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TUPELO NURSING AND REHABILITATION CENTER	1901 BRIAR RIDGE ROAD TUPELO, MS 38804

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M 000	Initial Comments The State Agency (SA) conducted an annual re-certification survey and complaint investigation (CI) MS# 18009, CI MS#18112, CI MS#18115, CI MS#18160, CI MS#18230 survey at the facility from 12/06/2021 to 12/09/2021. During the survey, the SA determined that the facility was not in compliance with the Mississippi Regulations for the Minimum Standards for Institutions for the Aged or Infirm and was cited M 475 Employee tuberculosis testing, M 500 Resident Rights, M 610 for Activities of Daily Living, M 1010 for failure to keep the facility in good repair and M 1220 for Handrails. During the survey CI MS# 18230 resident not groomed, was substantiated and was cited in the annual Survey. CI MS# 18009 related to no pressure Sore Precautions, Responsible party not notified, CI MS# 18112 resident left wet, body odor, CI MS # 18160 fall safety, treated with dignity, responsible party not notified and CI MS# 18115 for Resident safety were not substantiated. The facility was licensed for 120 beds and had a census of 98 at the time of the survey. The SA re-entered the facility on 12/20/21 - 12/21/21 for complaint investigations CI MS 00018369 and CI MS 00018374. CI MS 00018374 was substantiated for failure to provide Activities of Daily Living. CI MS 00018369 was not substantiated for feeding assistance and Resident Representative notification.	M 000		
M 475	45.16.6 Employee Testing for Tuberculosis Employee Testing for Tuberculosis 1. Each employee, upon employment of a licensed entity and prior to contact with any patient/resident, shall be evaluated for tuberculosis by one of the following methods:	M 475		2/11/22

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M 475	Continued From page 1 a. IGRA (blood test) and an evaluation of the individual for signs and symptoms of tuberculosis by medical personnel; or b. A two-step Mantoux tuberculin skin test administered and read by a licensed medical/nursing person certified in the techniques of tuberculin testing and an evaluation of the individual for signs and symptoms of tuberculosis by a licensed Physician, Physician ' s Assistant, Nurse Practitioner or a Registered Nurse. 2. The IGRA/Mantoux testing and the evaluation of signs/symptoms may be administered/conducted on the date of hire or administered/read no more than 30 days prior to the individual ' s date of hire; however, the individual must not be allowed contact with a patient or work in areas of the facility where patients have access until receipt of the results of the IGRA/assessment or at least the first of the two-step Mantoux test has been administered,/read and assessment for signs and symptoms completed. 3. If the Mantoux test is administered, results must be documented in millimeters. Documentation of the IGRA/TB skin test results and assessment must be documented in accordance with accepted standards of medical/nursing practice and must be placed in the individual ' s personnel file no later than 7 days of the individual ' s date of employment. If an IGRA is performed, results and quanitive values must be documented. 4. Any employee noted to have a newly positive IGRA, a newly positive Mantoux skin test or	M 475		

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signs/symptoms indicative of tuberculin disease (TB) that last longer than three weeks (regardless of the size of the skin test or results of the IGRA), shall have a chest x-ray interpreted by a board certified Radiologist and be evaluated for active tuberculosis by a licensed physician within 72 hours. The employee shall not be allowed to work in any area where residents have routine access until evaluated by a physician/nurse practitioner/physician assistant and approved to return. Exceptions to this requirement may be made if the employee is asymptomatic and;

a. The individual is currently receiving or can provide documentation of having received a course of tuberculosis prophylactic therapy approved by the Mississippi State Department of Health (MSDH) Tuberculosis Program for tuberculosis infection, or

b. The individual is currently receiving or can provide documentation of having received a course of multi-drug chemotherapy approved by the MSDH Tuberculosis Program; or

c. The individual has a documented previous significant tuberculin skin reaction or IGRA reaction.

4. For individuals noted to have a previous positive to either Mantoux testing or the IGRA, annual re-evaluation for the signs and symptoms must be conducted and must be maintained as part of the employee ' s annual health screening. A follow-up annual chest x-ray is NOT required unless symptoms of active tuberculosis develop.

