

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20GE	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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
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 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;	M 500		11/4/21

Mississippi State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/04/21

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M 500	Continued From page 1 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 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	M 500		

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M 500	Continued From page 2 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 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	M 500		

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M 500	Continued From page 3 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: Level IV Amendment 12/07/2021 Upon secondary Quality Assurance review, the State Survey Agency (SSA) determined the Immediate Jeopardy to be removed on 7/8/21 for M500 and the scope and severity was lowered to a Level II while the facility develops and implements a plan of correction and monitors effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Based on interviews, record reviews and facility policy review the facility failed to ensure a resident was protected from neglect as evidenced by a Temporary Nursing Assistant (TNA) neglected to obtain assistance required from	M 500	1. Immediate action(s) taken for the resident(s) found to have been affected include: On 07/03/2021, the on-call physician was made aware of Resident #31's fall, with the physician requesting x-rays of bilateral legs. On 07/03/2021, X-ray Personnel obtained the x-rays as ordered, revealing bilateral femur fractures. On 07/03/2021, the on-call doctor was made aware of the x-ray results, giving a telephone order to send Resident #31 to the emergency room. Resident #31 was transferred to the local hospital emergency department as ordered. The resident underwent intramedullary nailing surgery to her bilateral femur fractures on 7/8/2021 at an offsite orthopedic surgical center	

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M 500	Continued From page 4 licensed/certified staff when providing incontinent care that resulted in a resident obtaining a bilateral femur fracture for one (1) of three (3) residents reviewed for falls. Resident #31. On 7/3/21, TNA #1 neglected to obtain the assistance required when providing incontinent care for Resident #31. TNA #1 turned the resident to her side without removing the pillows from the resident's feet. This resulted in Resident #31 falling to the floor and sustaining bilateral femur fractures. The resident underwent intramedullary nailing surgery to her bilateral femur fractures on 7/8/21. The facility failed to protect Resident #31 and other residents from potential for further injury during the investigation process by not removing TNA #1 from the facility following the incident on 7/3/2021. The facility continued to allow TNA #1 to work until 7/05/21. The facility's failure to provide protection from abuse and neglect put Resident #31, a vulnerable resident and other residents at risk, and in a situation that caused and is likely to cause serious harm, serious injury, serious impairment, or possible death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 7/3/21 when TNA #1 provided care to Resident #31 without required assistance and the resident sustained a fall with major injury. The facility Administrator was notified of the IJ and SQC on 9/28/21 and presented with the IJ Template. The facility provided an acceptable Removal Plan on 9/30/21, in which the facility alleged that all corrective actions were completed to remove the IJ and SQC on 9/30/21, and the IJ	M 500	2. Identification of other residents having the potential to be affected was accomplished by: After a review of Census and Daily Assignment Sheets, the Administrator concluded that 19 of the 40 residents had the potential of receiving abuse/neglect from TNA #1. 19 out of 40 residents were identified as having the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Beginning 10/2/2021, the Director of Nursing (DON) will review Daily Assignment Sheets to ensure that the CNA and TNA staff remain properly paired to perform direct care weekly for a year and a log will be maintained by the DON weekly for four weeks, then monthly for three weeks, and then quarterly for a year. Beginning on 10/2/2021, the Lead CNA began observational rounds to monitor for proper staffing as set forth by the Daily Assignment Sheets, and he will continue to make these observational rounds weekly for a year, and a log will be maintained by the Lead CNA for a year. On 07/04/2021 and 07/05/2021, the Administrator continued in-servicing with staff on the topics of: ADLs and Care Plans and Care Guides, Abuse and Neglect, and Resident's Rights. On 07/05/2021, the Administrator suspended TNA #1 until further notice to complete the investigation. On 07/05/2021, the Administrator conducted and completed the investigation. On 07/12/2021, the Administrator terminated TNA #1 in efforts	

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M 500	Continued From page 5 and SQC was removed on 10/1/21. (Amendment 12/2/21 - The SSA determined the IJ to be removed on 7/8/21). The State Agency (SA) determined the IJ to be removed 7/8/21 and the scope and severity for Rule 45.17.2 - Resident Rights (M500) was lowered to a level II, while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's policy titled "Abuse Prevention Program", revised September 2013, revealed, "Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion..." Review of the facility policy titled "Abuse and Neglect - Clinical Protocol", revised April 2013, revealed the definition of neglect as, "Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress". Review of the facility's, "Activities of Daily Living (ADLs), Supporting" policy, revised January 12, 2021, revealed, "Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities pf daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene ...".	M 500	to prevent a reoccurrence of abuse/neglect to Resident #31. The fall of Resident #31 was taken to the QA Committee on 07/08/2021 for review. On 07/04/2021, the Administrator provided in-servicing to the Charge Nurse, Cart Nurse, Temporary Nursing Assistants, and Certified Nursing Assistants. The in-service topics included: following the Activities of Daily Living Care Plans and Care Guides, Abuse and Neglect, and Resident's Rights. On 09/16/2021, the Staff Development Nurse educated all Temporary Nursing Assistants and Certified Nursing Assistants on the subject of Temporary Nursing Assistants can provide resident care only with a Certified Nursing Assistant or Nurse present. On 9/16/2021, a form was created by the Staff Development Nurse for all TNA hire-in packets to ensure that all TNA new hires have proper education, training, and understanding that they must work directly with Certified Nursing Assistant. The Staff Development Nurse and the Administrator from a non-affiliated sister facility presented a directed in-service for all non-contracted staff, the Assistant Director of Maintenance, the Director of Housekeeping, and the Director of Therapy on Freedom From Abuse, Neglect, and Exploitation on 11/10/2021. 4.How the corrective action(s) will be monitored to ensure the practice will not reoccur? Beginning the week of 10/2/2021, the Staff Development Nurse will monitor the Lead CNA's documentation to monitor for any problems or concerns and will	

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M 500	Continued From page 6 Record review of the facility's, "Resident Rights" policy, revised December 2016, revealed, "Policy Statement, Employees shall treat all residents with kindness, respect, and dignity ...Policy Interpretation and Implementation ...c. be free from abuse, neglect, misappropriation of property and exploitation ...". Record review of the Resident Incident Report, dated 7/3/21, revealed "Incident Type: Fall/no head injury ...Date/Time: 7/03/21 02:00 PM ...Type of Injury: Fracture ...Location: Resident room ...Narrative of incident and description of injuries: Nurse entered room after being called by CNA, Resident on her knees on the floor at side of bed holding onto side rail. CNA providing incontinent care to resident, resident turned to right side of bed and she was holding to side rail CNA reports that resident started kicking her legs and fell out of the bed. To ER-X-Ray revealed bilateral femur fractures ..." Review of the local hospital Emergency Room Report dated 7/3/21 revealed Resident #31 was transferred to the local hospital emergency department on 7/3/21 due to a bilateral femur fracture from a fall. Record review of the Operative Report dated 7/8/21 revealed Resident #31 underwent intramedullary nailing surgery to her bilateral femur fractures on 7/8/21. Record review of Resident #31's Face Sheet revealed Resident #31 was admitted to the facility on 3/27/2020, with the diagnoses that included Major Depressive Disorder, Hypertension, Dementia and current diagnoses of Unspecified Fracture lower end of right femur and Unspecified	M 500	keep a log of findings weekly x4 weeks, then monthly x 3 months, and then quarterly for one year. The fall of Resident #31 was taken to the QA Committee on 07/08/2021 for review. This incident and a review of Resident's Rights was taken again to the QA team on 10/27/2021, and the QA Committee will continue meeting monthly for three months on these topics. Any new recommendations by the QA Committee will be implemented.	

