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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP MANOR HEALTH AND REHABILITATION CEI	101 KIRKLAND STREET UNION, MS 39365

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M 000	Initial Comments The State Agency (SA) conducted a recertification survey at the facility from 01/4/22 through 01/6/22. The SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm related to the failure to maintain a clean environment, improper storage of respiratory equipment, not labeling oxygen equipment, unsanitary dietary department, a nonfunctioning call light, and failure to provide appropriate Activities of Daily Living (ADL) care for residents. The SA cited deficiencies at M610, M655, M815, M1010 and M1230. At the time of the survey the facility census was 55 and the facility held a license for 60 beds.	M 000		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, staff and resident interview, record review and facility policy review, the facility failed to provide Activities of Daily Living (ADL) care for dependent residents as	M 610	Root Cause Analysis was conducted by Quality Assurance Performance Improvement(QAPI) Committee and based on record review and interview the facility failed to provide Activities of Daily (ADL) for resident # 1 and # 11 dependent	2/21/22

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M 610	Continued From page 1 evidenced by long facial and neck hair and long fingernails for two (2) of 24 residents reviewed. Resident #1 and Resident #1. Findings Include: Review of the facility policy titled, "Care of Nails" with a revision date of 9/1/2017, revealed under, "Procedure:" "trim fingernails" and "clean nails." Resident #11 An observation on 01/04/22 at 01:12 PM, revealed Resident # 11's hair was disheveled with long hair on the face and neck. Fingernails were long with a brown substance under one nail. An interview on 01/04/22 at 1:15 PM with Resident #11 confirmed that he wants a shave and his nails trimmed. Another observation on 01/05/22 at 1:45 PM, of Resident #11 revealed long hair on the resident's face and neck, hair disheveled, nails were long with a brown substance under one nail. An interview on 01/05/22 at 1:50 PM, revealed that Resident # 11 wanted to be shaved and have his nails trimmed and that they have not done it yet. Record review of Resident # 11's Admission Record revealed he was admitted to the facility 10/6/21, with diagnoses of the following: Cerebral infarction, Muscle Weakness, History of Falling, and Unsteadiness on Feet. Record review of Resident # 11's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/13/21, revealed a Brief Interview for	M 610	residents reviewed. Activities of Daily Living (ADL) was performed on 1/6/2022 for resident # 1 and #11 for nail care, shaving and grooming. Quality Review of current dependent residents conducted on 1/6/2022 by Director of Nurses(DON), Assistant Director of Nurses(ADON) and Unit Manager(UM) to ensure all dependent residents were provided Activities of Daily Living (ADL) care. All residents of the facility have the potential to be affected by this issue. Education initiated on 1/6/2022 with current Certified Nursing Assistant(CNA) and current nurses by DON, ADON on this regulation to ensure all dependent residents are provided Activities of Daily Living (ADL) care. All CNAs will have education on ADL care, new hires will receive education upon hire. Quality Review of Activities of Daily Living (ADL) for dependent residents to be conducted by DON or ADON 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then monthly began 1/10/2022. Findings will be reported by the DON at monthly QAPI Committee Meeting beginning on 2/21/22 for 6 months. Quality Review schedule will be modified based on findings. Root Cause Analysis (RCA) will be used by the committee and updates made based on findings.	

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M 610	Continued From page 2	M 610		

Mental Status (BIMS) score of 15, indicating the resident had full cognitive ability.

Resident #1

An observation on 01/04/22 at 11:06 AM, revealed that Resident # 1 had long nails and hair on his face and neck.

An observation again on 01/05/22 at 2:12 PM, revealed that Resident # 1 had long hair on his neck and face and long nails.

Record review of the Admission Record revealed Resident # 1 was admitted to the facility on 9/23/20 with a diagnosis of NEED FOR ASSISTANCE WITH PERSONAL CARE.

Record review of Resident #1's MDS with an ARD dated 12/17/21, revealed a BIMS score of 3, indicating the resident had severe cognitive impairment.

An interview on 01/05/22 at 1:55 PM, with Certified Nursing Assistant (CNA) # 3 revealed shaving and nail care is the responsibility of the CNAs. CNA # 3 revealed that the residents are shaved when we see it is needed or the resident asks to be shaved and nail care is given everyday if needed and nails are trimmed weekly; unless they are a diabetic then the nurse does it.

