 PM, regarding the inaccurate coding on Resident #22's quarterly MDS, the MDS Consultant confirmed, "The MDS was coded incorrectly." The DON stated that he was aware that the son takes the resident to the dentist for her dentures and that the daughter took the resident to Miracle Ear in February to repair the hearing aid. The DON stated that the resident has additional hearing aids in her room in a box.	F 641		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary	F 657		6/18/19

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F 657	Continued From page 16 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of the facility's policy, and interviews, the facility failed to ensure interventions were documented as to specific dates when the interventions were being implemented on the care plan as well as the care plans including all of the residents' care needs for seven (7) of seven (7) sampled residents' care plans reviewed, Resident #81, Resident #71, Resident #25, Resident #39, Resident #22, Resident #70, and Resident #55. Findings include: Review of the facility's policy titled, "Care Plans, Comprehensive Person- Centered", revised December 2016, indicated, "The comprehensive, person-centered care plan will: 8a. Include measurable objectives and timeframes; 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change." Resident #81 Review of Resident #81's care plan, dated 1/15/19, revealed a sentinel problem of social isolation. However, nothing else was present in the care plan to address the plan for pain management, follow-up plans for B-cell lymphoma, and potential discharge. During an interview with Resident #81 on 2/25/19 at 10:57 AM, he complained of pain in his back. On 3/25/19 at approximately 11:00 AM, Licensed	F 657	1. Root Cause Analysis(RCA) was completed by the Quality Assurance and Performance Improvement(QAPI) Committee on 6/7/19 and it was determined the facility failed to document onset dates for care plan interventions on resident #81, #71, #25, #39, #70, #22, and resident #55. Resident #81 was discharged home on 5/3/19. Resident #71 care plan for the Foley catheter and the C-pap onset dates added by the Unit Manager on 5/20/19. Resident #25 care plan for the fall intervention onset dates added by the Unit Manager on 5/20/19. Resident #39 was discharged from the restorative program on (10/24/18) so no care plan was developed and implemented for restorative since survey exit. Resident #70 was evaluated and put on therapy case load on 11/28/18 and was discharged from skilled therapy on 1/28/19. Resident #70 was screened by therapy again on 3/19/19 and was not picked up for additional therapy due to no indication of decline at that time. Resident #22 care plan for hearing difficulty and the use of hearing aides onset dates added by the Unit Manager on 5/20/19. Resident #55 care plan for the fall interventions onset dates added by the Unit Manager on 5/21/19. 2. All residents have the potential to be affected by this practice.	

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F 657	Continued From page 17 Nurse (LN) #5 stated Resident #81 had cancer and she would check on Resident #81's pain management plan; however, no documented evidence of a care plan addressing the pain was provided. Per interview with the facility's Unit Manager/Registered Nurse (RN) #1, Resident #81 had been refusing most treatments since his admission in January 2019; however, Resident #81 was receiving Aleve, as requested and needed. Review of Resident #81's "Physician Orders" revealed an order for Aleve 220 milligrams (mg) as needed since 3/4/19. According to the "Face Sheet" in the electronic medical record (EMR), Resident #81 was admitted to the facility on 1/17/19, with diagnoses B-Cell lymphoma, Pleural Effusion and Pneumonia due to community acquired MRSA (Methicillin-resistant Staphylococcus aureus), resolved at time of admission. According to the 1/17/19, "Pain Evaluation": Resident #81 was not in pain at the time of evaluation, and was only considered at risk for pain. Prescription and over the counter medications for pain were listed as "N/A (not applicable)." Resident #71 Review of Resident #71's care plan did not include the use or care of an indwelling catheter; nor the use and care of the Continuous Positive Airway Pressure (C-pap) machine.	F 657	3. Education with the Interdisciplinary Team(IDT)and the Minimum Data Set(MDS) nurse regarding the documentation of specific dates of interventions added to the resident care plan was given by the Corporate Nurse Consultant on 6/12/19. 4. Director of Nursing(DON)/Minimum Data Set(MDS) nurse to conduct a Quality Review of resident care plans for development and implementation with onset dates weekly x 4 weeks, then monthly x 3 months. Quality Review to be modified based on findings. The findings of the Quality Review to be reported in the monthly QAPI Committee Meeting and reviewed by the IDT for any further recommendation for 90 days.	