5. If using the Mantoux method, employees with a negative tuberculin skin test and a negative

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M 475	Continued From page 3 symptom assessment shall have the second step of the two-step Mantoux tuberculin skin test performed and documented in the employees ' personal record within fourteen (14) days of employment. 6. The IGRA or the two-step protocol is to be used for each employee who has not been previously skin tested and/or for whom a negative test cannot be documented within the past 12 months. If the employer has documentation that the employee has had a negative TB skin test within the past 12 months, a single test performed thirty (30) days prior to employment or immediately upon hire will fulfill the two-step requirements. As above, the employee shall not have contact with residents or be allowed to work in areas of the facility to which residents have routine access prior to reading the skin test, completing a signs and symptoms assessment and documenting the results and findings. 7. All staff noted as negative per the IGRA blood test or who do not have a significant Mantoux tuberculin skin test reaction (reaction of less than 5 millimeters in size) shall be retested annually within thirty (30) days of the anniversary of their last IGRA or Mantoux tuberculin skin test. Staff exposed to an active infectious case of tuberculosis between annual tuberculin skin tests shall be treated as contacts and be managed appropriately. Individuals found to have a significant Mantoux tuberculin skin test reaction and a chest x-ray not suggestive of active tuberculosis, shall be evaluated by a physician or nurse practitioner/physician assistant for treatment of latent tuberculin infection. This Statute is not met as evidenced by: Level II	M 475	1. On 12/16/2021, the Director of Nursing	

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M 475	Continued From page 4 Based on staff interview, record review, and facility policy review, the facility failed to maintain documentation of the Employee Tuberculosis Testing for five (5) of 5 new hire records reviewed. Record review of facility policy titled "Tuberculosis (TB) Surveillance" revealed policy stated "An initial and ongoing evaluation of the risk for transmission of TB is to be completed". The facility risk assessment of two step baseline for all Health Care Workers (HCW) and then every 12 month screening. During the Survey from 12/06/2021 to 12/09/2021 the State Agent (SA) was unable to verify Employee TB Surveillance Documentation for Staff #1 with a hire date of 9/22/21, Staff #2 with a hire date of 10/12/21, Staff #3 with a hire date of 10/26/21, Staff #4 with a hire date of 11/20/21, and Staff #5 with a hire date of 11/30/21. On 12/08/2021 at 1:45 PM, an interview with the Assistant Director of Nurses (ADON) revealed she was diligently searching for the binder with the employee TB documentation and will continue to search for it, but as of now she has not been able to locate the binder that contains the documentation of the TB skin test. On 12/09/2021 at 8:45 AM, an interview with the Administrator (ADM) related to the TB skin test documentation for staff members revealed that the previous Staff Development Nurse left the facility without notice, and did not tell anyone where she kept the TB log book. The ADM said that she had reached out to the nurse and was unable to find her cooperative. The present staff have searched the facility and are unable to locate the binder with the Employee Skin test TB	M 475	obtained TB Certification. On 12/20/2021, the facility initiated first step TB testing on staff, to be followed by second step in accord with Tuberculosis testing guidelines. 2. All residents have the potential to be affected by this deficient practice. 3. On 12/10/2021, the Administrator in-serviced the DON and Assistant DON regarding the policy for TB testing and recording. Beginning 12/31/2021, the DON and Administrator will audit and reconcile TB testing with active employee roster monthly for two months. Any concerns will be addressed at that time. Upon hire, employees will receive TB skin testing by the Director of Nursing, Staff Development Coordinator or TB Certified Nurse. 4. The Administrator will bring audit results to the Quality Assurance Performance Improvement committee for review and recommendation on 01/11/2022, then monthly for two months.	

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M 475	Continued From page 5 documentation. The ADM reported that she knew the TB test were being documented because she had seen the binder with the documents inside.	M 475		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy	M 500		2/11/22

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M 500	Continued From page 6 provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician	M 500		

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assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

13. may meet with, and participate in activities of, social, religious and community groups at his

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M 500	Continued From page 8 discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Based on observation, staff interviews, resident interview, and facility policy review, the facility failed to provide privacy during care as evidenced by no window covering for one (1) of twenty (20) residents observed. Resident #76. Findings include: Review of facility policy titled, "Resident Bill of Rights", dated 11/2017, revealed, "Facility residents shall have the right to: personal privacy and confidentiality in his or her accommodations,	M 500	1. Maintenance Director replaced blinds to the room of resident #76 on 12/8/2021. 2. All residents residing in the facility have the potential to be affected. 3. On 12/9/2021, a room audit of all rooms was conducted by the Maintenance Director and completed 12/10/2021 to ensure blinds not in disrepair, with no further negative findings. On 12/10/2021, the Administrator	

