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	255291	A. BUILDING _____ B. WING _____	C 11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPIAH LIVING CENTER	**806 WEST GEORGETOWN STREET CRYSTAL SPRINGS, MS 39059**

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		12/29/21

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

Electronically Signed | 12/10/2021

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F 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and facility policy review the facility failed to follow the comprehensive care plan for three (3) of (16) care plans reviewed. Resident #12, Resident #39 and Resident #51. Findings include: Record review of the facility's policy, "Care Plan Process" with a revision date of 08/17 revealed, "The care plan format includes the Problem Statement, the Goal, the Interventions, the staff responsible to carry out the interventions..." Resident #39 Record review of Resident #39's care plan with a "Problem onset" date of 2/4/2020 revealed " ...Is at high risk for skin break down and is frequently incontinent of bowel and bladder ...Approaches ...Incontinent care every two (2) hours and PRN(as needed) ...Provide peri care following each incontinence episode." During an incontinent care observation, on 11/09/21 at 10:00 AM, CNA # 3 failed to follow Resident #39's care plan by failure to provide care in a manner to prevent the possible spread of infection when she cleansed the residents peri area in a circular motion. CNA #3 wiped the peri area several times with the same side of the towel, then wiped down the middle of the vaginal area. CNA #3 turned the Resident over and	F 656	F 656 a. Certified Nursing Assistant (C.N.A) #3 was provided an Employee Education and In-service training on 11/10/21 by the Staff Development Nurse related to the proper procedure to administer incontinent/perineal care and following the plan of care. Resident #39 was assessed on 12/15/21 by the Director of Nurses for any signs/symptoms of infection. There were no sign/symptoms of infection noted. Licensed Practical Nurse (LPN) #2 was in-serviced on 11/10/21 by the Staff Development Nurse related to the following policy: Care Plan Process including following the plan of care. Licensed Practical Nurse (LPN) #3 was in-serviced on 11/10/21 by the Staff Development Nurse related to the following policy: Care Plan Process including following the plan of care. Resident #51 was observed on 11/10/21 by a Licensed Practical Nurse for any adverse effects related to not receiving the ordered medication on the dialysis days as ordered. There were no adverse effects noted. Resident #51 was assessed on 12/15/21 by the Director of	

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cleansed the Resident's buttocks wiping from back to front with soap and water. CNA #3 also wiped the Resident from back to front with the rinse water.

In an interview on 11/9/21 at 10:30 AM, interview with CNA #3 confirmed she failed to change the position of the towel while providing incontinent care. CNA #3 also confirmed she wiped the Resident from back to front while cleansing her buttocks. CNA #3 confirmed this could cause the Resident to get infections by not wiping from front to back.

During an interview on 11/10/21 at 6:00 PM, with License Practical Nurse (LPN) #4, explained once a care plan is in place, she expects the staff to follow the plan of care. LPN #4 said CNA #3 should change positions with each wipe. LPN #4 said this could cause the resident to get Urinary Tract Infections if the CNA does not change the area of the towel when providing incontinent care.

Record review of the Face Sheet revealed the facility admitted Resident #39 on 2/04/20 with the diagnosis that included Hemiplegia, Convulsions, and Hypertension. The Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 09/30/21, revealed Resident# 39 had a Brief Interview for Mental Status (BIMS) score of 14 that indicted Resident #39 is cognitively intact.

Resident #51

Record review of the Face Sheet revealed Resident #51 was admitted to the facility on 6/14/2017, with current diagnoses of Cerebral Infarction due to embolism of left post Cerebral

Nurses for any adverse effects related to not receiving the ordered medication on the dialysis days as ordered. There were no adverse effects noted. Physician #1 was notified on 11/10/21 with a change in medication administration time related to receiving dialysis. Resident # 51 care plan was updated on 11/10/21.