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F 657	Continued From page 18 According to the "Face Sheet" in the EMR, Resident #71 was admitted to the facility o 8/28/18, with current diagnoses including Diabetes Mellitus, Moderate Intellectual Disabilities, Bipolar Disorder, Obstructive Sleep Apnea, Neurogenic Bladder and Seizures. Review of the February 2019, "Physician Orders", revealed orders for Foley catheter changes, as needed, starting on 8/30/18, and apply Continuous positive airway pressure (C-Pap) at bedtime, starting on 9/3/18. During an interview with the Minimum Data Set (MDS) Coordinator on 2/27/19 at 3:00 PM, she indicated there were problems with the care plans and confirmed the missing information for Residents # 81 and Resident #71's care plans. The Director of Nursing (DON) was interviewed on 2/27/19 at 8:00 AM, and confirmed the care plans did not reflect the residents' needs. Further, review on 5/15/19 at 2:45 PM, of Resident #81 and Resident #71's care plans, revealed that the missing information had been added to the care plans, however, there wasn't a date when the information had been added. Further interview on 5/15/19 at 2:45 PM, the DON confirmed that Resident #81 and Resident #71's care plans were revised when the facility was preparing their Plan of Correction (POC) after the completion of the survey February 25-28, 2019. Resident #25 Review of the fall care plan with a "Problem Onset" date of 03/06/14, indicated "[name of Resident #25] is at risk for falls, related to decreased safety awareness from cognitive deficits related to Dementia." The care plan did	F 657		

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F 657	Continued From page 19 indicate two (2) falls (fall on 1/27/19 and 2/6/19). Multiple interventions were identified, however no specific timeframes as to when the interventions were implemented were on the care plan. Observation on 5/14/19 at 11:45 AM, revealed Resident #25 sitting in the dining room in a regular chair watching television along with several other residents awaiting lunch to be served. At this time a small front-wheeled walker was observed next to the resident. The resident was well groomed and observed conversing and laughing with other residents. The resident made no attempts to rise from the regular chair she was seated in. Observation of Resident #25's bedroom and bathroom on 5/14/19 at 11:50 AM, revealed the bed was in the lowest position and wheels were locked. Observation also revealed non-skid strips on the floor of the resident's bedroom, and a silver grab bar located on the right side of the toilet in the bathroom. Review of a "Resident Incident Report", dated 1/27/19, indicated, "Resident was trying to sit on toilet and loss [sic] her balance. Resident fell on right side and landed on the floor. Certified Nursing Assistant (CNA) tried to catch her before she fell but couldn't." Review of a "Resident Incident Report", dated 2/6/19, indicated, "Resident was ambulating in hallway when she fell into the wall with the right side of her body. A loud bang was heard, and nurses could see the resident through the surveillance window leaning on the wall with her bottom on the floor ...Resident could not give an accurate statement of how she fell. Walker was	F 657		

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F 657	Continued From page 20 nearby." During a phone interview with Family Member #1, on 5/14/19 at 4:30 PM, Family Member #1 stated, "The one (1) fall in January, they [referring to staff] were with her in the bathroom and she (Resident #25) leaned forward and fell. They put a grab rail in the bathroom next to the toilet and strips on the floor in her bedroom and I like that." Family Member #1 then stated, "With her second fall in February, I really can't say it was even a fall or not. I think she was just coming out of the dining room and leaned over to the right side. She may or may not even had her walker as she forgets to use it at times, and with her dementia, that's to be expected." Observation on 5/15/19 at 8:40 AM, revealed Resident #25 seated in the dining room in a regular chair watching television and laughing and conversing with several other residents. At this time, a front-wheeled walker was observed next to the resident. The resident made no attempts to rise from the regular chair she was seated in. Observation on 5/16/19 at 9:10 AM, revealed Resident #25 in the activity room participating in the activity of ball toss. The resident was laughing and actively participating with the other residents. There were no attempts to rise from the regular chair she was seated in. Observation on 5/15/19 at 10:00 AM, revealed Resident #25 walked from the dining room to the nursing station with the front-wheeled walker. Staff was observed walking next to the resident. Observation on 5/15/19 at 11:32 AM, revealed	F 657		