An interview on 01/05/22 at 2: 05 PM, with Registered Nurse (RN) # 1 revealed that shaving and nail care are the responsibility of the CNA, and they have a schedule. RN # 1 revealed that nail care is done by the CNA unless they are diabetic. RN # 1 confirmed that Resident #1 and Resident #11 needed to be shaved and will be shaved today and stated, "long hair on your neck

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M 610	Continued From page 3 is uncomfortable." An interview on 01/05/22 at 3:45 PM, with the Director of Nurses (DON) revealed the facility has an Activities of Daily Living (ADL) policy and that the CNAs are assigned the task of ADLs. She revealed that the CNAs know that a part of bathing is cleaning their nails and shaving. She revealed that they know to shave the residents if they need shaving and need their nails cleaned or trimmed then they know to do it unless they are a diabetic.	M 610		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observations, staff interview, record review and facility policy review the facility failed to properly label, date and store oxygen nebulizer mask and oxygen (O2) tubing to prevent contamination for two (2) of 12 residents receiving oxygen therapy. Resident #35 and Resident #99. Findings include: Review of the facility policy titled, "Oxygen Therapy", with a revision date of 8/28/2017	M 655	Root Cause Analysis was conducted by Quality Assurance Performance Improvement (QAPI) Committee and based on observations and interviews, the facility failed to properly label, date and store oxygen nebulizer mask and oxygen (O2) tubing to prevent contamination for resident #35 and resident #99. Oxygen tubing was properly labeled, dated and stored on 1/4/22 by the Unit Manager for residents receiving oxygen therapy. Quality Review of current residents receiving oxygen therapy was conducted	2/21/22

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M 655	Continued From page 4 revealed under procedure, to label tubing and humidifier with date and time. The procedure for nebulizer with a revision date of 3/20/2018, revealed place the entire unit in a bag to be maintained in the resident's room. Resident #35: An observation, on 01/04/22 at 01:06 PM, revealed Resident #35's O2 tubing was not dated or labeled. His nebulizer mask was laying on his bed not bagged. Record review of the Clinical Physicians Orders for Resident #35 revealed an order with a start date of 7/7/21 for O2 (oxygen) @ (at) 2L (liters) via (by) NC (nasal cannula) as needed for SOB (shortness of breath). Record review of the Clinical Physician's Orders printed 1/5/22 revealed an active order dated 8/24/21 for "Albuterol Sulfate Nebulization Solution 0.83 MG(milligrams)/3ML(milliters), 1 vial inhale orally via neb ..." Record review of Resident #35's Face Sheet revealed diagnoses that included, Chronic Obstructive Pulmonary Disease, End Stage Heart Disease, Anemia, and Dependence on Supplemental Oxygen. Resident #99: An observation and interview on 01/04/22 at 03:57 PM revealed Resident #99's oxygen tubing/cannula laying on the floor. The tubing was not dated and there was no bag for storage of the oxygen tubing in the room. Registered Nurse (RN) #1 confirmed the resident's oxygen tubing was laying in the floor. RN #1 confirmed that the tubing should be in a bag when not in use. RN #1 stated that it was an infection control issue	M 655	on 1/4/22 by Director of Nurses(DON), Assistant Director of Nurses(ADON) and Unit Manager to ensure residents receiving oxygen therapy tubing were properly labeled, dated and stored. Follow up based on findings. All residents receiving oxygen therapy have the potential to be affected by this issue. Education with current nurses was initiated by DON on 1/6/22 on this regulation to ensure residents receiving oxygen therapy tubing is properly labeled, dated, and stored. All nurses to be educated, new hires to receive education upon hire. Quality Review of residents receiving oxygen therapy to be conducted by Director of Nurses or Assistant Director of Nurses 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then monthly for 6 months to ensure residents receiving oxygen therapy tubing is properly labeled, dated, and stored, began on 1/10/2022. Findings of the quality review to be reported by the DON to the QAPI committee monthly beginning 2/21/22 for 6 months for review and recommendations.	