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M 500	Continued From page 7 Fracture lower end of left femur. Record review of the Admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 06/09/21 revealed Resident#31 had a Brief Interview for Mental Status (BIMS) score of 14 that indicated Resident #31 was cognitively intact. During an interview on 09/16/21 at 09:00 AM, with the Director of Nursing (DON) confirmed Resident #31 fell out of the bed to the floor on 7/3/21. The DON said on 7/6/21 she had TNA #1 come to the facility and re-enact the incident. The DON said TNA #1 was in the room providing incontinent care without CNA #1. TNA #1 turned Resident #31 to the right side and did not remove the pillows from the resident's feet. TNA #1 said when she turned the resident, she slid onto the floor on her knees. Resident #31 was still holding on to the bedrails. TNA #1 said she notified LPN #1. The DON said TNA #1 said she had read Resident #31's plan of care. TNA #1 said she knew Resident #31 was a two (2) person assist with bed mobility, but she thought she could do it without help. The DON said the TNAs and Certified Nursing Assistants (CNA) are trained that TNAs should not provide care without a licensed person being present. The DON confirmed TNA #1 failed to follow Resident #31 Care Plan because the Care Plan reveals the resident should have two (2) people with bed mobility and transfers. During an interview on 09/16/21 at 10:25 AM, with the Administrator revealed TNA #1 had been through the CNA class but she has not taken her test. The Administrator said TNA #1 was paired with CNA #1. The Administrator said on 7/3/21 LPN #1 called her and said Resident #31 slid to	M 500		

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M 500	Continued From page 8 the floor during care. The Administrator said she was told Resident #31's feet got tied up in the sheets. Resident #31 was kicking and fell out of the bed while TNA #1 was providing incontinent care. The Administrator said she came to the facility and started the investigation. The Administrator confirmed TNA #1 was not suspended at that time. The Administrator gave orders to the nurses that TNA #1 should not provide care to any of the residents without supervision. The Administrator said on 7/6/21 TNA #1 was called in to do a re-enactment of the incident. The Administrator said TNA #1 said she raised the bed to her waist. TNA #1 turned the resident over without moving the pillows. TNA #1 said she had just read Resident #31's Care Plan and knew that she was a two (2) person assist with Activities of Daily Living (ADL's). TNA #1 said she thought she could do the care without assistance. The Administrator said it was determined, because TNA #1 did not remove the pillows when she turned Resident #31 this caused the resident to fall out of bed. The Administrator said she started the in-services with the staff on Abuse/Neglect, Resident Rights, Following the Care Plan, ADL supporting and Accidents and Incidents. A Quality Assurance (QA) meeting was held on 7/8/21. The Administrator said she notified the ombudsman, the SA and the Attorney General's Office (AG) on 7/3/21. The Administrator stated that TNA #1 was suspended 7/5 21 and terminated 7/12/21 because she had been identified as having the potential of placing residents' safety at risk, leading the facility to terminate her employment. During an interview on 09/16/21 at 12:51 PM, with CNA #1 said she was paired with TNA #1 on 7/3/21. CNA #1 stated she went on the other side of the building to stock the linen cart. CNA #1 said	M 500		

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M 500	Continued From page 9 TNA #1 was at the nurse's station when she went to stock the cart. CNA #1 also said she did not know TNA #1 was providing incontinent care without assistance until Resident #31 was noted on the floor. CNA #1 revealed Licensed Practical Nurse (LPN) #2 and CNA #2 educates the staff daily that TNAs cannot provide care without assistance from a licensed/certified staff member. CNA #1 said TNA #1 has not had any other instances where she provided care without assistance. During an interview on 09/16/21 at 01:54 PM, with RN #1 said she was the supervisor for the day on 7/3/21. RN #1 said LPN #1 came down the hall extremely upset stating Resident #31 got her feet tied up in the sheets and slid out of the bed. RN #1 said she did not realize LPN #1 was not in the room with TNA #1 while she was providing care. RN #1 said she called the doctor and got an order for an X-ray. During an interview on 09/16/21 at 02:15 PM, with LPN #2/Staff Development, said the staff is trained during orientation and annually on ADL task, skills, and checkoffs. LPN #2 said during her training she tell the TNA's and CNA's that the TNAs cannot provide care without licensed/certified personnel. LPN #2 confirmed she cannot provide an in-service with TNA #1 stating she was trained to only provide care with a licensed person. LPN #2 confirmed TNA #1 failed to follow the care plan because Resident #31 was a two (2) person assist with all ADL's. During an interview on 9/16/21 at 02:30 PM, with CNA #2, said every day before the staff start working, he does a huddle with the CNA's and TNA's. CNA #2 said he reminds the staff that the TNA's can only provide care to residents with a	M 500		

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M 500	Continued From page 10 licensed or certified person. TNAs cannot provide care without a certified CNA or a nurse being present. CNA #2 said he was off the day the incident took place. CNA #2 confirmed TNA #1 failed to follow the facility policy and failed to follow the care plan by providing incontinent care to Resident #31 without having a licensed or certified person present. During an interview on 9/16/21 at 2:45 PM, with TNA #2 confirmed she started working at the facility in August 2021 and was in-serviced that she cannot provide care to residents unless a CNA or Nurse is present. During an interview on 9/16/21 at 3:30 PM, with TNA #1 stated she checked on Resident #31 and noted the resident had an incontinent episode. TNA #1 confirmed she provided incontinent care without a CNA or nurse with her. TNA #1 said she was told by CNA #2 that she only needed another staff member in the room when a lift is used for transfer. TNA #1 said she was not told that she could not provide incontinent care to the residents alone. TNA #1 said she has provided incontinent care alone with multiple residents. TNA #1 said she had looked at Resident #31's Care Plan when she first started working at the facility. TNA #1 said she forgot what the Care Plan said and that Resident #31 should have 2 people with care. TNA #1 confirmed she did not ask any of the other staff for assistance because she has provided incontinent care without help multiple times and the resident was ok. Review of the facility's fall Risk Evaluation dated 3/10/21 revealed Resident #31 was a high fall risk. Record review of Resident #31's Care Plan with a	M 500		

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M 500	Continued From page 11 Problem Onset date of 03/27/2020 revealed "(Formal Name) decline in ability to perform self care activities, (Formal Name) is unable to bear weight, (Formal Name) at risk for soiling clothing ...Approaches: Provide extensive assistance X2 (of two persons) with bed mobility...Provide total assistance X2 with toileting ..." Record review of the Nurse Aides' Information Sheet, undated, revealed Resident #31 required total assistance X2 with incontinent care for bowel and bladder and extensive assistance X2 for turning and repositioning. Record review of the Time Card Report revealed on 7/3/21, TNA#1 clocked into work at 06:50 AM and clocked out at 19:25 (7:25 PM). On 7/4/21, TNA#1 clocked in at 06:49 AM and clocked out at 19:12 (7:12 PM). On 7/5/21, TNA #1 clocked in at 06:49 AM and clocked out at 10:34 AM. Record review of Resident #31's ADL RECORD, for the month of July 2021 revealed that TNA #1 provided personal care to the resident on 7/3/21 and 7/4/21. Record review of the facility's CNA Assignments sheet dated 7/3/21 and 7/4/21 revealed TNA #1 and CNA #1 were assigned to Resident #31. Record review of the facility Counseling Statement dated 7/4/21 revealed TNA #1 was counseled with respect to not following the ADL Plan of Care and the importance of following proper ADL assistance while providing care. TNA #1 was suspended by the Administrator on 7/5/21 at 10:24 AM while investigation of the fall was completed to ensure safety of all residents. Record review of the facility's Termination Report	M 500		

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M 500	Continued From page 12 revealed TNA #1 was terminated on 7/12/21 because the employee has been identified as having the potential of placing residents' safety at risk, leading this facility to terminate her employment. Review of the facility Nurse Assistant Skills Check Off revealed TNA #1 was checked off "PROVIDES PERINEAL CARE FOR FEMALE" on 4/30/21. Review of the facility inservices revealed TNA # 1 was inserviced on the following: Falls, Safety and Reporting in-service on 6/24/21, Abuse/Neglect on 1/12/21 and 6/24/21, Transfer in-service on 1/12/21, Accident, Incidents and Resident Rights and Vulnerable Adult in-service titled, "History of the Vulnerable Persons Act", on 12/29/20. The facility provided an acceptable Removal Plan on 9/30/21, for the IJ. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: Removal Plan Immediate Jeopardy (IJ) was called on 9/28/2021 at 12:35 PM. The IJ template was provided on 9/28/2021 at 12:35 PM. Beginning 7/3/2021 when Temporary Nursing Assistant (TNA) #1 failed to obtain the necessary assistance to provide incontinent care to resident #31 resulting in a major injury with fracture of bilateral knees. The State Agency notified the Administrator and the Director of Nursing (DON) that an IJ had been identified. Brief Summary of Events The facility failed to ensure a resident was	M 500		