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F 657	Continued From page 21 Resident #25 walked from the dining room to the nursing station with the front-wheeled walker. Staff was observed walking next to the resident. Review of Resident #25's undated "Face Sheet" found in the EMR, indicated the facility admitted Resident #25 with diagnoses that included, "Dementia and Vascular Dementia. Review of Resident #25's quarterly "MDS" with an Assessment Reference Date (ARD) of 3/27/19, specified the resident had a "Brief Interview for Mental Status (BIMS)" score of 05 out of 15, which indicated Resident #25 had severe cognitive impairment. Further review of the MDS indicated Resident #25 requires Supervision with one-person physical assistance for transfers, bed mobility, walking in room, and locomotion on the unit. The MDS further indicated no functional limitation in range of motion of the upper or lower extremities and uses a walker as a mobility device. The MDS indicated Resident #25 has had two (2) falls since admission/entry or reentry. During an interview on 5/14/19 at 3:20 PM, Registered Nurse (RN) #1 stated, "We were having a lot of change over in staff towards the end of last year. Staff were coming and going, and I took over this role in January. She [referring to Resident #25] was one the first ones I looked at for care plans. I had to figure out my way, learn my role as a lot of people had quit. It was just a matter of sitting down and learning how to do this. I just had to sit down and play with the keys in the computer software to figure out on my own." RN #1 then stated, "With regards to [name of Resident #25's] falls, I had gone into the electronic computer charting and did enter falls with the interventions, but I was finding for some	F 657		

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F 657	Continued From page 22	F 657		

reason, the dates entered for the interventions were not being saved. I did update the care plan back then, but the dates were not being saved." RN #1 then stated, "During this time, we did have our morning clinical meeting reviews where we review all the 24-hour reports, Incident reports, nurses' notes. Therapy is involved in those meetings and we talk about what interventions to put into place. We have a computer in the room and are making updates and indicating what interventions right then. I know I was going through the electronic computer system and putting the dates of the falls, but I couldn't figure out how to get it to save the actual dates."

An interview on 5/15/19 at 2:45 PM, the DON confirmed that the resident' care plan cited in the original survey February 25- 28, 2019, the information regarding their care was not added until after the survey and the facility was preparing their POC.

Resident #39
Review of Resident #39's care plan revealed the restorative plan, provided by therapy for nursing to follow in order to provide restorative nursing care, was not addressed on the resident's care plan.

Resident #39 was evaluated and admitted to Physical Therapy (PT) on 6/19/18. Resident #39 met her PT goals on 7/23/18. Review of the "PT Discharge Summary" dated 7/23/18, indicated, "Discharge Disposition: skilled services no longer justified ... Follow-up Care Recommended: Restorative treatment ..."

Review of the document titled, "Restorative Plan" dated 7/19/18, documented that the therapist

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F 657	Continued From page 23 provided the restorative plan to the previous DON on 07/23/18. In an interview with the DON on 5/16/19 at 3:00 PM, the DON confirmed that he had reviewed Resident #39's care plan and that the restorative plan, provided by therapy for nursing to follow in order to provide restorative nursing care, was not addressed on the resident's care plan. Resident #70 Review of Resident #70's care plan revealed that a "Restorative Plan" had not been included. Resident #70 was evaluated and admitted to physical therapy (PT) and occupational therapy (OT) on 8/20/18. On 10/18/18, Resident #70 met his therapy goals. Review of the "PT/OT Discharge Summary" dated 10/18/18, indicated, "Discharge Disposition: skilled services no longer justified ...Follow-up Care Recommended: Restorative treatment ..." Review of the "Restorative Plans" dated 10/17/18, documented that the therapist provided the restorative plan to Licensed Nurse (LN) #9 on 10/17/18. Interview with the Rehab Director on 5/15/19 at 3:38 PM revealed that therapy creates the restorative plan then nursing adds the restorative plan to the resident's care plan. In an interview with the DON on 5/16/19 at 3:00 PM, the DON confirmed that he had reviewed Resident #70's care plan and that the restorative plan, provided by therapy for nursing to follow in order to provide restorative nursing care, was not addressed on the resident's care plan.	F 657		