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M 500	Continued From page 9 personal and medical treatments and records, written and telephone communications, personal care, visits, and meetings of family and resident groups." An interview on 12/9/2021 at 11:47 AM, with Director of Nurses (DON), revealed the facility did not have a specific policy on privacy or dignity. She revealed the "Resident Bill of Rights" was used for dignity and privacy concerns. During an observation and interview on 12/7/2021 at 10:00 AM, Resident #76 revealed his window blinds had been broken for two to three months and he told the staff, but the window blinds were not replaced. Resident #76 stated that at times, he had been incontinent and had to be changed by the facility staff. He stated he felt exposed and uncomfortable being changed with no window covering. He stated he did not know if anyone was outside of his window, but if anyone was there, he was exposed to them. An observation revealed Resident #76's window blinds were broken and unable to close to cover the window for privacy. An interview on 12/7/2021 at 4:30 PM, with Resident #76 revealed his broken blinds were removed. Resident revealed he hoped the blinds would be replaced before dark so he would not feel that he was being looked at through the uncovered window. An interview with Resident #76 on 12/8/2021 at 8:45 AM, revealed the blinds had not been replaced and he slept without any window covering. He revealed he did not have to be changed by the facility staff through the night, but he used the urinal and got dressed and he felt uncomfortable with no window covering.	M 500	in-serviced the Maintenance Director and Maintenance Director Assistant regarding Resident Rights, Dignity, and Respect. On 12/15/2021, the Administrator initiated education with staff regarding Resident Rights, Dignity and Respect, and appropriate reporting of maintenance concerns. Beginning the week of 1/05/2022, the department managers will conduct room inspection audit (blinds, base boards and furniture) three times a week for two weeks,and then weekly for four weeks. On 1/7/2022, the room inspection audits will be reviewed weekly by the Administrator and Maintenance to ensure any negative findings are addressed and corrective action completed. 4. Beginning the week of 01/10/2022, the Administrator conduct resident room rounds weekly for four weeks to ensure corrective measures have been completed and sustained. Findings will be corrected and brought to the monthly Quality Assurance Performance Improvement Committee 01/11/2022 monthly for two months.	

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M 500	Continued From page 10 An interview on 12/8/2021 at 4:55 PM, with the Administrator revealed each resident should be treated with dignity and offered privacy. She revealed that resident care being performed next to an uncovered window did not protect Resident #76's dignity and privacy. The Administrator confirmed that the facility failed to protect the resident's dignity and privacy by not providing a functioning window covering. An interview on 12/9/2021 at 9:00 AM, with Certified Nurse Assistant (CNA) #3, revealed that Resident #76's blinds had been broken and the window was unable to be covered for privacy and this had been reported. CNA #3 revealed she performed care and changed the resident with the broken blinds. She stated she "tries her best to protect his privacy", but it was not completely possible. She confirmed that Resident #76 was at risk of being exposed when the window was uncovered. An interview on 12/9/2021 at 9:05 AM, with Licensed Practical Nurse (LPN) #2, revealed Resident #76's window was uncovered due to the blinds being broken and unable to close or open properly. She revealed the resident was continent most of the time, but he had occasional accidents, especially when he had diarrhea, and required being changed by staff. LPN #2 confirmed that doing resident care in front of an uncovered window was not protecting the resident's dignity and privacy. Record review of Resident #76's Face Sheet revealed the resident was admitted to the facility on 11/5/2020. Record review revealed the resident with diagnoses of Obstructive Sleep Apnea, Hypertension, Anxiety, Schizophrenia,	M 500		

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M 500	Continued From page 11 Bipolar Disorder, and acquired absence of left and right leg below knees. Record review of Minimum Data Set (MDS) dated 10/21/2021, Section C, Cognitive, revealed Resident #76 with a Brief Interview for Mental Status (BIMS) score of 15, which indicated resident was cognitively intact. Level II Based on observation, staff interviews, resident interview, record review and facility policy review, the facility failed to provide privacy during care as evidenced by no window covering for one (1) of twenty (20) residents observed. Resident #76. Findings include: Review of facility policy titled, "Resident Bill of Rights", dated 11/2017, revealed, "Facility residents shall have the right to: personal privacy and confidentiality in his or her accommodations, personal and medical treatments and records, written and telephone communications, personal care, visits, and meetings of family and resident groups." An interview on 12/9/2021 at 11:47 AM, with Director of Nurses (DON), revealed the facility did	M 500		

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not have a specific policy on privacy or dignity. She revealed the "Resident Bill of Rights" was used for dignity and privacy concerns.