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M 500	Continued From page 13 protected from neglect as evidence by (AEB) an unlicensed TNA neglected to obtain assistance required when providing incontinent care that resulted in Resident #31 obtaining a fracture. ON 7/3/21, immediate action was taken by the cart nurse to notify the doctor and obtain bilateral knee x-rays. The facility failed to follow the comprehensive care plan while providing incontinent care AEB Resident #31 is extensive assist and always needs two people during care. The facility failed to ensure a vulnerable resident was protected from accidents and hazards when a TNA#1 failed to ask for help while providing incontinent care, which caused Resident #31 to fall with a major injury to bilateral knees. The facility failed to protect Resident #31 and other residents from potential for further injury during the investigation process by not removing TNA #1 from the facility following an incident on 7/3/2021. The Facility continued to allow TNA #1 to work until 7/05/21. Corrective Action: - On 7/3/2021, the Administrator provided education to the Charge Nurse, two (2) TNAs, 2 Cart Registered Nurses (RN), and three (3) Certified Nursing Assistants (CNA) directly involved in the fall of Resident #31. On 7/3/2021, the in-service topics included following the Activities of Living (ADL) Care Plan and Care Guide, Abuse and Neglect, and Residents' Rights. On 7/4/2021 and 7/5/2021, the Administrator continued in-servicing with all staff on the above topics. No staff will be allowed to work until in-services are completed. - On 07/03/21, the Administrator identified that Resident #31 sustained a fall with injury and initiated an investigation.	M 500		

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M 500	Continued From page 14 3. On 07/05/2021 at 10:24 AM, the Administrator suspended TNA #1 until further notice to complete investigation. On 07/05/2021 the Administrator conducted and completed the investigation. On 07/12/21 the Administrator terminated TNA #1. 4. On 7/5/2021 at 10:00 AM, each resident under the care from TNA #1 who was identified as at risk for falls was assessed with no further falls identified. 5. On 07/05/2021 at 10 AM, the Minimum Data Set Nurse (MDS) conducted a 100 percent audit of Resident's Fall Risk Assessments and Care Plans for accuracy with no concerns identified. 6. Each resident has a care guide specific to their needs located in a binder at each nurse's station. These are reviewed by the CNAs prior to the start of each shift and to be followed to provide care to the residents. On 07/05/2021, the MDS Nurse performed a 100 percent audit of the care guides with no concerns identified. On 07/05/2021 The Administrator in-serviced CNAs and TNAs on the following: ADL care guides specific to each resident. On 07/05/2021, the MDS Nurse performed a 100 percent audit on ADLs of residents identified at risk for falls and failure to follow the ADL Plan of Care. All residents at risk needing two-person assist were identified and reviewed. On 9/16/2021, the Staff Development Nurse educated all TNAs and CNAs on providing resident care only with a CNA or Nurse present, no staff will be allowed to work until in serviced. TNAs and CNAs were instructed to review ADL care plan prior to each shift. 19 of the 40 residents were identified as at risk for falls and failure for the ADL Plan of Care to be followed. A form was developed and created for	M 500		

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M 500	Continued From page 15 all TNA new hires to have proper education, training, and understanding that they must work directly with a licensed CNA and to follow and know their ADL plan of care. On 9/21/2021, the Staff Development Nurse educated all staff that all TNA's can only provide resident care with a CNA or Nurse present, no staff will be allowed to work until in-serviced. 7. The Administrator requested an in-person Quality Assurance Performance Improvement (QAPI) meeting to review events leading to this occurrence and corrective action taken. QAPI meeting occurred on July 8, 2021, and included the Administrator, Director of Nursing, Medical Director, MDS Nurse, Wound Care Nurse, Care Plan Nurse, Medical Records Nurse, Infection Preventionist, Physical Therapist, Administrator Assistant, and the Billing Office Manager. The meeting specifically discussed this fall, identified cause of the fall, number of previous falls, fall risk and potential harm, prevention of recurrence, abuse/neglect, following ADL care plan, Resident's Rights, ADL support and serious injury/harm and reporting. On 07/06/21, the Administrator in serviced the DON and Charge Nurse on the topic of removing any staff from the building for alleged violations of abuse, neglect, exploitation, or misappropriation of resident property until the investigation is completed. No changes to fall policy were required after being reviewed by QAPI. 8. On 9/16/2021, a form was created for all TNA hire in packets to ensure all TNA new hires have proper education, training, and understanding that they must work directly with a licensed CNA. 9. The Administrator and DON conducted a 100 percent audit on all accidents and incidents from	M 500		

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M 500	Continued From page 16 07/04/2021 through 9/30/2021 to ensure that injury or negative outcomes was not identified related to unsupervised TNAs. On 07/05/21, the Administrator in-serviced all staff on fall related policies. Falls are reviewed at stand up meeting every morning and Quarterly Quality Assurance (QA) meeting. On 07/05/21 at 7AM, the Administrator continued on-going in servicing to reiterate with all staff that TNAs must provide care only with CNA assist. 10. The facility alleges that all corrective actions to remove the IJ were completed on 9/30/21, and the IJ was removed on 10/1/21. Validation On 10/2/21, the State Survey Agency (SSA) validated the facility's Removal Plan by staff interviews, record reviews, and review of in-service sign-in sheets. The SSA verified the facility had implemented the following measures to remove IJ: 1. The SSA validated through interview with the Administrator and in-service sign in sheets that on 7/3/2021, the Administrator provided education to the Charge Nurse, two (2) TNAs, 2 Cart Registered Nurses (RN), and three (3) Certified Nursing Assistants (CNA) directly involved in the fall of Resident #31. On 7/3/2021, the in-service topics included following the Activities of Living (ADL) Care Plan and Care Guide, Abuse and Neglect, and Residents' Rights. On 7/4/2021 and 7/5/2021, the Administrator continued in-servicing with all staff on the above topics. No staff will be allowed to work until in-services are completed. 2. The SSA validated through interview on 10/1/21 that on 07/03/21, the Administrator	M 500		

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M 500	Continued From page 17 identified Resident #31 sustained a fall with injury and initiated an investigation. 3. The SSA validated through interview and record review that on 07/05/2021 at 10:24 AM, the Administrator suspended TNA #1 until further notice to complete investigation and on 07/05/2021 the Administrator conducted and completed the investigation. On 07/12/21 the Administrator terminated TNA #1. 4. The SSA validated through interview with DON and record review that on 7/5/2021 at 10:00 AM, each resident under the care from TNA #1 who was identified as at risk for falls was assessed with no further falls identified. 5. The SSA validated through interview with the Minimum Data Set Nurse (MDS) nurse and record review on 07/05/2021 at 10 AM, the MDS nurse conducted a 100 percent audit of Resident's Fall Risk Assessments and Care Plans for accuracy with no concerns identified. 6. The SSA validated through staff interviews, record reviews and signed in-services that each resident has a care guide specific to their needs located in a binder at each nurse's station. These are reviewed by the CNAs prior to the start of each shift and to be followed to provide care to the residents. On 07/05/2021, the MDS Nurse performed a 100 percent audit of the care guides with no concerns identified. On 07/05/2021 The Administrator in-serviced CNAs and TNAs on the following: ADL care guides specific to each resident. On 07/05/2021, the MDS Nurse performed a 100 percent audit on ADLs of residents identified at risk for falls and failure to follow the ADL Plan of Care. All residents at risk needing two-person assist were identified and	M 500		