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M 655	Continued From page 5 because the tubing was contaminated and was a risk for infections. An interview, on 1/5/22 at 3:30 PM, with the Director of Nursing (DON) revealed she had seen oxygen tubing not bagged and laying on the floor yesterday. She stated that was an infection control issue. The DON confirmed that all oxygen tubing and nebulizers should be bagged, and oxygen tubing should be dated. Record review of Resident #99's Clinical Physicians Orders revealed an order with a start date of 12/14/21 for Oxygen 2 L/min (minute) per NC as needed PRN. Record review of Resident #99's Face Sheet revealed diagnoses of Pneumonia and Dependence on Supplemental Oxygen.	M 655		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Based on observations, staff interviews, record review and facility policy review, the facility failed to provide a safe and clean environment for preparation and storage of food and ice for two (2) of three (3) kitchen tours. Findings include: Review of the facility policy titled, "Equipment", revised 9/2017, revealed all food service	M 815	On 1/4/2022 two pitchers of tea and eight glasses of milk that were not dated were removed for the refrigerator by the Dietary Manager(DM). On 1/4/2022 (3) baking sheets, 2 muffin pans, (2) 9x13 pans, (2) 10 inch skillets, and (1) 12 inch skillet were taken out of service and replaced with new cookware by the DM. On 1/4/2022 the inside and outside of the walk-in cooler were cleaned by the DM.	2/21/22

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M 815	Continued From page 6 equipment will be clean, sanitary, and in proper working order. All food contact equipment will be cleaned and sanitized after each use. All non-food contact equipment will be clean and free of debris. An observation of the kitchen on 01/4/22 at 10:05 AM, during the initial tour, revealed two (2) pitchers of tea and eight (8) glasses of milk in the refrigerator not dated. There were three (3) baking sheets, (2) muffin pans and (2) 9x13 pans covered with thick, rough black build up and (2) 10 inch skillets and one (1) 12 inch skillet with the outside coated with brownish black build up. The outside of the walk-in refrigerator door and handle was covered with brown and white splashes of debris and build up. The inside of the door was covered with a thin brownish film and the walls were splattered with dry brownish and white colored areas that had run down the walls. The ice machine had black buildup around the seal of the lid. On 01/05/22 at 11:05 AM, an observation and interview with the Dietary Manager (DM) and the District Dietary Manager (DDM) confirmed that the ice machine had buildup around the seal of the lid and noted an approximately 0.5 centimeter (cm) black flake in the center of the ice. The DDM confirmed the black flake in the ice and stated that it probably fell off the ice machine seal and stated that the ice was contaminated. An interview on 01/5/22 at 10:50 AM, with the DM stated that she saw a lot of "dirtiness" in the kitchen. An interview on 01/5/22 at 10:55 AM, with the DDM revealed he stated that the kitchen needed a good cleaning.	M 815	The ice machine was taken out of service, emptied, cleaned, and sanitized by the Maintenance Director(MD). A quality review was conducted by the Executive Director(ED) on 1/6/2022 of the dietary department. All residents of the facility have the potential to be affected by this issue. On 1/6/2022 education was started with dietary staff by the ED on dating and proper storage of food and beverages, all dietary staff to be educated, new hires to receive education upon hire. Routine cleaning schedule was initiated on 1/6/2022 by the District Manager. On 1/6/2022 the MD was educated by the ED on documentation and cleaning of the ice machine. The ED or Human Resources Coordinator(HRC) will conduct a quality review of the dietary department to observe for any food/beverage items not covered or dated, carbon build-up on pots and pans, and cleanliness of the kitchen began on 1/10/2022. Quality Review to be conducted 3 times a week for 4 weeks, 2 times a week for 4 weeks, and then to continue weekly for 8 weeks. Results will be reported to the Quality Assurance Performance Improvement(QAPI) committee monthly beginning 2/21/22 for 6 months by the ED for review and recommendations.	