During an observation and interview on 12/7/2021 at 10:00 AM, Resident #76 revealed his window blinds had been broken for two to three months and he told the staff, but the window blinds were not replaced. Resident #76 stated that at times, he had been incontinent and had to be changed by the facility staff. He stated he felt exposed and uncomfortable being changed with no window covering. He stated he did not know if anyone was outside of his window, but if anyone was there, he was exposed to them. An observation revealed Resident #76's window blinds were broken and unable to close to cover the window for privacy.

An interview on 12/7/2021 at 4:30 PM, with Resident #76 revealed his broken blinds were removed. Resident revealed he hoped the blinds would be replaced before dark so he would not feel that he was being looked at through the uncovered window.

An interview with Resident #76 on 12/8/2021 at 8:45 AM, revealed the blinds had not been replaced and he slept without any window covering. He revealed he did not have to be changed by the facility staff through the night, but he used the urinal and got dressed and he felt uncomfortable with no window covering.

An interview on 12/8/2021 at 4:55 PM, with the Administrator revealed each resident should be treated with dignity and offered privacy. She revealed that resident care being performed next to an uncovered window did not protect Resident #76's dignity and privacy. The Administrator

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M 500	Continued From page 13	M 500		

confirmed that the facility failed to protect the resident's dignity and privacy by not providing a functioning window covering.

An interview on 12/9/2021 at 9:00 AM, with Certified Nurse Assistant (CNA) #3, revealed that Resident #76's blinds had been broken and the window was unable to be covered for privacy and this had been reported. CNA #3 revealed she performed care and changed the resident with the broken blinds. She stated she "tries her best to protect his privacy", but it was not completely possible. She confirmed that Resident #76 was at risk of being exposed when the window was uncovered.

An interview on 12/9/2021 at 9:05 AM, with Licensed Practical Nurse (LPN) #2, revealed Resident #76's window was uncovered due to the blinds being broken and unable to close or open properly. She revealed the resident was continent most of the time, but he had occasional accidents, especially when he had diarrhea, and required being changed by staff. LPN #2 confirmed that doing resident care in front of an uncovered window was not protecting the resident's dignity and privacy.

Record review of Resident #76's Face Sheet revealed the resident was admitted to the facility on 11/5/2020. Record review revealed the resident with diagnoses of Obstructive Sleep Apnea, Hypertension, Anxiety, Schizophrenia, Bipolar Disorder, and acquired absence of left and right leg below knees.

Record review of Minimum Data Set (MDS) dated 10/21/2021, Section C, Cognitive, revealed Resident #76 with a Brief Interview for Mental Status (BIMS) score of 15, which indicated

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M 500	Continued From page 14 resident was cognitively intact.	M 500		
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: Based on observation, staff and resident interviews, record review and facility policy review, the facility failed to provide nail care, facial shaving, and hair washing for two (2) of eight (8) residents observed. Resident #4 and Resident #59. Findings Include: Record review of Bath/Shower-Dependent policy, HISTORY ...8/11 revealed, "POLICY: A bath (shower/tub) for cleanliness and comfort is scheduled at least weekly for each resident. RESPONSIBILITY: Nursing Assistants or Licensed Nurses monitored by Charge Nurse". This policy revealed under Procedure: # 12 "Shampoo hair unless done by beautician ..." Review of A.M. Care Policy, HISTORY 10/09 revealed, POLICY: A.M. Care will be given to	M 610	1. On 12/9/2021, the Director of Nursing trimmed and cleaned the fingernails for Resident #4. On 12/10/2021, per his request, Resident #4 received a shower and shampoo. On 12/9/2021, Resident #59 received a shower with shave and shampoo by the certified nurse assistant. 2. Any resident residing in the facility has the potential to be affected. 3. On 12/10/2021, the Director of Nursing initiated education with direct care staff regarding Activities of Daily Living care and documentation. On 12/13/2021 an audit of nail care for residents was completed by the DON, Assistant DON, Treatment Nurse, and charge nurse to ensure all residents were	2/11/22