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M 500	Continued From page 18 reviewed. On 9/16/2021, the Staff Development Nurse educated all TNAs and CNAs on providing resident care only with a CNA or Nurse present, no staff will be allowed to work until in serviced. TNAs and CNAs were instructed to review ADL care plan prior to each shift. 19 of the 40 residents were identified as at risk for falls and failure for the ADL Plan of Care to be followed. A form was developed and created for all TNA new hires to have proper education, training, and understanding that they must work directly with a licensed CNA and to follow and know their ADL plan of care. On 9/21/2021, the Staff Development Nurse educated all staff that all TNA's can only provide resident care with a CNA or Nurse present, no staff will be allowed to work until in-serviced. 7. The SSA validated through staff interviews, record review and signed in-service sheets that the Administrator requested an in-person Quality Assurance Performance Improvement (QAPI) meeting to review events leading to this occurrence and corrective action taken. The QAPI meeting occurred on July 8, 2021, and included the Administrator, Director of Nursing, Medical Director, MDS Nurse, Wound Care Nurse, Care Plan Nurse, Medical Records Nurse, Infection Preventionist, Physical Therapist, Administrator Assistant, and the Billing Office Manager. The meeting specifically discussed this fall, identified cause of the fall, number of previous falls, fall risk and potential harm, prevention of recurrence, abuse/neglect, following ADL care plan, Resident's Rights, ADL support and serious injury/harm and reporting. On 07/06/21, the Administrator in serviced the DON and Charge Nurse on the topic of removing any staff from the building for alleged violations of abuse, neglect, exploitation, or misappropriation	M 500		

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M 500	Continued From page 19 of resident property until the investigation is completed. No changes to fall policy were required after being reviewed by QAPI. 8. The SSA validated through an interview with the Administrator and record review that on 9/16/2021, a form was created for all TNA's hire in packets to ensure all TNA new hires have proper education, training, and understanding that they must work directly with a licensed CNA. 9. The SSA validated through record review, signed in-services and interview with the Administrator and DON that a 100 percent audit was conducted on all accidents and incidents from 07/04/2021 through 9/30/2021 to ensure that injury or negative outcomes was not identified related to unsupervised TNAs. On 07/05/21, the Administrator in-serviced all staff on fall related policies. Falls are reviewed at stand up meeting every morning and Quarterly Quality Assurance (QA) meeting. On 07/05/21 at 7AM, the Administrator continued on-going in servicing to reiterate with all staff that TNAs must provide care only with CNA assist. 10. Amendment 12/2/21 - The SSA validated that all corrective actions to remove the IJ had been completed as of 7/8/21, and the IJ removed on 7/8/21.	M 500		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to	M 640		11/4/21

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M 640	Continued From page 20 appropriate state agencies. This Statute is not met as evidenced by: Level IV Amendment 12/07/2021 Upon secondary Quality Assurance review, the State Survey Agency (SSA) determined the Immediate Jeopardy to be removed on 7/8/21 for M640 and the scope and severity was lowered to a Level II, while the facility develops and implements a plan of correction and monitors effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Based on staff interview, record reviews and facility policy review the facility failed to ensure a vulnerable resident was protected from accidents and hazards when a Temporary Nursing Assistant (TNA) failed to obtain the required assistance while providing incontinent care which caused a fall with a major injury for Resident #31. The facility failed to ensure the residents were free from rodents in the facility as evidenced by (AEB) a mouse was seen in the bed with Resident #31 and mouse droppings were under four (4) residents beds and in chests of drawers for seven (7) of 16 residents reviewed for accidents and hazards. Resident #3, Resident #6, Resident 12, Resident #13, Resident #31 and Resident #35, Resident #42. On 7/3/21, TNA #1 neglected to obtain the assistance required when providing incontinent care for Resident #31. TNA #1 turned the resident to her side without removing the pillows from the resident's feet. This resulted in Resident #31 falling to the floor and sustaining bilateral femur	M 640	1.Immediate action(s) taken for the resident(s) found to have been affected include: On 07/03/2021 the on-call physician was made aware of Resident #31's fall, with the physician requesting x-rays of bilateral legs. On 07/03/2021, X-ray Personnel obtained the x-rays as ordered, revealing bilateral femur fractures. On 07/03/2021, the on-call doctor was made aware of the x-ray results, giving a telephone order to send Resident #31 to the emergency room. Resident #31 was transferred to the local hospital emergency department as ordered. The resident underwent intramedullary nailing surgery to her bilateral femur fractures on 7/8/2021 at an offsite orthopedic surgical center. On 07/12/2021, the Administrator terminated TNA #1 in efforts to prevent a reoccurrence of an accident. On 10/7/2021, the Administrator was made aware of an unobserved lesion to Resident #31's left great toe. On 10/7/2021, the Cart Nurse contacted Resident #31's Primary Care Physician (PCP), making him aware of the unobserved lesion, accepting and implementing new orders. On 10/7/2021, the Administrator notified the on-call Maintenance Personnel of a mouse sighting in Resident #31's room/bed. On 10/7/2021, Resident #31 was immediately removed from her room and transferred to an available room in the facility. On 10/7/2021, the Wound Care Nurse was notified of the lesion to the left great toe	

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M 640	Continued From page 21 fractures. The resident underwent intramedullary nailing surgery to her bilateral femur fractures on 7/8/21. The facility failed to protect Resident #31 and other residents from potential for further injury during the investigation process by not removing TNA #1 from the facility following the incident on 7/3/2021. The facility continued to allow TNA #1 to work until 7/05/21. The State Survey Agency (SSA) extended the survey upon receipt of two (2) complaint investigations, CI: #18152 dated 10/08/21 and CI# 18165 dated 10/11/21 from an anonymous complainant alleging the facility is infested with rats. The complainant revealed that a rat was observed chewing on Resident #'s 13 feeding tube. The Complainant also said a rat was observed in the Resident's boot on one of her feet. The Complainant said the rat had eaten part of Resident #31's foot. The Complainant also said the staff is killing the rats because the facility Administration refuses to do anything about them. The facility's failure to provide supervision for a resident who is vulnerable and needs extensive assistance with all care is likely to cause injury and harm to other residents. This is evidenced by Resident #31 falling to the floor receiving bilateral femur fractures. These actions had the likelihood to cause all residents residing in the facility serious harm, serious injury, serious impairment, or possible death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 7/3/21 when TNA #1 failed to obtain the required assistance resulting in Resident #31 falling from bed and receiving a major injury. The facility Administrator was notified of the IJ on 9/28/21 and provided the IJ	M 640	and reassessed the lesion with measurements documented. On 10/7/2021, the Exterminator treated Resident #31's room for pest control. On 10/7/2021, Maintenance Personnel performed an environmental check of Resident #31's room in attempt to identify cause(s) of pest. These potential causes were corrected by the Maintenance Department on 10/7/2021. On 10/7/2021, housekeeping performed a terminal cleaning of Resident #31's room. This incident was taken before the QA team on 10/12/2021 to be discussed for interventions to prevent a future reoccurrence. On 10/7/2021, the Lead CNA placed a container in Resident #31's room for opened food storage. On 10/7/2021, the Administrator in-serviced staff on pest interventions to be implemented immediately upon suspicion or sightings of pest. 2. Identification of other residents having the potential to be affected was accomplished by: The Administrator identified 19 of the 40 residents as at risk for falls, while in the care of Temporary Nursing Assistant (TNA) #1. On 07/05/2021, the Minimum Data Set (MDS) Nurse conducted a 100 percent audit of Residents' Fall Risk Assessments and Care Plans for accuracy with no concerns identified. On 07/05/2021, each resident who was identified at risk for falls was assessed with no further falls identified. On 07/05/2021, the Minimum Data Set Nurse performed a 100 percent audit of the Care Guides with no concerns identified. All	