Resident #12 was observed on 11/10/21 by a Licensed Practical Nurse for any adverse effects related to not receiving the ordered medication on the dialysis days as ordered. There were no adverse effects noted. Resident #12 was assessed on 12/15/21 by the Director of Nurses for any adverse effects related to not receiving the ordered medication on the dialysis days as ordered. There were no adverse effects noted. Physician #2 was notified on 11/10/21 with a change in medication administration time related to receiving dialysis. Resident #12 care plan was updated on 11/10/21.

b. All residents have the potential to be affected by the deficient practice.

c. A Directed In-Service for all Certified Nurse Aides, Licensed Practical Nurses and Registered Nurses by a Registered Nurse not affiliated with Copiah Living Center on 12/14/21 with a completion of training on 12/15/21 on the following: Care Plan Process including following the plan of care. Newly hired Certified Nursing Assistants, Licensed Practical Nurses and Registered Nurses will be in-serviced on upon hire on the following: Care Plan

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F 656	Continued From page 3 Artery, Acute on Chronic systolic Congestive Heart Failure (CHF), Chronic Pulmonary Disease (CPD), Type II Diabetes Mellitus (DM), Chronic Kidney Disease (CKD), Hypotension, Anxiety Disorder (AD), Recurrent Depression Disorder (RDD), Essential (primary) Hypertension, Gastro-esophageal reflux disease without esophagitis (GERD), Dependence on renal dialysis and Cardiomyopathy. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 10/11/21, revealed in Section C, a Brief Interview for Mental Status (BIMS) score of 09 out of 15 which indicated moderate cognitive impairment. Record review of Resident #51's Physician's Orders revealed an order dated 10/16/20 for "Levemir 100 units/ML vial-give 18 units subcutaneous every morning related to DM". Record review of the Resident 51's Electronic Medication Administration Record (EMAR) revealed on, 11/1/21,11/3/21, 11/5/21, 11/8/21 and 11/10/21 the facility failed to administer the 9:00 AM dose of Levemir 100 units/ML. Record review of Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 7/01/2017, and a Goal and Target Date of 1/11/22 of "Diabetes Mellitus 2 "Goal" of resident will "have early detection of signs of hypo/hyperglycemia through next review date 1/11/22... Interventions...Administer medications as ordered..." Record review of Resident #51's Physician's Orders revealed an order dated 9/29/17 for Famotidine 20 MG tablet give one tablet by mouth	F 656	Process to include following the plan of care. A Quality Assurance Committee Meeting was held on 11/10/21 member consisting of Director of Nursing, Staff Development Nurse/Infection Preventionist, Accounts Manager, Administrator, Regional Administrator, Medical Records, Social Services, Medical Director on call. Quality Assurance Committee Meeting reviewed Care Plan process including following the plan of care with no recommend changes to facility policy. d. Director of Nursing and/or Staff Development Nurse will monitor care plan implementation via two medication administration observations and two care observations 3 x per week x 2 months until substantial compliance is attained. Care Plan implementation monitoring began on 12/01/21. Areas in need of correction will be reviewed by the Quality Assurance Committee Meeting for corrective action to include in-service training, and/or disciplinary action. The facility Quality Assurance Committee Meeting shall be held monthly until substantial compliance is attained.	

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daily for GERD.

Record review of the Resident 51's Electronic Medication Administration Record (EMAR) revealed on, 11/1/21,11/3/21, 11/5/21, 11/8/21 and 11/10/21 the facility failed to administer the 9:00 AM dose of Famotidine 20 MG.

Record review of Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 7/01/2017, and a Goal and Target Date of 1/11/22 of "Diabetes Mellitus 2". Approaches included..." Administer medications as ordered...."

Record review of Resident #51's Physician's Orders revealed an order dated 1/20/21 for "Lexapro 5 MG tablet one tablet by mouth daily related to depression (target behavior, tearful, anger, withdrawal).

Record review of the Resident 51's Electronic Medication Administration Record (EMAR) revealed on 11/1/21,11/3/21, 11/5/21, 11/8/21 and 11/10/21, the facility failed to administer the 9:00 AM dose of Lexapro 5MG by mouth at 9:00 AM.

Record review of Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 1/20/21, and a Goal and Target Date of 1/11/22 of "Potential for altered mood state related to depression. "Goal" will maintain on lowest effective dose of antidepressant medication to help control mood and behavior with minimal or no side effects through next review date of 1/11/22.". Approaches included... "Administer Medications as ordered."

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Record review of Resident #51's Physician's Orders revealed an order dated 8/5/21 for "Clopidogrel 75 MG tablet one tablet by mouth daily related to circulation. (Acute or chronic systolic CHF).

Record review of the Resident 51's Electronic Medication Administration Record (EMAR) revealed on 11/1/21,11/3/21, 11/5/21, 11/8/21 and 11/10/21, the facility failed to administer the 9:00 AM dose of Clopidogrel 75 MG by mouth at 9:00 AM.