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M 610	Continued From page 15 residents daily. RESPONSIBILITY: All Nursing Assistants ...PROCEDURE: ...10. Provide nail care as needed 11. Provide/assist with shaving (male and female) as needed ..." Resident #4 An observation on 12/06/21 at 11:45 AM, revealed Resident # 4 sitting in the dining room eating lunch with his hands. Resident # 4's fingernails had a brown substance on top and under all of his fingernails, hair stubble on his face and his hair appeared greasy and unwashed. An interview on 12/8/21 at 9:20 AM, with Resident #4 revealed that he tries to clean his own nails and prefers to eat with his hands. Resident #4 revealed he would like to have his nails trimmed and filed. An observation on 12/9/21 at 8:53 AM, revealed that Resident # 4's nails had a brown substance under them and were long. An interview on 12/9/21 at 9:03 AM, with Certified Nursing Assistant (CNA) #4 revealed that when the residents get a bath, the CNAs cut nails, shave, wash hair and blow dry their hair if they want that done but confirmed that that is not something that they have to document in the computer system. During an interview and observation on 12/9/21 at 12:00 PM, with the Director of Nursing (DON) and Resident #4, the DON confirmed that Resident #4 needed his nails cleaned and trimmed and stated "he refused to let me cut his nails yesterday." Resident #4 stated that he wanted his nails trimmed and needed them cleaned.	M 610	provided nail care per resident preference. Any identified concerns were addressed at that time. The DON initiated education on 12/13/2021 with nurses and nursing assistants in regards to ADL's, nail care, and documentation of care refusals. In-services to be completed by 12/27/2021. Newly hired nurses and nursing assistants will be in-serviced during orientation by the DON or Staff Development Coordinator. Beginning 12/10/2021, 10% observation of ADL care to include verification of showers, shave and nail care will be completed by the DON weekly for 8 weeks, then monthly for two months utilizing the ADL audit tool. Any areas of identified concern will be addressed by the DON. 4. The Administrator will present the findings of the ADL audit tools to the Quality Assurance Performance Improvement Committee for review and recommendation on 01/11/2022, then monthly for two months.	

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M 610	Continued From page 16 Record review of Resident # 4's Care Plan with a problem onset date of 5/3/21 revealed, "Problem/Need ... I require assist with my ADLs (Activities of Daily Living) related to impaired mobility." The goal for this care plan was, "My ADL needs will be met thru next review date ...Approaches ... Assist me with my shower/bath 3x (three times) weekly and as needed." Record review of Resident # 4's Face Sheet revealed he was admitted to the facility on 05/03/21 with diagnoses including Encounter for orthopedic aftercare following surgical amp, Anemia, Acquired absence of right leg below knee, and Acquired absence of left leg below knee. Record review of Resident # 4's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/2/21 revealed a Brief Interview for Mental Status of 15 indicating full cognitive ability. Resident #59 An observation on 12/07/21 at 08:55 AM, of Resident # 59 revealed he has hair growth on his chin and above his lip with hair stubble on his cheeks and his hair appeared greasy and unwashed. Record review of Resident # 59's Face Sheet revealed an admission date of 07/17/20 with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Dementia, and Depressive Disorder. Record review of Resident # 59's Care Plan with a problem onset date of 7/22/2020 revealed "Problem/Need I require assist with my ADLs	M 610		

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M 610	Continued From page 17 (Activities of Daily Living) related to impaired mobility and incontinence". The goal for this care plan was "My ADLs will be met thru next review date." The interventions for this care plan included, " ...Assist me with my shower/bath 3x (three times) weekly and as needed". An interview on 12/8/21 at 9:40 AM, with the Director of Nurses (DON) revealed that the residents are on a schedule for their baths or showers, and they can request different days. The DON revealed that Resident #4 had three baths per week documented. The DON revealed the Certified Nursing Assistant(CNA)s document when showers occur and if the resident refuses, they are to tell the nurse. The DON revealed that the CNAs document when the resident has a bath, but there is no specific place in the computer system for the CNA to document about particular things like nail care and shaving. The DON revealed that the CNAs know that nail care and shaving is just part of a bath. An interview on 12/9/21 at 11:00 AM, with Assistant Director of Nurses (ADON) verified there is no area in their computer system for the CNAs to document specifics about the residents' baths such as nail care and shaving. The ADON verified that there was no place for the nurse to verify that the residents nail care and shaving had been completed. The ADON verified that an area would have to be added to our system for them to document nail care and shaving and that it doesn't let the CNAs know to perform that area of care.	M 610		

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Level II

Based on observation, staff and resident interviews, record review and facility policy review, the facility failed to provide nail care, facial shaving, and hair washing for two (2) of eight (8) residents observed. Resident #4 and Resident #59.

Findings Include:

Record review of Bath/Shower-Dependent policy, HISTORY ...8/11 revealed, "POLICY: A bath (shower/tub) for cleanliness and comfort is scheduled at least weekly for each resident. RESPONSIBILITY: Nursing Assistants or Licensed Nurses monitored by Charge Nurse". This policy revealed under Procedure: # 12 "Shampoo hair unless done by beautician ..."