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M 815	Continued From page 7 An interview on 01/6/22 at 9:05 AM, with the Administrator (ADM) revealed that unlabeled food could cause food borne illness and the ice machine needed cleaning. He stated that he did not like that, "it was nasty". The ADM stated that pans with carbon build up can harbor germs that the dishwasher might not handle, and it could be a fire hazard. He stated that they have new pans in storage, and they should have replaced them. An interview on 01/6/22 at 12:30 PM, with the DM confirmed there was not a cleaning schedule for the kitchen staff to follow. An interview on 01/6/22 at 12:35 PM, with Dietary Staff #1 confirmed there was no cleaning schedule posted for cleaning the kitchen and stated that they just did what they could. An interview with the Maintenance Director revealed that the ice machine is cleaned every month and that he thinks it was cleaned in December. Record review of the Work History report revealed the due date for cleaning ice machines was 10/31/2021. The task completion column revealed no action recorded. For due date 11/30/2021, the task completed column revealed marked done on time on 12/8/2021. For due date 12/31/2021, the task completed column was marked done on time on 12/8/2021.	M 815		
M1010	45.35.1 Housekeeping Facilities and Services Housekeeping Facilities and Services. 1. The physical plant shall be kept in good repair,	M1010		2/21/22

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M1010	Continued From page 8 neat, and attractive. The safety and comfort of the resident shall be the first consideration. 2. Janitor closets shall be provided with a mop-cleaning sink and be large enough in area to store house cleaning supplies and equipment. A separate janitor closet area and equipment should be provided for the food service area. This Statute is not met as evidenced by: Level II Based on observations, staff interviews and facility policy review, the facility failed to maintain an environment that was clean and free of odors for two (2) of three (3) days of survey. Findings include: Review of the facility policy titled, "Nursing Home Cleaning Routine," stated, "Cleaning Responsibilities: .....7:00-7:45 Morning walk through of your hall, sweep debris from the rooms, mop up spills in rooms, shower rooms. 1:20-1:50 Clean shower rooms, 1:50-2:00 Perform a final walk through of your area. Sweep up any debris, mop up any spills." Facility policy titled, "Nursing Home Floor Care Routine For: Floor Tech," stated, "The floortech is responsible for floor care throughout the building. Dust mop and mop all halls plus the lobby area. Follow buffing, clean the dining room, follow buffing and perform final walk through, sweep up any debris, mop up any spills." An observation was made on 01/04/22 upon entrance to the building at 10:00 AM the State Agency (SA) smelled a strong odor of urine upon entrance inside the building and also on the South hallway around rooms 101-103. The SA	M1010	On 1/6/2022 Housekeeping Staff were trained on use of the autoscrubber machine, hallways of the facility were cleaned on 1/6/2022. On 1/5/2022 soiled shower mats were removed from shower rooms of the facility, on 1/6/2022 showers were deep cleaned to remove any build up on walls and floors. Rooms 101,102,103,104,112,113,133 and 117 were cleaned to remove any urine odors and stains from residents□ rooms. Floor at the front entrance was cleaned to remove any urine odors from the front entrance on 1/6/2022. A quality review of housekeeping practices was conducted by the Executive Director on 1/6/2022. All residents have the potential to be affected by this issue. Education of housekeeping staff on 1/6/2022 by the District Manager was conducted on routine cleaning schedules. All new hires will be educated on cleaning schedule upon hire. Housekeeping staff to adhere to routine cleaning schedule and address areas of concern as needed. The Executive Director(ED) or Director of Nurses(DON) will conduct a quality review	

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M1010	Continued From page 9 smelled odors of urine on 01/05/22 upon entrance to the building at 8:15 AM in the front lobby and around room 117 at 3:00 PM on the North Hallway and on the South Hallway around rooms 101-103 at 3:10 PM and again at 4:05 PM on the South Hallway on 01/05/22. An observation was made on 01/04/22 at 11:30 AM of the floors on the North and South hallways of dirt and debris, medicine cups, plastic wrapping from cracker packs, leaves and visible pieces of dirt and mud all throughout the facility on both hallways. An observation on 01/04/22 from 11:30 AM through 1:00 PM, on the North and South hallways of visible spills on the floors and dried liquid spills that have dirt dried on the top of the spills are observed in rooms 101, 112, 113, 117 and 133. An observation on 01/05/22 at 3:35 PM, revealed an area about the size of a small plate of a dark brown soiled area on the floor outside of room 117. The Housekeeping Supervisor later confirmed at 4:20 PM on 01/05/22, that it was from the wall hand sanitizer leaking onto the floor and it had dried with accumulated dirt and debris on the area and that it had not been cleaned up. An interview on 01/05/22 at 4:00 PM, with the Housekeeping Supervisor and the District Housekeeping Manager stated that the floor cleaner had broken down about a year ago and the facility was responsible for replacing the equipment and they had not gotten a replacement until about two weeks ago. The District Housekeeping Manager stated that the floor cleaner will deodorize, clean, mop and buff the floors but that he has not had a chance to	M1010	of resident rooms and common areas 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then weekly for 4 weeks to begin on 1/10/2022. Monitoring will continue weekly and as needed. Result of quality review will be reported to the Quality Assurance Performance Improvement(QAPI)committee by the ED on 2/21/22 and monthly times 6 months for review and recommendations.	