Record review of Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 7/1/17, and a Goal and Target Date of 1/11/21 of "Has a diagnosis of Hypo and Hypertension HF/CHF "Goal" will not have any complications through next review 1/11/22.". Approaches included..." Administer Medications as ordered..."

Record review of Resident #51's Physician's Orders revealed an order dated 8/9/21Aspirin 81 MG chewable tablet-give 4 tablets to equal 325 MG by mouth daily related to circulation. (Acute or chronic systolic CHF)

Record review of the Resident 51's Electronic Medication Administration Record (EMAR) revealed on 11/1/21,11/3/21, 11/5/21, 11/8/21 and 11/10/21, the facility failed to administer the 9:00 AM dose of Aspirin 81 MG chewable tablet-give 4 tablets to equal 325 MG by mouth daily related to circulation. (Acute or chronic systolic CHF)

Record review of Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 7/1/17, and a Goal and Target

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Date of 1/11/21 of "Has a diagnosis of Hypo and Hypertension HF/CHF "Goal" will not have any complications through next review 1/11/22.". Approaches included..." Administer Medications as ordered..."

Record review of Resident #51's Physician's Orders revealed an order dated 11/8/17 Ferrous Sulfate 325 MG tablet give one tablet by mouth twice daily related to Anemia iron supplement.

Record review of the Resident 51's Electronic Medication Administration Record (EMAR) revealed on 11/1/21,11/3/21, 11/5/21, 11/8/21 and 11/10/21, the facility failed to administer the 9:00 AM dose of Ferrous Sulfate 325 MG tablet give, one tablet by mouth twice daily related to Anemia iron supplement.

Record review of Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 7/1/17, and a Goal and Target Date of 1/11/22Have no complications through next review". Approaches included..." Administer Medications as ordered..."

Record review of Resident #51's Physician's Orders revealed an order dated 9/30/21, house liquid protein supplement 30 CC by mouth twice daily related to End Stage Renal Disease (ESRD).

Record review of the Resident 51's Electronic Medication Administration Record (EMAR) revealed on 11/1/21,11/3/21, 11/5/21, and 11/8/21 the facility failed to give house liquid protein supplement 30 CC by mouth twice daily related to End Stage Renal Disease (ESRD).

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Record review of Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 6/15/17, and a Goal and Target Date of 1/12/21 Therapeutic diet no added salt/low concentrated sweets double large portion of meat/eggs at each meal/1000 ML fluid restrictions. Will attempt for resident to receive adequate nutrition daily through staff . Approaches included "...House liquid protein supplement 30 CC by mouth twice daily related to End Stage Renal Disease (ESRD)."

Record review of Resident #51's Physician's Orders revealed an order dated 8/5/21, Midodrine HCL 2.5 MG tablet one tablet by mouth three times a day.

Record review of the Resident 51's Electronic Medication Administration Record (EMAR) revealed on 11/1/21,11/3/21, 11/5/21, and 11/8/21 the facility failed to give 9 :00 AM dose of Midodrine HCL 2.5 MG tablet one tablet by mouth three times a day. Related to Hypotension

Record review of Resident #51's Care Plan revealed Resident #51 had the "Problem/Need" with "onset" date of 7/1/17, and a Goal and Target Date of 1/11/21 of "Has a diagnosis of Hypo and Hypertension HF/CHF "Goal" will not have any complications through next review 1/11/22.". Approaches included...."Administer Medications as ordered..."

Surveyor: Howard, Wendy

Resident #12

Record review of Resident #12's Face Sheet revealed the facility admitted Resident #12 on

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08/13/20 with the diagnoses of Chronic Systolic Congestive Heart Failure, End Stage Renal Disease, Type 2 Diabetes Mellitus, Dementia, Hypertension, Anxiety, Major Depressive Disorder, and Dependence of renal dialysis.

Record review of Resident #12's yearly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 08/02/2021 section C revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated Resident #12 had severe cognitive impairment.

A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Renvela 800 milligram (mg) tablet, one (1) tablet by mouth with meals three times daily related to end stage renal disease.

A record review of Resident #12's Electronic Medication Administration Record (EMAR) revealed on 11/01/21, 11/03/21, 11/05/21, 11/08/21 and 11/10/21 the facility failed to administer the 7:30 AM dose of Renvela 800 mg.