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F 657	Continued From page 24 Resident #22 Review of Resident #22's care plan on 5/15/19 at 2:45 PM, revealed that the resident's hearing difficulty and use of the hearing aid was addressed on the care plan. However, the DON was interviewed during the survey on February 25-28, 2019 on 2/27/19 at 8:00 AM, and confirmed the care plans did not reflect the resident's hearing difficulty and the use of the hearing aid. Further interview on 5/15/19 at 2:45 PM, revealed the DON confirmed that Resident #22's care plan did not initially identify the resident's hearing difficulty and/or the use of hearing aids and had been revised when the facility was preparing their POC, after the completion of the survey February 25-28, 2019. Resident #55 Review of Resident #55's care plan revealed that a fall on 5/7/19, with current interventions of a "reacher", quarter side rails, and a low bed, were not included in the care plan. The care plan indicated that the last fall the resident had was dated 9/14. During the initial tour on 5/14/19 at 10:00 AM, Resident #55 was seated in a wheelchair and rolled down the hallway in front of the surveyor. Resident #55 stated that she fell over the weekend and that her side (pointing to her rib cage area) and her left knee was sore. Review of the admission "MDS" with an ARD date of 3/28/19, indicated that Resident #55 was cognitively intact.	F 657		

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F 657	Continued From page 25 Review of the facility's document titled, "Resident Incident Report" dated 5/7/19, indicated that resident fell on 5/7/19 at 10:10 PM, while sitting on the bed she was trying to put on her slippers so that she could go to the bathroom and fell off the bed. Observation of Resident #55 in bed asleep on 5/15/19 at 2:15 PM, and 5/16/19 at 12:15 PM, revealed the bed was in a low position but not touching the floor, both upper quarter side rails were raised, the resident's slippers were next to the bed and the "reacher" device was on the bed side stand next to her bed. In an interview with the DON on 5/15/19 at 2:45 PM, the DON confirmed that Resident #55 was given the "reacher" device by therapy when Resident #55 was receiving therapy so that she could reach for items and not have to bend over. The DON confirmed after reviewing Resident #55's care plan, that the 5/7/19 fall, the use of the "reacher" device, the positioning of the bed, and the quarter upper side rails were not addressed on the care plan.	F 657		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and	F 688		6/18/19

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F 688	Continued From page 26 services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, the facility failed to implement the therapy restorative nursing plan for two (2) residents, Resident #70 and Resident #39, of seven (7) residents reviewed for restorative nursing. Findings include: Review of the facility's policy titled, "Restorative Nursing Services", revised July 2017, indicated, "Residents will receive restorative nursing care as needed to help promote optimal safety and independence ...2. Residents may be started on restorative nursing ...when discharged from rehabilitative care. 3. Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care ..." During an interview on 5/15/19 at 3:38 PM, the Therapy Rehab Director (TRD) stated that Therapy has always screened each resident quarterly and more often if the resident experiences a fall or if nursing noticed a change in the resident. She stated that Therapy was conducting these screenings, which if the results of the screening indicated therapy, an evaluation and treatment program would be conducted. She	F 688	1. Root Cause Analysis was completed by the Quality Assurance and Performance Improvement (QAPI) Committee on 3/14/19 and again on 6/7/19. Based on findings the facility failed to provide care and services to maintain, improve, or prevent potentially avoidable declines in range of motion and mobility for resident #39, and #70. Resident #39 was screened by a Certified Occupational Therapy Assistant (COTA) and put on case load on 3/12/19. Resident #70 was screened by a COTA on 3/19/19 and it was determined an evaluation was not needed at that time due to being at baseline. All residents are screened quarterly and as needed by the therapy department for any declines in functional status. 2. All residents have the potential to be affected by this practice. 3. Education was initiated for clinical staff on 3/12/19 by the Director of Nurses(DON) and was completed on 4/3/19 regarding providing care and services to maintain, improve, or prevent potentially avoidable declines in range of	