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M1010	Continued From page 10	M1010		

in-service the staff to use it yet so that is why the floors look so bad. The Housekeeping Supervisor stated that all they have to clean the floors with at this time is a mop and a broom and that they have not been able to buff the floors in over a year.

An observation on 01/05/22 from 4:00 PM until 4:25 PM, with the District Housekeeping Manager and the Housekeeping Supervisor along with the SA made walking rounds of the building and they confirmed that the areas around rooms 101-103 had strong urine odors in the hallways and also outside of room 117. The Housekeeping Supervisor confirmed that they had deodorizer sprayers mounted in the hallways but when she checked the wall mounted device, the deodorizer can was empty in the hallway outside of rooms 101-103. During this tour of the facility an observation of the two shower rooms on the South Hallway were observed to have dark black growth and an orange tan color build up on the shower floors and along the walls of the tile in the showers and on the rubber mat on the shower room floors in two (2) of two shower rooms on the South hallway. An interview with the Housekeeping Supervisor and the District Housekeeping Manager at the time of the observation confirmed that they have not cleaned or scrubbed the shower floors and walls for several weeks and she stated, "We just need to throw those shower mats away. We come in the shower rooms and mop each day but we haven't had time to scrub the mold in the shower room floors and the walls for some time."

An Interview with Certified Nursing Assistant (CNA) #3 on 01/05/22 at 4:30 PM, confirmed that both of the shower rooms on the South hall are used for resident care. each day and that is the

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HILLTOP MANOR HEALTH AND REHABILITATION CEI	101 KIRKLAND STREET UNION, MS 39365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M1010	Continued From page 11 only shower rooms in the building. An interview with the Housekeeping Supervisor on 01/05/22 at 4:45 PM, stated, "We haven't had a chance to watch the video to operate the floor cleaner yet." The District Housekeeping Manager stated, "I'm going to educate the staff on how to use it before I leave today." The District Housekeeping Manager and the Housekeeping Supervisor confirmed that they do not have a floor tech employed right now and stated, "We are thinking about hiring someone to work about 3-4 hours in the evening to do that job." The Housekeeping Supervisor confirmed that it is herself and one other employee to clean the building daily and that they have one employee that is in the laundry department. An interview with the DON on 01/06/22 at 8:45 AM, stated that she had verbally talked with the District Housekeeping Manager several times over the last two weeks since the floor machine had been delivered to get them to train and in-service the housekeepers on how to use the new floor machine "Because we needed our floors cleaned badly and he told me several times that he would do it and hasn't until you pointed it out to them yesterday about how bad the floors looked, so now they are running it today for the first time."	M1010		
M1230	45.40.11 Call System Call System. A call system shall be in place at the nurses' station to receive resident calls through a communication system to include audible and visual signals from bedrooms, toilets, and bathing facilities.	M1230		2/21/22