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M 640	Continued From page 22 Template. The State Survey Agency (SSA) received an acceptable Removal Plan on 9/30/21, in which the facility alleged that all corrective actions were completed as of 9/30/21, and the IJ was removed on 10/1/21. (Amendment 12/2/21 - The SSA determined that the IJ was removed on 7/8/21). The SSA validated the Removal Plan on 7/8/21 and determined the IJ to be removed on 7/8/21. Therefore, the scope and severity for IJ at Rule 45.21.8 - Accidents- M640 was lowered to a Level II, while the facility develops and implements a plan of correction and monitors effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's "Accident and Incidents-Investigating and Reporting", dated 07/2017, revealed "Policy Statement: It is the policy that all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator... Policy Interpretation and Implementation...5. The Nurse Supervisor/ Charge Nurse and/or the department director or supervisor shall complete a Report of Incident/ Accident form and submit the original of the Director of Nursing services within 24 hours. of the incident or accident. 6.The Director of Nursing shall ensure that the Administrator receives a copy of the Report of Incident/Accident form for each occurrence. 7.Incident/Accident reports will be reviewed by the Quality Assurance (QA) committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities."	M 640	residents at risk needing two-person assist were identified and reviewed. On 10/7/2021, the Lead Certified Nursing Assistant (CNA) performed room rounds and monitored for pests, with no additional problems identified. With a census of 39, we identified that the 16 residents located on the 300-hall have the potential to be affected (these are Residents located in rooms on the same hall as Resident #31). Beginning on 11/8/2021, all of the rooms on the 300-hall have been placed on the maintenance list to be assessed for potential pest entry points with identified areas to be corrected. Once Maintenance has completed their assessments and corrections, Housekeeping Staff will perform a terminal cleaning on all rooms on the 300-hall. The Lead CNA placed containers in all residents' rooms identified as having the potential of being affected. This incident was taken to QA on 10/27/2020 3.Actions taken/systems put into place to reduce the risk of future occurrence include: On 07/04/2021, the Administrator provided in servicing to the Charge Nurse, Cart Nurse, Temporary Nursing Assistants (TNA), and Certified Nursing Assistants (CNA) involved in Resident #31's direct care. The in-service topics included: following the Activities of Daily Living Care Plans and Care Guides, Abuse and Neglect, and Resident's Rights. On 07/04/2021 and 07/05/2021, the Administrator continued in-servicing with staff on the above topics. On 07/05/2021, the Administrator suspended TNA #1 until	

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M 640	Continued From page 23 Review of the facility's "Fall Risk Assessment Policy", revised March 2018, revealed " Policy Statment, The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information... Policy Interpretation and Implementation...7. The staff, with the support of the attending physician, will evaluate functional and psychological factors that my increase fall risk, including ambulation, mobility, gait balance, excessive motor activity, Activities of Daily Living (ADL) capabilities, activity tolerance, continence, and cognition...." Interview on 09/16/21 at 09:00 AM, with the Director of Nursing (DON) revealed on 7/3/21 Resident #31 fell out of the bed to the floor while TNA #1 as providing care. The DON also stated that on 7/6/21 TNA #1 came to the facility and re-enacted the incident. The DON said TNA #1 said she was providing incontinent care alone and turned Resident #31 to the right side. TNA #1 said she did not remove the pillows from the resident's feet. TNA #1 said Resident #31 slid to the floor on her knees. Resident #31 was still holding on to the bedrails. TNA #1 revealed she notified Licensed Practice Nurse (LPN) #1. The DON said TNA #1 confirmed she had read Resident #31's plan of care. TNA #1 said she knew Resident #31 was a two (2) person assist with bed mobility, but she thought she could do it without help. The DON said the TNA's and Certified Nursing Assistants (CNA) are trained that TNAs should not provide care without a license person being present. During an interview on 09/16/21 at 10:25 AM, with	M 640	further notice to complete the investigation. On 07/05/2021, the Administrator conducted and completed the investigation. Beginning 10/2/2021, the Director of Nursing (DON) will review Daily Assignment Sheets to ensure that the CNA and TNA staff remain properly paired to perform direct care weekly for a year and a log will be maintained by the DON weekly for four weeks, then monthly for three weeks, and then quarterly for a year. Beginning on 10/2/2021, the Lead CNA began observational rounds to monitor for proper staffing as set forth by the Daily Assignment Sheets, and he will continue to make these observational rounds weekly for a year, and a log will be maintained by the Lead CNA for a year. The Staff Development Nurse and the Administrator from a non-affiliated sister facility presented a directed in-service for all non-contracted staff, the Assistant Director of Maintenance, the Director of Housekeeping, and the Director of Therapy on Freedom from Abuse, Neglect, and Exploitation on 11/10/2021. On 10/02/2021, a rodent checklist was placed at each Nursing Station for Nursing Staff to complete in the event that a rodent is suspected or detected. On 10/08/2021, the Lead CNA placed plastic containers in each residents' room to ensure that all opened food is properly stored, and he will continue making sure that plastic containers are in Long-Term Care Residents' rooms weekly. Beginning 10/8/2021, all Long-Term Care Residents' rooms will be placed on a schedule to be terminally cleaned every quarter and as needed (PRN), and a log of	

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M 640	Continued From page 24 the Administrator revealed TNA #1 had been through the CNA class but she has not taken her test. The Administrator said TNA #1 was paired with CNA #1. The Administrator said on 7/3/21 LPN #1 called her and said Resident #31 had slid to the floor during care. The Administrator said she was told Resident #31's feet got tied up in the sheets. Resident #31 was kicking and fell out of the bed while TNA #1 was providing incontinent care. The Administrator said she came to the facility and started the investigation. The Administrator confirmed TNA #1 was not suspended at that time. The Administrator gave orders to the nurses that TNA #1 should not provide care to any of the residents without supervision. The Administrator said on 7/6/21 TNA #1 was called in to do a re-enactment of the incident. The Administrator said TNA #1 said she raised the bed to her waist. TNA #1 turned the resident over without moving the pillows. TNA #1 said she had just read Resident #31 care plan and knew that she was a two (2) person assist with Activities of Daily Living (ADL's). TNA #1 said she thought she could do the care without assistance. The Administrator said it was determined during the investigation TNA #1 did not remove the pillows when she turned Resident #31, this caused the resident to fall out of bed. The Administrator said in-services were started with the staff on Abuse/Neglect, Resident rights, Following the care plan, ADL supporting and Accidents and Incidents. A Quality Assurance (QA) meeting was done 7/8/21. The Administrator said the Ombudsman, Mississippi State Department of Health (MSDH) and the Attorney General's (AG's) Office was notified on 7/3/21. The Administrator stated that TNA #1 was suspended 7/5/21 and terminated 7/12/21 because she had been identified as having the potential of placing residents' at a safety at risk,	M 640	these cleanings will be maintained by the Housekeeping Director for a year. On 10/07/2021, Resident #31 and all other Residents on the 300-hall that were identified as being potentially affected, received room inspections by the Maintenance Department to look for any rodent points of entry. Then, beginning on 10/08/2021, we moved Resident #31 and initiated moving the other Residents on the 300-hall from their rooms to receive terminal cleanings, and then any problems that were identified during the Maintenance environmental inspections have corrections initiated and are in progress. Beginning 10/8/2021, all Long-Term Care Residents' rooms will be placed on a schedule to be inspected by the Maintenance Department to monitor for rodent points of entry quarterly, and those logs of the inspections and finding will be maintained by the Assistant Director of Maintenance for a year. The Exterminator will be notified by the Maintenance Department for a return visit for any detection of rodents. Rodent traps, if indicated, will be placed in any resident(s) room(s) for two weeks after rodent sighting. Beginning 10/8/2021, the grounds surrounding the facility will be inspected weekly by the Maintenance Department to monitor for ants for a year, and a log will be maintained. On 10/7/2021, the Lead CNA performed room rounds and audited for pests with no additional problems notified, and he will continue room rounds and monitor for pests weekly for a year. The Staff Development Nurse and the Administrator from a non-affiliated Sister Facility	