Record review of Resident #12's Care Plan revealed "Problem/Need" with "onset" date of 08/13/2021 and a Goal and Target Date of 1/26/22 revealed "Diagnosis of Renal Insufficiency/Renal Failure/End Stage Renal Disease" and "Receives Dialysis" ... with the "Goal" of resident will "have no complications through next review 1/26/22", and Approaches included " Administer medications as ordered ... Resident is prescribed Renvela."

A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Abilify 2 mg tablet one (1) tablet by mouth every

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F 656	Continued From page 9 day related to Dementia. A record review of Resident #12's EMAR revealed on 11/01/21, 11/03/21, 11/05/21, 11/08/21, and 11/10/21 the facility failed to administer the 8:00 AM dose of Abilify 2 mg. Record review of Resident #12's Care Plan revealed Resident 12 had the "Problem/Need" with "onset" date of 10/19/2020 and a Goal and Target Date of 01/26/22 of "Altered Thought Process related to Moderately Impaired Cognition related to Alzheimer's/Dementia" with the "Goal" of resident will "have needs met through next review 01/26/22", and "Approaches include ... Resident is prescribed Abilify. A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Memantine HCL 10 mg tablet one (1) tablet by mouth twice a day related to Dementia. A record review of Resident #12's EMAR revealed on 11/01/21, 11/03/21, 11/05/21, 11/08/21, and 11/10/21 the facility failed to administer the 9:00 AM dose of Memantine HCL 10 mg. Record review of Resident #12's Care Plan revealed Resident 12 had the "Problem/Need" with "onset" date of 10/19/2020 and a Goal and Target Date of 01/26/22 of "Altered Thought Process related to Moderately Impaired Cognition related to Alzheimer's/Dementia" with the "Goal" of resident will "have needs met through next review 01/26/22", and "Approaches" include " ... Resident is prescribed Memantine HCL."	F 656		

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A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Aspirin 81 mg chewable tablet one (1) tablet my mouth every day related to heart failure.

A record review of Resident #12's EMAR revealed on 11/01/21, 11/03/21, 11/05/21, 11/08/21, and 11/10/21 the facility failed to administer the 8:00 AM dose of Aspirin 81 mg.

Record review of Resident #12's Care Plan revealed Resident 12 had the "Problem/Need" with "onset" date of 10/19/2020 and a Goal and Target Date of 01/26/22 of "Diagnosis of Heart Failure/Hypertension" with the "Goal" of resident will be of any complications through next review 01/26/22, and "Approaches" include ... " Administer medications as ordered ...Resident is prescribed Aspirin."

A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Metoprolol Succinate ER 25 mg tab take one (1) tablet by mouth every day related to hypertension.

A record review of Resident #12's EMAR revealed on 11/01/21, 11/03/21, 11/05/21, 11/08/21, and 11/10/21 the facility failed to administer the 8:00 AM dose of Metoprolol Succinate ER 25 mg.

Record review of Resident #12's Care Plan revealed Resident 12 had the "Problem/Need" with "onset" date of 10/19/2020 and a Goal and Target Date of 01/26/22 of "Diagnosis of Heart Failure/Hypertension" with the "Goal" of resident will be of any complications through next review 01/26/22, and "Approaches" include "

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 11 ...Administer medications as ordered ...Resident is prescribed Metoprolol Succinate." A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Brilinta 90 mg tablet take one (1) tablet by mouth twice a day related to heart failure. A record review of Resident #12's EMAR revealed on 11/01/21, 11/03/21, 11/05/21, 11/08/21, and 11/10/21 the facility failed to administer the 9:00 AM dose of Brilinta 90 mg. A record review of Resident #12's Care Plan revealed Resident 12 had the "Problem/Need" with "onset" date of 10/19/2020 and a Goal and Target Date of 01/26/22 of "Diagnosis of Heart Failure/Hypertension" with the "Goal" of resident will be of any complications through next review 01/26/22, and "Approaches" include " ...Administer medications as ordered ...Resident is prescribed Brilinta." A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Hydralazine HCL 25 mg tablet take one (1) tablet by mouth three times a day related to hypertension (hold if systolic blood pressure is below 110). A record review of Resident #12's EMAR revealed on 11/01/21, 11/03/21, 11/05/21, 11/08/21, and 11/10/21 the facility failed to administer the 9:00 AM dose of Hydralazine HCL 25 mg. A record review of Resident #12's Care Plan revealed Resident 12 had the "Problem/Need" with "onset" date of 10/19/2020 and a Goal and Target Date of 01/26/22 of "Diagnosis of Heart	F 656		

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	255291	A. BUILDING _____ B. WING _____	C 11/10/2021

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F 656	Continued From page 12	F 656		

Failure/Hypertension" with the "Goal" of resident will be of any complications through next review 01/26/22, and "Approaches" include... Administer medications as ordered...Resident is prescribed Hydralazine HCL."