Review of A.M. Care Policy, HISTORY 10/09 revealed, POLICY: A.M. Care will be given to

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M 610	Continued From page 19	M 610		

residents daily. RESPONSIBILITY: All Nursing Assistants ...PROCEDURE: ...10. Provide nail care as needed 11. Provide/assist with shaving (male and female) as needed ..."

Resident #4

An observation on 12/06/21 at 11:45 AM, revealed Resident # 4 sitting in the dining room eating lunch with his hands. Resident # 4's fingernails had a brown substance on top and under all of his fingernails, hair stubble on his face and his hair appeared greasy and unwashed.

An interview on 12/8/21 at 9:20 AM, with Resident #4 revealed that he tries to clean his own nails and prefers to eat with his hands. Resident #4 revealed he would like to have his nails trimmed and filed.

An observation on 12/9/21 at 8:53 AM, revealed that Resident # 4's nails had a brown substance under them and were long.

An interview on 12/9/21 at 9:03 AM, with Certified Nursing Assistant (CNA) #4 revealed that when the residents get a bath, the CNAs cut nails, shave, wash hair and blow dry their hair if they want that done but confirmed that that is not something that they have to document in the computer system.

During an interview and observation on 12/9/21 at 12:00 PM, with the Director of Nursing (DON) and Resident #4, the DON confirmed that Resident #4 needed his nails cleaned and trimmed and stated "he refused to let me cut his nails yesterday." Resident #4 stated that he wanted his nails trimmed and needed them cleaned.

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M 610	Continued From page 20 Record review of Resident # 4's Care Plan with a problem onset date of 5/3/21 revealed, "Problem/Need ... I require assist with my ADLs (Activities of Daily Living) related to impaired mobility." The goal for this care plan was, "My ADL needs will be met thru next review date ...Approaches ... Assist me with my shower/bath 3x (three times) weekly and as needed." Record review of Resident # 4's Face Sheet revealed he was admitted to the facility on 05/03/21 with diagnoses including Encounter for orthopedic aftercare following surgical amp, Anemia, Acquired absence of right leg below knee, and Acquired absence of left leg below knee. Record review of Resident # 4's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/2/21 revealed a Brief Interview for Mental Status of 15 indicating full cognitive ability. Resident #59 An observation on 12/07/21 at 08:55 AM, of Resident # 59 revealed he has hair growth on his chin and above his lip with hair stubble on his cheeks and his hair appeared greasy and unwashed. Record review of Resident # 59's Face Sheet revealed an admission date of 07/17/20 with diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Hypertension, Dementia, and Depressive Disorder. Record review of Resident # 59's Care Plan with a problem onset date of 7/22/2020 revealed "Problem/Need I require assist with my ADLs	M 610		

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M 610	Continued From page 21 (Activities of Daily Living) related to impaired mobility and incontinence". The goal for this care plan was "My ADLs will be met thru next review date." The interventions for this care plan included, " ...Assist me with my shower/bath 3x (three times) weekly and as needed". An interview on 12/8/21 at 9:40 AM, with the Director of Nurses (DON) revealed that the residents are on a schedule for their baths or showers, and they can request different days. The DON revealed that Resident #4 had three baths per week documented. The DON revealed the Certified Nursing Assistant(CNA)s document when showers occur and if the resident refuses, they are to tell the nurse. The DON revealed that the CNAs document when the resident has a bath, but there is no specific place in the computer system for the CNA to document about particular things like nail care and shaving. The DON revealed that the CNAs know that nail care and shaving is just part of a bath. An interview on 12/9/21 at 11:00 AM, with Assistant Director of Nurses (ADON) verified there is no area in their computer system for the CNAs to document specifics about the residents' baths such as nail care and shaving. The ADON verified that there was no place for the nurse to verify that the residents nail care and shaving had been completed. The ADON verified that an area would have to be added to our system for them to document nail care and shaving and that it doesn't let the CNAs know to perform that area of care.	M 610		
M1010	45.35.1 Housekeeping Facilities and Services Housekeeping Facilities and Services.	M1010		2/11/22