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M1230	Continued From page 12 This Statute is not met as evidenced by: Level II Based on observation, record review, staff and resident interview and facility policy review, the facility failed to ensure that the call system was working for Resident # 8 for one (1) of 60 resident call lights in the facility. Findings include: Review of the facility policy titled, "Call Bell System-Inoperable," dated 11/30/14, stated, "Resident must have, at all times, a system to notify staff when assistance is needed. The call bell system is to be inspected on a regularly scheduled basis by Maintenance. If the call bell system is inoperable, in one room, one hall, or the entire unit, the following procedure must be followed: Maintenance, the Executive Director, and the Director of Clinical Services must be notified immediately if any call bell or the system is inoperable. Hand bells or tap type bells will be placed within reach of any resident affected by an inoperable call bell." On 01/04/22 at 12:30 PM an observation and interview was conducted with Resident # 8 in her room. She was laying in the bed and stated that she had moved into this private room last week and that she liked it but that her call light wasn't working. She stated that Maintenance had worked on it Friday and stated, "I think he is having to order a part, I'm not sure." The State Agency (SA) pushed the resident's call light and did not hear it buzzing at the nurse's desk, nor was the call light over the door lighting up. The SA confirmed with Resident #8 through observation and interview that she did not have a device to utilize in order to call for assistance.	M1230	Root Cause Analysis was conducted by Quality Assurance Performance Improvement(QAPI) Committee and based on observation, interviews, and policy review, the facility failed to ensure the call system was working for resident #8. Resident #8 received a bell on 1/4/22 and call system was functioning as of 1/5/22. Quality of Review of all residents with call system was conducted on 1/4/22 by Director of Nurses and Assistant Director of Nurses to ensure call system were operable. All residents have the tendency to be affected by this issue. Education initiated on 1/4/22 by Director of Nurses(DON) and Assistant Director of Nurses(ADON) on this regulation to ensure call system is operable. New hires will be trained during orientation and as needed. Quality Review of call system for residents to be conducted by Maintenance Director or Executive Director 3 times weekly for 4 weeks, then 2 times weekly for 4 weeks, then weekly for 8 weeks, began on 1/10/2022 . Results to be reported monthly by the Maintenance Director or Executive Director to the QAPI committee beginning 2/21/22 for 6 months, for review and or recommendations.	

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M1230	Continued From page 13 The SA walked to the only nurse's desk in the building and did not see or hear the light blinking to identify that the call light had been pushed. An interview with Registered Nurse (RN) #2 on 01/04/22 at 12:35 PM stated if the call light is not buzzing or if it doesn't light up over the door then we would not know which room is needing assistance and we would have to check every resident in their rooms to see if anyone needs anything. RN#2 confirmed through interview and observation that she did not hear or see a call light buzzing or blinking at a resident's room. The SA told RN #2 that the call light for Resident #8 was pushed right now and RN#2 verified that she could not tell which room it was that needed assistance because the light was not working and the panel at the nurse's desk was not buzzing. An interview with the Maintenance Director on 01/04/22 at 12:45 PM stated that the resident had moved into that private room on Friday (12/31/21) and that her call light wasn't working and that he thought he had fixed it. The Maintenance Director went into the resident's room and confirmed that it was not currently working and that Resident #8 did not have a device to call for assistance if her call light was not working. The Maintenance Director immediately began to work on the call light to address the issue of why it was not working. He confirmed through interview that he did not follow back up to ensure that the call light was working after the repair on 12/31/21 and stated, "I thought I had fixed it." An interview on 01/04/22 at 12:50 PM with the Resident #8 stated that she had pushed her call light the other night (01/03/22) around 8 o'clock or so and that no one ever came to her room so she got up and got in her wheelchair and went down	M1230		

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M1230	Continued From page 14	M1230		

to the nurse's desk to ask for some chap stick and that there was a girl that she told that her light wasn't working but she could not remember who she was.

On 01/04/22 at 12:45 PM an observation of the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) making room to room rounds checking all the call lights in every resident's room and bathroom was observed. An interview at that time with the DON confirmed that all the call lights in the building were working properly except for Resident #8's room. The DON immediately placed a bell at the bedside of Resident #8's bed and instructed her how to utilize the bell while the Maintenance Director was working on the call light. The DON confirmed that she was not made aware that the resident's call light was not working last week.

An interview with the Administrator on 01/04/22 at 1:00 PM confirmed that he was not aware that the resident's call light was not working last week and was not made aware that it was not working properly until now.

Interview with the DON on 01/05/22 at 2:00 PM stated that she had investigated into who the resident had told that her call light wasn't working and it was Certified Nursing Assistant (CNA) #2 on the night of 01/03/22 around 9 PM. She said that CNA #2 confirmed to her on a phone interview on 01/04/22 that she failed to report to anyone that the call light for Resident #8 was not working, and she failed to provide an alternate way to call for assistance when the resident needed help.

Record review of Resident # 8 medical record revealed that she was admitted to the facility on

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M1230	Continued From page 15 05/22/21 with diagnosis of Cognitive Communication Deficit, Difficulty in Walking and Lack of Coordination. The most recent Brief Interview for Mental Status (BIMS) completed on 10/13/21 revealed a BIMS score of 15, indicating the resident had full cognitive ability.	M1230		