A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Klonopin 0.5 mg generic Clonazepam tablet take one (1) tablet by mouth everyday related to anxiety.

A record review of Resident #12's EMAR revealed on 11/01/21, 11/03/21, 11/05/21, 11/08/21, and 11/10/21 the facility failed to administer the 8:00 AM dose of Klonopin 0.5 mg.

Record review of Resident #12's Care Plan revealed Resident 12 had the "Problem/Need" with "onset" date of 10/19/2020 and a Goal and Target Date of 01/26/22 of "Risk for Depression/Anxiety" with the "Goal" of resident will have no complications through next review and resident will not show an increase in depression mood through next review 01/26/22 and "Approaches" include ... " Administer medications as ordered ...Resident is prescribed Clonazepam."

A record review of Resident #12's "Physician Orders" for November 2021 revealed orders for Venlafaxine HCL 75 mg tablet take one (1) tablet by mouth daily related to depression.

A record review of Resident #12's EMAR revealed on 11/01/21, 11/03/21, 11/05/21, 11/08/21, and 11/10/21 the facility failed to administer the 9:00 AM dose of Venlafaxine HCL.

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F 656	Continued From page 13	F 656		

Record review of Resident #12's Care Plan revealed Resident 12 had the "Problem/Need" with "onset" date of 10/19/2020 and a Goal and Target Date of 01/26/22 of "Risk for Depression/Anxiety" with the "Goal" of resident will have no complications through next review and resident will not show an increase in depression mood through next review 01/26/22, and "Approaches" include ... Administer medications as ordered ... Resident is prescribed Venlafaxine HCL."

On 11/10/21 at 10:45 AM, during interview with LPN #2 reviewed the current EMAR and explained the "N" represented medication not given and further explained none of the medications are given for the morning medication pass. When asked if meds are given when resident returns to the facility, she explained no, the morning medications are not given at all on the day resident goes to the dialysis. She further explained the nurse does not send any medications with the residents. She stated she did not notify the physician the resident's medication was not given. She explained the nurses have never sent medications with Resident #12 to dialysis and she has not given Resident #12 any morning medications after dialysis. She stated she did not follow physician orders and that could cause a significant medication error. She stated it is important that the resident get medications as ordered.

On 11/10/21 at 11:00 AM, during a phone interview with RN#2 from the local dialysis treatment center, she explained the dialysis clinic only gives the resident the medications listed on the communication forms sent back to the facility and the facility is responsible for all other

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F 656	Continued From page 14	F 656		

medications.

On 11/10/21 at 11:30 AM, during an interview with the interim Director of Nursing (DON), he explained he is not aware of medications not being given on dialysis days. He explained as a Corporate Nurse Consultant, he understood medications were to be given when residents returned to the facility from dialysis unless the physician had ordered something else.

On 11/10/21 at 11:55 AM, in an interview with Physician #2 he explained he was not aware Resident #12 was not getting medication on dialysis days. He stated he thought the facility set times for dialysis resident to get medications on dialysis days. He stated he has not been contacted to ask about dialysis residents medications. He stated he assumed medications were given as ordered. He stated they could give Resident #12's medication when resident returns. He explained he expects medications to be given as ordered and it is very important for resident to receive all medications daily.

On 11/10/21 at 3:30 PM interview with LPN #3, when asked what "N" meant on the EMAR, she explained it means "no" and the medication was not given. She explained she has never sent medications with Resident #12 and morning medications were not given to resident after dialysis. She explained she did not follow physician orders and Resident #12 missing medications could cause a significant medication error. She stated it is important that Resident #12 gets medications.

On 11/10/21 at 6:00 PM, interview with the MDS nurse, LPN #4, she explained once a care plan is

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F 656	Continued From page 15 in place, she expects the staff to follow the plan of care. She explained if a medication is ordered, she expects the medications to be given unless there is an order in place to hold medication for any reason. She explained if a resident refuses or misses three (3) doses or more of medications, the physician should be notified of the reason for the resident not receiving medications. She explained administering medications is part of the resident's care at the facility.	F 656		