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F 688	Continued From page 27 stated that the therapy evaluation and treatment would include Physical, Occupational and Speech therapy. She stated since the survey on 2/28/19, Therapy has continued to conduct the therapy screening quarterly and more often if warranted and if the resident required therapy, the therapy department would keep that resident on their case load until the resident's goals are met. After the resident met their goals, Therapy would screen again quarterly and more often if necessary. If Therapy determined an evaluation is warranted, Therapy would add this resident to their case and and develop the therapy plan. She stated that Therapists has been providing the therapy for any resident warranted, until the resident meets their goals. Resident #70 Review of the medical record revealed Resident #70 was evaluated and admitted to physical therapy (PT) and occupational therapy (OT) on 8/20/18. On 10/18/18, Resident #70 met his therapy goals. Review of the "PT/OT Discharge Summary" dated 10/18/18, indicated, "Discharge Disposition: skilled services no longer justified ...Follow-up Care Recommended: Restorative treatment ..." Review of the "Restorative Plans" dated 10/17/18, documented that the therapist provided the restorative plan to Licensed Nurse (LN) #9 on 10/17/18. The document indicated signatures by both the therapist and LN #9. Review of the restorative documents indicated: 1. Restorative Plan-Active Range of Motion. Instructions: perform activity in : Sitting/Standing/Lying Down, Other sitting and standing special instructions:...kickouts (knee flexion and extension) side kickouts (hip	F 688	motion and mobility of residents. Education was initiated by Staff Development Nurse on 6/11/19 and 6/13/19 with current clinical staff regarding providing the care and services to maintain, improve, or prevent potentially avoidable declines in range of motion and mobility of residents. All newly hired clinical staff will be educated by the Staff Development Nurse during orientation regarding providing care and services to maintain, improve, or prevent potentially avoidable declines in range of motion and mobility of residents. A restorative contract went into effect on 4/10/19 with the therapy department and 2 restorative aides have been hired and interviews continue for additional restorative staff. 4. Director of Nurses/Unit Manager to conduct a Quality Review of residents who have had any declines in range of motion based on their prior level of function and mobility weekly x 4 weeks then monthly x 3 months. Quality Review to be modified based on findings. The findings of the Quality Review to be reported in the monthly QAPI Committee Meeting and reviewed by the Interdisciplinary Team for any further recommendations for 90 days.	

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F 688	Continued From page 28 abduction/adduction) heel raises (plantar/dorsal flexion) marching (hip flexion) ball squeeze, wheelchair pushups, bike x 10-15 minutes. Repetition: repeat all 20 times per set. Do three (3) session per day. 2. Restorative Plans-Gait. Instructions: Perform gait using: rolling walker/standard walker/wheelchair/cane. Special instructions: using gait belt GT, assist patient from therapy to his room. Patient requiring stand by assist. Distance to walk: 75-100 feet. Number of repetitions: 1-2. Do one (1) session per day. Review of Resident #70's care plan revealed that the "Restorative Plan" had not been included. Interview with the Rehab Director (RD) on 5/15/19 at 3:38 PM, revealed that once therapy educates nursing staff on the restorative plan, then therapy turns over the care of the resident to nursing. The Rehab Director stated that therapy creates the restorative plan, then nursing adds the restorative plan to the resident's care plan and implements the plan. During this interview, the RD stated that Resident #70 received therapy from 8/20/18 through 10/18/18, and was discharged to restorative nursing. She stated that on 11/19/18, the resident was admitted to the hospital, due to his respiratory condition, and returned from the hospital on 11/20/18. She stated that Resident #70 was picked up by therapy until he was discharged from therapy on 1/28/19, due to his goals were met. The RD stated that Resident #70 was then screened quarterly, the last on 3/12/19, with the recommendation that a therapy evaluation and treatment was not needed. The RD stated that meant that Resident #70 had not declined from his functional status when he was discharged from therapy. She stated that therapy will	F 688		

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F 688	Continued From page 29 continue to screen the resident quarterly, or more often, if nursing notices a change in the resident. Review of the "Therapy Services Screening" document dated 3/12/19, indicated: "Patient observed and evaluation is not recommended". Resident #39 Review of the medical record revealed Resident #39 was evaluated and admitted to PT on 6/198/18. Resident #39 met her PT goals on 7/23/18. Review of the "PT Discharge Summary", dated 7/23/18, indicated, "Discharge Disposition: skilled services no longer justified ... Follow-up Care Recommended: Restorative treatment ..." Review of the "Restorative Plan" dated 7/19/18, documented that the therapist provided the restorative plan to the previous Director of Nursing (DON) on 07/23/18. This document indicated signatures by both the therapist and the previous DON. Review of the "Restorative Documents", revealed: 1. Restorative Plan-Active Range of Motion. Instructions: Perform activity in : Sitting/Standing/Lying Down...kickouts (knee flexion and extension)-side kickouts (hip abduction) heel raises (plantar flexion) bike times 10-15 minutes, Repetition: Repeat all 20 times per set. Do three (3) session per day. 2. Restorative Plans-Gait. Instructions: Perform gait using: rolling walker/standard walker/wheelchair/cane. Special Instruction: walk to dine with patient time (x) two (2). Distance to walk: 150 feet. Number of repetitions-three (3). 3. Repetition: Do 1-2 sessions per day. The DON was interviewed on 02/27/19 at 3:45 PM. He verified there had been no formal	F 688		