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M 640	Continued From page 25 leading the facility to terminate her employment. Interview on 09/16/21 at 12:51 PM, with CNA #1 said she was assigned to work with TNA #1 on 7/3/21. CNA #1 she went on the other side of the building to stock the linen cart. CNA #1 also revealed TNA #1 was at the nurse's station when she went to stock the cart. CNA #1 said she did not know CNA #1 was providing incontinent care without her until Resident #31 was reported on the floor. CNA #1 revealed LPN #2 and CNA #2 in-serviced the staff daily that TNAs cannot provide care without assistance of a licensed or certified staff member. CNA #1 said TNA #1 has not had any other instances where she provided care without assistance. Interview on 09/16/21 at 01:54 PM, with Registered Nurse (RN) #1 said she was the supervisor for the day. RN #1 said LPN #1 came down the hall extremely upset stating Resident #31 got her feet tied up in the sheets and slid out of the bed. RN #1 said she thought LPN #1 was in the room with TNA #1 while she was providing care. RN #1 said she received an order for an X-ray of Resident #31's bilateral knees from the medical doctor. During an interview with LPN #2 on 09/16/21 at 2:15 PM, confirmed the staff is trained during orientation and annually on Activities of daily Living (ADL) task, skills, and checkoffs. LPN #2 said during her training she tells the TNA's and CNA's that the TNAs cannot provide care without licensed or certified personnel. LPN #2 confirmed she cannot provide an in-service with TNA #1 indicating she was trained to only provide care with a licensed or certified person. During an interview with CNA #2 on 9/16/21 at	M 640	in-serviced all non-contracted staff, the Assistant Director of Maintenance, the Director of Maintenance, the Director of Therapy, and the Director of Housekeeping on Maintains Effective Pest Control on 11/10/2021. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: Beginning the week of 10/2/2021, the Staff Development Nurse will monitor the Lead CNA's documentation to monitor for any problems or concerns and will keep a log of findings weekly x4 weeks, then monthly x 3 months, and then quarterly for one year. The fall of Resident #31 was taken to the QA Committee on 07/08/2021 for review. This incident and a review of Resident's Rights was taken again to the QA team on 10/27/2021, and the QA Committee will continue meeting monthly for three months on these topics. Any new recommendations by the QA Committee will be implemented. Also, beginning on 10/8/2021, the Staff Development Nurse will monitor the logs of findings kept by the Assistant Director of Maintenance, the Director of Environmental Services, and the Lead CNA to prevent reoccurrence weekly for four weeks, then monthly for three months and then quarterly for a year. On 10/12/2021, the QA team met and discussed rodent issues and concerns and the incident related to Resident #31. This event was taken to the Quality Assurance (QA) Committee again on 10/27/2021 with no new recommendations. The QA Committee will	

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M 640	Continued From page 26 2:30 PM, revealed he is at work every day at 6:00 AM. CNA #2 said he has a meeting with the CNA's and TNA's. CNA #2 reminds the staff that the TNA's can only provide care to residents with a licensed or certified person. TNAs cannot provide care without a certified CNA or a nurse being present. CNA #2 confirmed TNA #1 failed to follow the facility policy by providing incontinent care to Resident #31 without having another CNA or nurse present. During an interview with TNA #1 on 9/16/21 at 3:30 PM, revealed she checked on Resident #31 and noted the resident had an incontinent episode. TNA #1 confirmed she provided incontinent care without a CNA or Nurse with her. TNA #1 revealed she was told by CNA #2 that she only needed another staff member in the room when a lift is used for transfer. TNA #1 said she was not told that she could not provide incontinent care to the residents alone. TNA #1 said she has provided incontinent care alone with multiple residents. TNA #1 said she reviewed Resident #31's care plan when she first started working at the facility. TNA #1 said she did not remember Resident #31 plan of care required two (2) persons assist with ADL's. TNA #1 confirmed she did not ask any of the other staff for assistance because she has provided incontinent care without help multiple times and the resident was ok. Review of the facility's Nurse Aides Information Sheet plan of care revealed Resident #31 requires two person/extensive assist with incontinent care, Hoyer lifts, bed baths, showers, turn and reposition and dressing. Record review of Resident #31's Care Plan with a Problem Onset date of 03/27/2020 revealed	M 640	meet on this topic monthly for three months. Any new recommendations from the QA committee will be added and implemented.	

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M 640	Continued From page 27 "(Formal Name) decline in ability to perform self care activities, (Formal Name) is unable to bear weight, (Formal Name) at risk for soiling clothing ...Approaches: Provide extensive assistance X2 (of two persons) with bed mobility...Provide total assistance X2 with toileting ..." Record review of the Face Sheet revealed Resident #31 was admitted to the facility on 3/27/20 with diagnoses which included Major depressive disorder, Dementia, Psychotic disorder with delusions, Anxiety disorder, and Sarcopenia. Record review of Resident #31's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/09/2021 revealed Resident # 31 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #31 is cognitively intact. CI #18152 and CI #18165 Review of the facility's, "Pest Control", dated 8/20/18, revealed policy to establish a safe and reliable method of pest and rodent control for (Formal Name of Facility) .Procedure:1. Pest Control for the facility will be through a licensed, bonded commercial firm. 2. The pest control action will be carefully coordinated with appropriate Administrator and/or Director of Nursing and the Director of Maintenance. 3. Spraying and other means of pest control will be performed during a time of low patient flow. Generally, the day will be Friday afternoon to reduce the level of fumes for patients, staff. 4. Recording of chemical spraying for (Formal Name) will be done through the use of a pest control spray log. The person in charge of maintenance will insure that entries in the log are completed in an accurate and timely basis.5.	M 640		

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M 640	Continued From page 28 Spraying and pest control activities will be kept to an absolute minimum." During an observation of the facility on 10/12/21 at 09:00 AM, revealed Resident # 13 lying in bed with the head of the bed elevated. The Resident was nonverbal with Jevity 1.2 infusing at (@) 50 cubic centimeters (cc)/hour (hr) per continuous tube feeding. The Resident did not have any lesions or broken skin noted on either foot. The SSA observed mice droppings in the residents chest of drawers. The SSA also observed a cardboard mouse hotel noted under the resident's bed. The SSA also observed Resident #31's left big toe on 10/12/21 at 9:00 during the tour. The toe had two (2) red areas. No blood or drainage was noted. The SSA observed mice hotels in all the residents' rooms on the 300 halls underneath their beds. During an interview on 10/12/21 at 09:15 AM, the Administrator confirmed the facility has a problem with mice. The Administrator said the staff notified her of the mice in the building about a month and a half ago. The Administrator said the staff told her they saw mice at the nurse's station and in the offices on the 300 halls. The Administrator said the maintenance department put out sticky traps at the nurse's station, offices, and utility rooms. The Administrator said she was notified on 10/7/21 at 06:00 AM that Resident #31 had a mouse in her bed. The Administrator also said she was told Resident #31 had a possible bite on her left toe. The Administrator said she immediately notified maintenance and started an investigation. Resident #31 was assessed and removed from that room. The Resident's room was thoroughly cleaned. The Administrator said	M 640		

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M 640	Continued From page 29 she was told the mice has only been seen at night. The day shift said they have not seen any mice. The Administrator said the (Formal name of pest control company) comes out monthly and sprays for all pest and rodents. The facility is in the process of reconstruction of the 200, 300 and 400 halls. The Administrator also said the facility is removing all the residents off the 300 hall and re-doing their rooms first because of the mice citings. Review of the facility's, "pest control invoice", revealed the pest control company made a visit to the facility on 9/9/21 and 9/30/21. During an interview on 10/12/21 at 10:30 AM, CNA #2 confirmed the facility has problems with mice. CNA #2 said he has removed 4 mice out of the building in the last few months. CNA #2 said he removed two (2) out of Residents rooms and two (2) out of the nurse's offices. CNA #2 said the mice were in the mice hotels. CNA #2 revealed he started seeing and hearing about the mice in the building about eight months ago when the facility started reconstruction on the kitchen. CNA #2 said maintenance put out sticky traps at the nurse's station and in the utility closet. CNA #2 said the staff will call him if a mouse enters the mouse hotel to remove it. During an interview on 10/12/21 at 11:00 AM, with RN # 2 revealed he was consulted to assess Resident #31's wound on her left great toe. RN #2 said the lesion measured at 0.4 centimeters (cm) x 0.3 cm x 0.2 cm. The wound was red and open with no drainage or odor. RN #2 said he received an order to cleanse the area with normal saline, apply triple antibiotic cream and cover with a dry dressing. RN #2 said he has seen CNA #2 taking a mouse out of the facility in the mouse	M 640		

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M 640	Continued From page 30 hotel. He has not removed any mice himself. During an interview on 10/12/21 at 11:15 AM, with the Maintenance Director confirmed the facility has a problem with mice in the facility. The Maintenance Director said this was brought to his attention about a month and a half ago. The staff complained of seeing mice running across the nurse's station. The Maintenance Director said he put out sticky traps at the nurses station and in the utility rooms. The Maintenance Director also said (name of pest control company) comes out monthly and as needed. The pest control company has placed five (5) bait stations under the facility with mice bait. The Maintenance Director said it was brought to his attention again on the 10/7/21, when he was told Resident #31 had a mouse in her bed. The Maintenance Director said he put out 38 mouse baits on the rehab side of the facility in the residents' rooms and 17 on the long-term side. The Maintenance Director said no one has reported seeing any mice on the Rehab side. During an interview on 10/12/21 at 12:30 PM, with the Medical Director (MD) revealed he looked at the resident's foot and believe she has two (2) lesions on her left toe. From what, he does not know. The MD said he could not tell what kind of bite it is. The MD said the Resident was started on Doxycycline which is appropriate for a mouse bite. The Resident is also orderd triple antibiotic cream every shift and as needed. During an interview on 10/12/21 at 1:00 PM, with Resident #31's primary Physician confirmed he was notified on 10/7/21 that Resident #31 could have received a possible mouse bite. The primary Physician said he ordered Doxycycline 100 milligrams (mg) orally twice a day, for ten days.	M 640		