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M1010	Continued From page 22 1. The physical plant shall be kept in good repair, 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 observation, staff and resident interviews and facility policy review, the facility failed to maintain a homelike environment as evidenced by dirty floors, gouged walls, and nonfunctional window blinds for three (3) of four (4) hallways. Findings include: Review of the facility policy titled," Housekeeping Cleaning Procedures/Hallway Cleaning" revealed it is the responsibility of the housekeeping staff to: #3 dust mop floors, #4 Autoscrub floors w/red pads as needed, #5 Burnish floors after auto scrubbing, #6 Use spray buff where needed to repair/enhance gloss level, and #7 Spot clean hallway walls with BLUE microfiber cloth. An observation, on 12/6/21 at 11:55 AM, revealed the overbed table in Room C2A and D5C had torn sharp edges that are peeled up and the bedside table in Room C 9 had edges that were rough and partially covered with a torn white tape-like substance. An interview, on 12/6/21 at 12:00 PM, with	M1010	1. On 12/7/2021, the Maintenance Director replaced both of the over-bed tables for room C2A and D5C and disposed of damaged tables. On 12/7/2021, the nightstand in room C9 with torn edges was removed and replaced. On 12/8/2021, Maintenance Director replaced the blinds to the room of resident #76. Additionally, on 12/9/2021, the Maintenance Director initiated repairs to the sheet rock (areas filled with sheet rock mud, allowed to dry and area sanded) and completed repairs on 12/15/2021. On 12/8/2021, corrective actions was taken by the housekeeper who cleaned brownish material from the wall on hall D. Corrective action was verified by the Administrator on 12/8/2021. On 12/15/2021, the base boards in D14 were replaced by the Maintenance Director and gouged area to wall in D14 repaired. On 12/08/21, housekeeping services swept the room and removed all	

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M1010	Continued From page 23 Resident #80 revealed that she had not had any injury due to the rough sharp edges on the overbed table, but that the staff was aware it was damaged. An observation on 12/7/21 at 8:15 AM, revealed Resident #76's bed positioned in front of the window. The window blinds were pulled up and tangled. There were no curtains on the window. The wall behind the resident's bed had two (2) areas that were gouged through the sheet rock and a pile of tan and brownish colored powdery substance was present on the floor under the gouged-out areas in the wall. The wall behind the A bed area also had deep gouges in the sheet rock. An interview, on 12/07/21 at 8:16 AM with Resident #76 revealed his blinds had been pulled up and tangled like that for quite a while. He stated that he had mentioned it to the staff. An observation, on 12/7/21 at 8:35 AM, revealed Room C2A room door was painted with a thin coat of white paint that was scratched and marred over the entire door. An observation of Room D14A revealed the wall behind the bed was scratched and gouged in several places. The base boards are pulled away from the wall and laying loose on the floor with a whitish powdery substance on the floor behind the headboard. An observation in the D hallway on 12/7/21 at 12:20 PM, revealed dry brownish material that had run down the wall between Room D 11 and D 13. The housekeeper was observed cleaning the handrails over this area and did not clean the wall. An observation of the area between Room D11	M1010	powdery substances on the floor. On 12/15/2021, the housekeeping services conducted deep cleaning to room D14. On 12/14/2021, the Maintenance Director painted the door to room C2. Additionally, wall gouges to rooms C2 and C9 were repaired on 12/15/2021. 2. All residents residing in the facility have the potential to be affected. 3. On 12/8/2021, the Administrator in-serviced the housekeeper assigned to D hall regarding cleaning of common areas and surfaces to include hand rails and walls. On 12/10/2021, the Administrator in-serviced the Maintenance Director, Maintenance Assistant and Housekeeping Staff regarding Resident Rights, Privacy, Dignity and Respect, Routine preventative maintenance, and room cleaning/detailing work. On 12/10/2021, the Administrator initiated education to housekeeping staff regarding cleaning resident rooms and deep cleaning schedules. Beginning on 12/9/2021, Resident room audit was conducted by the Maintenance Director and completed on 12/10/2021. Audit included inspection of blinds and window coverings, condition of furniture in room, baseboards and sheet rock. Items with sharp edges were immediately removed or repaired. Beginning 01/10/2022, Resident rooms	

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TUPELO NURSING AND REHABILITATION CENTER	1901 BRIAR RIDGE ROAD TUPELO, MS 38804