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F 688	Continued From page 30	F 688		

restorative nursing program in the building since the previous Restorative Nurse was separated from the facility in November 2018. He said when he was hired as the DON, he received a staffing schedule which included two (2) Restorative Nursing Assistants (RNAs), but neither of them ever reported to work. The DON said he never saw them and never met them. The facility terminated both RNAs for abandonment of job duties. He state that he had not yet reached the point where he could fill the vacancies in a formal restorative program. The DON explained, "We are struggling to meet the basic clinical needs of the residents".

In an interview with the DON on 5/16/19 at 3:00 PM, the DON confirmed that he had reviewed Resident #70 and Resident #39's clinical records and the documents in the medical record's room, that were loose in a box for various residents, and that he could not locate any documentation that the restorative plan was implemented by nursing for either resident. Also, during this interview the DON confirmed that neither resident's care plan addressed the restorative plan developed by therapy. The DON confirmed the restorative plans were not implemented, as recommended by therapy and should have been completed by staff during routine care.

Review of therapy quarterly screenings for Resident #39, dated 8/24/18, 11/27/18, 12/11/18, and 2/29/19, indicated "Patient observed and evaluation not recommended".

In an interview on 5/15/19 at 3:38 PM, the Rehab Director stated that even though Resident #39 was referred to restorative nursing on 7/24/18, therapy continued to screen the resident at least

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F 688	Continued From page 31 quarterly and more often if nursing noticed any changes in the resident. The RD stated based on these screenings, Resident #39 did not decline from her functional status that was achieved on 7/23/18, when she was discharged from therapy. The RD stated nursing noticed Resident #39 was limping on 3/12/19, a screening was conducted, and an evaluation was recommended. The RD stated the resident was being seen by her physician for a problem with her toe nail, and requested to wait until the toe healed before further therapy evaluation and treatment.	F 688		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the "Refrigerators and Freezers"	F 812	1. Root Cause Analysis was completed by the Quality Assurance and	6/18/19

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F 812	Continued From page 32 policy, the facility failed to ensure the kitchen and dining services were sanitary for 86 out of 88 current residents and had: -cooking trays free from grease build-up; -cooking pans free from debris; -stove burner grates in good repair; and -expired milk had been discarded per facility policy. Findings include: The facility policy "Refrigerators and Freezers" from the Food and Nutrition Services Policy and Procedure Manual (Revised December 2014), revealed the following under Policy Interpretation and Implementation "8. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates. Supervisors should contact vendors or manufacturers when expiration dates are in question or to decipher codes...9. Supervisors will inspect refrigerators and freezers for gasket condition, fan condition, presence of rust, excess condensation and any other damage or maintenance needs. Necessary repairs will be initiated immediately. Maintenance schedules per manufacturer guidelines will be scheduled and followed." During the initial walkthrough of the kitchen on 02/25/19, commencing at 11:15 AM, a food storage cart was observed with two (2) trays caked with grease around the exterior lips of the pans. Per concurrent interview with the Dietary Manager (DM), the DM explained the trays were used exclusively for cooking but were still in need of cleaning. During a subsequent interview with the DM on	F 812	Performance Improvement Committee(QAPI) on 3/14/19 and again on 6/7/19. Based on findings the facility failed to remove expired milk from the cooler, replace pitted trays with grease build up, and replace stove grates. Expired milk was removed from the milk cooler and placed in the main cooler with a label of expired milk on the crate by the dietary manager on 2/25/19. On 2/28/19 the expired milk was picked up and credit was given by the vendor. On 2/28/19 trays were ordered by the dietary manager and delivered on 2/28/19 to replace the pitted trays with grease that could not be removed. On 2/26/19 new stove grates were ordered by maintenance and they were delivered and installed on 3/25/19 by maintenance. 2. All residents who receive food from dietary have the potential to be affected by this practice. 3. In-service education was completed on 3/1/19 by the dietary manager with all dietary staff regarding expired food items and policy and procedure for removal of expired food items. In-service education was completed on 5/27/19 for all of the dietary staff by the Administrator on storage, preparation, and sanitation. A review of all pans and bake ware was conducted by the dietary manager on 2/25/19. The vendor was contacted by the dietary manager about their practice of removing expired milk upon delivery of new product on 2/25/19. Registered Dietitian will perform a Quality Review for	