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M 640	Continued From page 31 During an interview on 10/12/21 at 2:00 PM, with the local pest control staff revealed he treats the facility once a month for all pest and rodents. The facility will call him for extra treatments when needed. He said he was called on 10/7/21 for an extra treatment because the facility saw a mouse in a resident's bed. He stated he placed bait stations under the facility. He has recommended that the facility would put snap traps out at the nurse's station and in the utility closets. He said he told them not to put them in the resident's room. He said he doesn't know why the facility has seen an increase in mouse citations. During an interview per phone on 10/12/21 at 8:30 PM, with CNA #3 said she pulled Resident #31's cover back to provide incontinent care. CNA #3 said she saw the mouse run in Resident #31's boot. CNA #3 said she screamed. CNA #4 pulled the cover off the bed. The mouse ran down the bed and jumped off the bed and ran in a hole that was next to the closet in the resident's room. CNA #3 said she had never seen a mouse in a resident's bed before. CNA #3 said she has seen mice for several months running down the hall and at the nurse's station. CNA #3 said she has seen mice droppings in several residents' drawers. She reported the mice to CNA #2. She reported the maintenance department put out sticky traps. During an interview per phone on 10/12/21 at 8:45 PM, with LPN #3 confirmed she was called into Resident #31's room by CNA #3 and CNA #4. LPN #3 said the mouse ran out of Resident #31's Prevalon boot and jumped off the bed onto the floor and ran in a hole in the wall under the closet door. LPN #3 said there was mouse droppings on the floor and in the residents' bed linen from top	M 640		

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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) COMPLETE DATE
M 640	Continued From page 32 to bottom of the bed. Resident #31 had two (2) open lesions to her left great toe, active bright red blood was noted on the residents left toe. The primary Physician ordered doxycycline 100 mg orally twice a day times ten days. The wounds were cleansed with normal saline and triple antibiotic ointment was applied. The Administrator, DON and family was notified of the incident. During an interview per phone on 10/12/21 at 9:00 PM, with CNA #4 revealed she was attempting to provide incontinent care to Resident #31. CNA #4 said CNA #3 pulled the cover back on Resident #31. A mouse ran into Resident #31's Prevalon boot. CNA #4 said she pulled the cover off the bed and the mouse ran out of the boot up to the head of the bed and jumped off the bed and ran in a hole in the wall near the closet. CNA #4 also said the mouse had droppings from the head of the bed to the bottom. There were mouse droppings all over the floor. CNA #4 said she has seen mice running up and down the halls several times ever since the facility started tearing down the kitchen eight months ago. CNA #4 said she reported the mice to the CNA #2. CNA #2 reported it to maintenance. CNA #4 said maintenance put out sticky traps. CNA #4 said she has seen mouse droppings in several of the resident's drawers on the 300 hall. During an observation on 10/13/21 at 10:00 AM, of the rooms on the 300 halls with CNA #2 revealed mouse droppings in the chest of drawers and on the floor under the Residents beds in four (4) resident rooms. Resident #3, Resident #6, Resident #12, and Resident #35 resided in the rooms that were identified with mouse droppings.	M 640		

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M 640	Continued From page 33 Record review of the Face Sheet revealed Resident #3 was admitted to the facility with the diagnoses that included Dementia with behavioral disturbance, Hypertension, and History of falls. Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/18/21 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of eight (8) that indicated Resident #3 has moderate cognitive impairment. Record review of the Face Sheet revealed Resident #6 was admitted to the facility on 12/29/17 with diagnoses that included Alzheimer's disease, Diabetes Mellitus, and Hypertension. Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/25/21 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of three (3) that indicated Resident #6 has severe cognitive impairment. Record review of the Face Sheet revealed Resident #12 was admitted to the facility on 10/14/13 with diagnoses that included Multiple Sclerosis, Dementia and Rhabdomyolysis. Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/8/21 revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of ten (10) that indicated Resident #12 has moderate cognitive impairment. Interview with Resident #12 on 10/13/21 at 10:15 AM, revealed she has not seen any mice in her room. She did not know she had mice droppings in her chest of drawers and under her bed.	M 640		

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M 640	Continued From page 34 Record review of the Face Sheet revealed Resident #31 was admitted to the facility on 03/27/20 with diagnoses that included Major depressive disorder, Dementia, Psychotic disorder with delusions, Anxiety disorder, and Sarcopenia. Record review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/21/2021 revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of one (1) which indicated Resident #31 has severe cognitive impairment. Record review of the Face Sheet revealed Resident #35 was admitted to the facility on 11/3/19 with diagnoses that included Amputation of the Right Leg, Peripheral Vascular Disease (PVD), Diabetes Mellitus and High Blood Pressure. Record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/28/21 revealed Resident #35 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) that indicated Resident #35 is cognitively intact. Record review of the Face Sheet revealed Resident #42 was admitted to the facility on 9/28/21 with diagnoses that included Osteomyelitis, Diabetes Mellitus, and Hypertension. Record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/5/21 revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) that indicated Resident #42 is	M 640		

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M 640	Continued From page 35 cognitively intact. Interview on 10/13/21 at 10:42 AM, with Resident #42 confirmed he saw a mouse run across the floor in his room. He also said he has reported it to CNA #2 that he saw mice droppings under his bed. The Resident said CNA #2 put a mouse hotel in his room and he has not seen them again. The facility provided an acceptable Removal Plan on 9/30/21, for the IJ. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: Removal Plan Immediate Jeopardy (IJ) was called on 9/28/2021 at 12:35 PM. The IJ template was provided on 9/28/2021 at 12:35 PM. Beginning 7/3/2021 when Temporary Nursing Assistant (TNA) #1 failed to obtain the necessary assistance to provide incontinent care to resident #31 resulting in a major injury with fracture of bilateral knees. The State Agency notified the Administrator and the Director of Nursing (DON) that an IJ had been identified. Brief Summary of Events The facility failed to ensure a resident was protected from neglect as evidence by (AEB) an unlicensed TNA neglected to obtain assistance required when providing incontinent care that resulted in Resident #31 obtaining a fracture. ON 7/3/21, immediate action was taken by the cart nurse to notify the doctor and obtain bilateral knee x-rays. The facility failed to follow the comprehensive care plan while providing incontinent care AEB Resident #31 is extensive assist and always needs two people during care.	M 640		

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M 640	Continued From page 36 The facility failed to ensure a vulnerable resident was protected from accidents and hazards when a TNA #1 failed to ask for help while providing incontinent care, which caused Resident #31 to fall with a major injury to bilateral knees. The facility failed to protect Resident #31 and other residents from potential for further injury during the investigation process by not removing TNA #1 from the facility following an incident on 7/3/2021. The Facility continued to allow TNA #1 to work until 7/05/21. Corrective Actions: - On 7/3/2021, the Administrator provided education to the Charge Nurse, two (2) TNAs, 2 Cart Registered Nurses (RN), and three (3) Certified Nursing Assistants (CNA) directly involved in the fall of Resident #31. On 7/3/2021, the in-service topics included following the Activities of Living (ADL) Care Plan and Care Guide, Abuse and Neglect, and Residents' Rights. On 7/4/2021 and 7/5/2021, the Administrator continued in-servicing with all staff on the above topics. No staff will be allowed to work until in-services are completed. - On 07/03/21, the Administrator identified that Resident #31 sustained a fall with injury and initiated an investigation. - On 07/05/2021 at 10:24 AM, the Administrator suspended TNA #1 until further notice to complete investigation. On 07/05/2021 the Administrator conducted and completed the investigation. On 07/12/21 the Administrator terminated TNA #1. - On 7/5/2021 at 10:00 AM, each resident under the care from TNA #1 who was identified as at risk for falls was assessed with no further	M 640		