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M1010	Continued From page 24 and D13 on 12/8/21 at 9:00 AM, revealed the brownish material remained on the wall. An interview, on 12/8/21 at 9:15 AM, with Housekeeping Staff #2, confirmed the brownish material on the wall in the hall between Room D11 and D13. She stated that she guessed she just overlooked it when she was cleaning. She stated that it does not look nice, and she should have seen it. She stated that the floors need some work too. An interview on 12/8/21 at 9:05 AM, with the Administrator (ADM), confirmed she was aware the blinds in Resident #76's room needed to be replaced. She confirmed that the resident should have blinds or curtains to provide privacy. The ADM confirmed that the wall behind the beds in the room needed repair due to the damage done by the beds being raised up and down. The ADM confirmed the floors needed cleaning. She stated that the D hall was worse. The ADM stated that the housekeeper should have seen the wall between D11 and D13 and cleaned it. The ADM stated that the condition of the wall and baseboards in Room D14 was unacceptable. The ADM stated staff members are to do daily walk throughs in assigned areas. She stated that all these things should have been reported. The ADM confirmed the wall behind the bed in Room C9A was damaged. The gouged area was measured by the Administrator at 25.5 inches long by 4 inches wide by 2 inches deep. She confirmed that the wall behind the bed in Room C2A was gouged and paint was scuffed off and the entry door to the room was scratched and scuffed. The ADM confirmed the damaged walls, bedside tables and overbed tables, and the dirty wall. She stated that the rough edges could cause skin tears to the residents.	M1010	will be monitored by means of rounds with the Administrator, Housekeeping Supervisor and Maintenance Director weekly for two months, then monthly for two months. A list of any areas of concern will be compiled and completion date of repairs will be tracked by the Maintenance Director and reviewed weekly by the Administrator for two months to ensure all work orders are completed timely. 4. The Administrator will compile a list of repairs monthly and present to the Quality Assurance and Performance Improvement Committee for review and recommendations on 01/11/2022, then every month for two months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41LM	A. BUILDING: _____ B. WING _____	12/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M1010	Continued From page 25 An interview on 12/8/21 at 9:15 AM, with the Maintenance Director revealed Resident #76's window blind was "torn to pieces and not functional". He confirmed that the damage to the wall behind the beds and base boards pulled away from the wall should have been reported and repaired. He confirmed that the floors were dirty and could be cleaner. An interview on 12/8/21 at 9:20 AM, with Licensed Practical Nurse (LPN) #1 revealed that she had been in Room D14A every day this week. She stated that she had not noticed the damage to the wall and baseboards in the resident's room. She stated that she should have because she was responsible for all aspects of the resident's care. An interview, on 12/8/21 at 10:50 AM, with Housekeeping Staff #3, confirmed the floors were dirty. She stated that "they could be better."	M1010		
M1220	45.40.9 Handrails Handrails. Handrails shall be installed on both sides of all corridors and hallways used by residents. The handrails should be installed from thirty-two (32) inches to thirty-six (36) inches above the floors. The handrails should have a return to the wall at each rail ending. Exception may be made for existing facilities. This Statute is not met as evidenced by: Level II Based on observation and staff interviews, the facility failed to maintain handrails that were	M1220	1. On 12/8/2021, the Maintenance Director covered edges of hand rails to prevent injury. On 12/16/2021, the Administrator submitted order for handrails to D corridor. On 01/05/2022,	2/11/22

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M1220	Continued From page 26 secured and affixed to the walls for one (1) of four (4) hallways. Hallway D. Findings Include: An observation on 12/08/21 at 8:00 AM, revealed D Hall handrails missing between rooms D9 and D11, rooms D8 and the conference room door, between rooms D5 and D6, and D3 and D4. The curved edges were not on the ends of the remaining side rails leaving the ends with sharp silver-colored exposed edges. These sharp edges were located outside the medical records door, room D11, room D13 and outside the data processing door and remaining rails were not well secured to the walls and were loose on Hallway D. An interview on 12/8/21 at 8:05 AM, with the Administrator revealed she was aware of issues with the handrails missing and being loose. She stated that she was not aware of the rough sharp edges exposed. She stated that this could cause skin damage/tears to the residents and that the residents who are on that hall would use the handrails. The Administrator stated they did not have a policy to address handrails, to maintain them in a safe and secure manner.	M1220	the Maintenance Director initiated installation of temporary hand rails to be in place until permanent hand rails arrive at facility. Plan for completion of hand rail replacement to be completed by 01/17/2022. 2. Any resident residing in the facility has the potential to be affected. 3. On 12/8/2021, the Administrator and Maintenance Director conducted an audit of hand rails to all other corridors (A, B, C) with no negative findings. Beginning the week of 12/17/2021, the Maintenance Director and Administrator to monitor compliance by observation rounds (hand rails secured to wall, temporary coverings to any uneven edges in place, no other broken or rough edges noted to hand rails) weekly for four weeks then monthly for two months. 4. The Administrator will bring results of findings to the Quality Assurance Performance Improvement committee for review and recommendations on 01/11/2022, then monthly for two months.	