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	255338	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	6428 US HIGHWAY 11 LUMBERTON, MS 39455

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F 812	Continued From page 33 02/28/19 at 9:15 AM, he stated the trays could not be cleaned any further and had placed an order to replace 10 of them. Examination of the kitchen stove on 02/25/19 at approximately 11:15 AM, revealed two (2) grates were rusted with missing tips. The DM was present for the observation and stated he would contact maintenance for replacement. An observation of the refrigerated milk products on 02/25/19 at approximately 11:15 AM, revealed all the pint-sized cartons of chocolate milk and 2% milk revealed an expiration date of 02/22/19. The DM, who was present during the observation, pulled the entire crate from the refrigerator, examined a few of the milk container dates and stated it was the responsibility of the delivery company to ensure its products were pulled when the expiration date occurred. He also explained milk deliveries occurred twice a week on Tuesdays and Fridays. On 02/28/19, commencing at 9:15 AM, in a subsequent tour of the kitchen, observation revealed one (1) of three (3) facility's food preparation pans was noted to be pitted and coated with a film-like substance that could not be removed when the DM attempted to remove it with his finger. The DM stated in response to the observation he would also order new cooking pans.	F 812	kitchen food service observation quarterly that includes expired milk, pitted pans with grease build up, and stove grates in good repair. 4. 5 x a week observation and sanitation audits will be completed by the Dietary Manager for expired milk, pitted trays, trays with grease build up, and stove grates not in good repair x 4 weeks. Administrator will complete weekly observation rounds and reviews of documented audits x 4 weeks. The findings of the Quality Review to be reported in the monthly Quality Assurance and Performance Improvement Committee Meeting and reviewed by the Interdisciplinary Team for any further recommendations for 90 days.	

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	255338	A. BUILDING **01 - LAMAR HEALTHCARE & REHABILITATION CENTER** B. WING _____	**02/25/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAMAR HEALTHCARE & REHABILITATION CENTER	**6428 US HIGHWAY 11 LUMBERTON, MS 39455**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		3/1/19

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

Electronically Signed — 04/15/2019

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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	255338	A. BUILDING **01 - LAMAR HEALTHCARE & REHABILITATION CENTER** B. WING _____	**02/25/2019**

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K 918	Continued From page 1 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and testing, the facility failed to provided a generator that transfer power to the facility within 10 seconds in accordance NFPA 110. This deficient practice has the potential to affect the entire facility on day of facility survey. Findings include: While testing the generator on 2-25-19 at 10:50 AM, observation revealed the generator failed to transfer power to the facility within 10 seconds. The generator transferred power to the facility in 14.28 seconds. The findings were acknowledged by the Administrator and the Maintenance Director verified this observation during the exit interview on 2-25-19.	K 918	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists for that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.Observation by surveyor revealed the generator failed to transfer power to the facility within 10 seconds. This was addressed by maintenance supervisor calling Contract Company to come and adjust time delays to shorten the time it takes to get the generator online. On 3/1/19 the generator passed the 10 second test. 2. All residents have the potential to be affected. 3. A Generator Check form has been developed and will be used weekly x 3 months to audit the start time of the generator. After 3 months, the generator will be checked monthly. Any changes to the testing of the generator will be	

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	255338	A. BUILDING **01 - LAMAR HEALTHCARE & REHABILITATION CENTER** B. WING _____	**02/25/2019**

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LAMAR HEALTHCARE & REHABILITATION CENTER	**6428 US HIGHWAY 11** **LUMBERTON, MS 39455**

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K 918	Continued From page 2	K 918	approved by the Safety Committee and the Executive Director. 4. Any variance to the 10 second test will be reported to the Executive Director and QAPI team monthly. 0	

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 2/25/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

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