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M 640	Continued From page 37 falls identified. 5. On 07/05/2021 at 10 AM, the Minimum Data Set Nurse (MDS) conducted a 100 percent audit of Resident's Fall Risk Assessments and Care Plans for accuracy with no concerns identified. 6. Each resident has a care guide specific to their needs located in a binder at each nurse's station. These are reviewed by the CNAs prior to the start of each shift and to be followed to provide care to the residents. On 07/05/2021, the MDS Nurse performed a 100 percent audit of the care guides with no concerns identified. On 07/05/2021 The Administrator in-serviced CNAs and TNAs on the following: ADL care guides specific to each resident. On 07/05/2021, the MDS Nurse performed a 100 percent audit on ADLs of residents identified at risk for falls and failure to follow the ADL Plan of Care. All residents at risk needing two-person assist were identified and reviewed. On 9/16/2021, the Staff Development Nurse educated all TNAs and CNAs on providing resident care only with a CNA or Nurse present, no staff will be allowed to work until in serviced. TNAs and CNAs were instructed to review ADL care plan prior to each shift. 19 of the 40 residents were identified as at risk for falls and failure for the ADL Plan of Care to be followed. A form was developed and created for all TNA new hires to have proper education, training, and understanding that they must work directly with a licensed CNA and to follow and know their ADL plan of care. On 9/21/2021, the Staff Development Nurse educated all staff that all TNA's can only provide resident care with a CNA or Nurse present, no staff will be allowed to work until in-serviced. 7. The Administrator requested an in-person	M 640		

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M 640	Continued From page 38 Quality Assurance Performance Improvement (QAPI) meeting to review events leading to this occurrence and corrective action taken. QAPI meeting occurred on July 8, 2021, and included the Administrator, Director of Nursing, Medical Director, MDS Nurse, Wound Care Nurse, Care Plan Nurse, Medical Records Nurse, Infection Preventionist, Physical Therapist, Administrator Assistant, and the Billing Office Manager. The meeting specifically discussed this fall, identified cause of the fall, number of previous falls, fall risk and potential harm, prevention of recurrence, abuse/neglect, following ADL care plan, Resident's Rights, ADL support and serious injury/harm and reporting. On 07/06/21, the Administrator in serviced the DON and Charge Nurse on the topic of removing any staff from the building for alleged violations of abuse, neglect, exploitation, or misappropriation of resident property until the investigation is completed. No changes to fall policy were required after being reviewed by QAPI. 8. On 9/16/2021, a form was created for all TNA hire in packets to ensure all TNA new hires have proper education, training, and understanding that they must work directly with a licensed CNA. 9. The Administrator and DON conducted a 100 percent audit on all accidents and incidents from 07/04/2021 through 9/30/2021 to ensure that injury or negative outcomes was not identified related to unsupervised TNAs. On 07/05/21, the Administrator in-serviced all staff on fall related policies. Falls are reviewed at stand up meeting every morning and Quarterly Quality Assurance (QA) meeting. On 07/05/21 at 7AM, the Administrator continued on-going in servicing to reiterate with all staff that TNAs must provide care only with CNA assist.	M 640		

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M 640	Continued From page 39 10. The facility alleges that all corrective actions to remove the IJ were completed on 9/30/21, and the IJ was removed on 10/1/21. On 10/2/21, the State Survey Agency (SSA) validated the facility's Removal Plan by staff interviews, record reviews, and review of in-service sign-in sheets. The SSA verified the facility had implemented the following measures to remove IJ: Validation: 1. The SSA validated through interview with the Administrator and in-service sign in sheets that on 7/3/2021, the Administrator provided education to the Charge Nurse, two (2) TNAs, 2 Cart Registered Nurses (RN), and three (3) Certified Nursing Assistants (CNA) directly involved in the fall of Resident #31. On 7/3/2021, the in-service topics included following the Activities of Living (ADL) Care Plan and Care Guide, Abuse and Neglect, and Residents' Rights. On 7/4/2021 and 7/5/2021, the Administrator continued in-servicing with all staff on the above topics. No staff will be allowed to work until in-services are completed. 2. The SSA validated through interview on 10/1/21 that on 07/03/21, the Administrator identified Resident #31 sustained a fall with injury and initiated an investigation. 3. The SSA validated through interview and record review that on 07/05/2021 at 10:24 AM, the Administrator suspended TNA #1 until further notice to complete investigation and on 07/05/2021 the Administrator conducted and completed the investigation. On 07/12/21 the Administrator terminated TNA#1.	M 640		

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M 640	Continued From page 40 4. The SSA validated through interview with DON and record review that on 7/5/2021 at 10:00 AM, each resident under the care from TNA #1 who was identified as at risk for falls was assessed with no further falls identified. 5. The SSA validated through interview with the Minimum Data Set Nurse (MDS) nurse and record review on 07/05/2021 at 10 AM, the MDS nurse conducted a 100 percent audit of Resident's Fall Risk Assessments and Care Plans for accuracy with no concerns identified. 6. The SSA validated through staff interviews, record reviews and signed in-services that each resident has a care guide specific to their needs located in a binder at each nurse's station. These are reviewed by the CNAs prior to the start of each shift and to be followed to provide care to the residents. On 07/05/2021, the MDS Nurse performed a 100 percent audit of the care guides with no concerns identified. On 07/05/2021 The Administrator in-serviced CNAs and TNAs on the following: ADL care guides specific to each resident. On 07/05/2021, the MDS Nurse performed a 100 percent audit on ADLs of residents identified at risk for falls and failure to follow the ADL Plan of Care. All residents at risk needing two-person assist were identified and reviewed. On 9/16/2021, the Staff Development Nurse educated all TNAs and CNAs on providing resident care only with a CNA or Nurse present, no staff will be allowed to work until in serviced. TNAs and CNAs were instructed to review ADL care plan prior to each shift. 19 of the 40 residents were identified as at risk for falls and failure for the ADL Plan of Care to be followed. A form was developed and created for all TNA new hires to have proper education, training, and	M 640		

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M 640	Continued From page 41 understanding that they must work directly with a licensed CNA and to follow and know their ADL plan of care. On 9/21/2021, the Staff Development Nurse educated all staff that all TNA's can only provide resident care with a CNA or Nurse present, no staff will be allowed to work until in-serviced. 7. The SSA validated through staff interviews, record review and signed in-service sheets that the Administrator requested an in-person Quality Assurance Performance Improvement (QAPI) meeting to review events leading to this occurrence and corrective action taken. The QAPI meeting occurred on July 8, 2021, and included the Administrator, Director of Nursing, Medical Director, MDS Nurse, Wound Care Nurse, Care Plan Nurse, Medical Records Nurse, Infection Preventionist, Physical Therapist, Administrator Assistant, and the Billing Office Manager. The meeting specifically discussed this fall, identified cause of the fall, number of previous falls, fall risk and potential harm, prevention of recurrence, abuse/neglect, following ADL care plan, Resident's Rights, ADL support and serious injury/harm and reporting. On 07/06/21, the Administrator in serviced the DON and Charge Nurse on the topic of removing any staff from the building for alleged violations of abuse, neglect, exploitation, or misappropriation of resident property until the investigation is completed. No changes to fall policy were required after being reviewed by QAPI. 8. The SSA validated through an interview with the Administrator and record review that on 9/16/2021, a form was created for all TNA's hire in packets to ensure all TNA new hires have proper education, training, and understanding that they must work directly with a licensed CNA.	M 640		

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M 640	Continued From page 42 9. The SSA validated through record review, signed in-services and interview with the Administrator and DON that a 100 percent audit was conducted on all accidents and incidents from 07/04/2021 through 9/30/2021 to ensure that injury or negative outcomes was not identified related to unsupervised TNAs. On 07/05/21, the Administrator in-serviced all staff on fall related policies. Falls are reviewed at stand up meeting every morning and Quarterly Quality Assurance (QA) meeting. On 07/05/21 at 7AM, the Administrator continued on-going in servicing to reiterate with all staff that TNAs must provide care only with CNA assist. 10. The SSA validated that all corrective actions to remove the IJ had been completed as of 7/8/21, and the IJ removed on 7/8/21.	M 640		