STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	C 09/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

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F 000	INITIAL COMMENTS The State Survey Agency (SSA) conducted six (6) complaint investigations, CI #17522, CI # 17852, CI #18016, CI #18047, CI# 18048 and CI # 18077 at the facility from 9/20/21 to 9/24/21. During the investigations, the SSA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SSA substantiated CI #17852 for pressure ulcers, CI #18016 for diversion of medication, CI #18048 for not providing incontinent care in a timely manner and CI #18077 for failing to prevent the resident from ant bites. The SA unsubstantiated CI #17522 for infection control and social distancing, and CI #18047 for carrying out physician orders and notification of the Resident Representative. The SSA cited F-585, F-600, F-602, F-656, F-677, F686 and F-689. The facility held a license for 100 beds with a census of 79.	F 000		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in	F 585		11/23/21

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

Electronically Signed | 10/29/2021

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accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing

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written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on staff, family, and resident interviews,

1. Resident #2 was given a shower by

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F 585	Continued From page 3 review of the facility's Grievance logs, and facility policy review, the facility failed to resolve two (2) grievance's filed by Resident #2 regarding Activities of Daily Living (ADL) care for two (2) of three (3) filed grievances. Resident #2. Findings include: Record review of the facility's policy "Resident and Family Grievances" with an implemented date of 08/06/2019 revealed, " Policy: It is the policy of this facility to support each resident's and family member's right to voice a grievance ...Definitions: "Prompt efforts to resolve" include facility acknowledgment of a complaint/grievance and actively work toward resolution of that complaint/grievance. Policy Explanation and Compliance Guidelines: 1. The Social Worker has been designated as the Grievance Official ... 2. The Grievance Official is responsible for overseeing the grievance process; receiving and tracking grievance through to their conclusion; leading any necessary investigations by the facility ...10. Procedure ...b...ii. Report any allegations involving neglect, abuse, injuries of unknown source, and/or misappropriation of resident property immediately to the administrator and follow procedures for those allegations ...d. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form ...e. The Grievance Official or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances ...12. The facility will make prompt efforts to resolve grievances." Record review of facility's Grievance Logs revealed in the past 5 months revealed in June	F 585	certified nursing assistant on 9/23/2021. 2. All residents are at risk for this deficient practice. 3. The Grievance process has been modified by implementing a more in-depth and informative grievance log and resident/representative complaint form on 10/28/2021. All grievances will be reviewed for completion daily at the interdisciplinary meeting beginning 11/01/2021. A directed in-service training on the Grievance Policy and new forms was given by Mississippi Gulf Coast Community College Registered Nursing instructor for all current staff beginning 11/06/2021 and will be completed on 11/08/2021. After completion of the directed in-service, the staff development nurse will in-service all new staff and contracted personnel on the grievance process and updated forms during the orientation process, beginning 11/09/2021. The updated grievance forms will be displayed in areas of easy access around the facility, the activity room, and front office. A receiving box will be placed in the activity room for forms to be placed by 11/14/2021. 4. The Grievance log will be maintained daily by social services beginning on 10/28/2021. All new grievance forms will be brought to the daily interdisciplinary meeting daily for	

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F 585	Continued From page 4 2021 Resident #2 filed a grievance on 6/11/21regarding multiple concerns of showers and therapies. In September 2021 Resident #2 again filed a grievance on 9/10/21 regarding "unattended". The grievance logs revealed all grievances had been resolved. On 09/22/21 at 10:35 AM, during an interview with Resident #2 when asked regarding the care at the facility, he explained he has had a problem with the care several times since he has been at the facility. He explained he did file grievances with the facility regarding care and his friends did too. He explained care did get a little better but the problem still occurred. He explained the nurses won't or don't check behind the Certified Nursing Assistants (CNAs) to make sure they do their job. He explained the facility have had shorter staff and at times it would take all day to change him after a bowel movement. He further explained sometimes he does not get showers or baths and has waited 3 weeks at a time for a shower. He stated, "I probably would not have gotten my shower yesterday if you weren't here to watch." He explained he is scheduled for showers on Tuesday, Thursday, and Saturdays and reported he usually gets only one shower a week. On 9/22/21 at 3:35 PM, during an interview with the Administrator when asked regarding the process for investigation and resolving grievances, neither the Administrator or facility staff were able to provide any documentation related to Resident #2's grievances, other than the Grievance Log. On 09/22/21 at 4:00 PM, interview with Social Services, when asked if there is any other documentation other than the grievance logs	F 585	daily discussion and resolution beginning on 11/01/2021. To ensure improvements are sustained, the Administrator will review and audit the grievance logs weekly beginning 11/08/2021 and will present the findings to the quality assurance committee for review to make recommendations and changes as needed beginning 11/16/2021 and will end 02/01/2022. 5. All corrective action will be completed by 11/23/2021.	

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related to Resident #2's grievances, she stated " No."

On 09/23/21 at 12:45 PM, during a phone interview with Complainant regarding Resident #2, she explained Resident #2 has filed several complaints with the facility regarding poor care including not getting changed and not getting showers. She explained the facility had care plan meetings with her and Resident #2 in the past, but the problem has not been resolved and continues to happen. She explained it is not the resident's fault and he deserves to be treated with respect and taken care of. She explained she does not feel she should move Resident #2 to another facility because this facility does not do their job. She explained she did speak to the Administrator two weeks ago and was informed the facility was taking care of Resident #2 and the problem, but feels the resident is still having problems with getting changed and showers.

On 09/24/21 at 12:00 PM, during an interview with the Director of Nurses (DON), when asked regarding the grievances filed by Resident #2 related to showers and incontinent care, she explained the nursing department handled his grievance and resolved the problems but there was no documentation of the findings in the audit and she had no proof grievances were resolved. She explained the audit was completed in June but there has not been another audit since then. When asked if Resident #2 had another grievance filed months after the first grievance, does it seem the grievance was resolved, she replied, "no, the grievance does not appear resolved." Resident #2's Functional Status Report for bathing for May, June, July, August, and September 2021 was reviewed with the DON.

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The DON explained if not documented it was not done and confirmed Resident #2 is still not getting showers as scheduled.

Record review of Resident #2's Section G - Functional Status report for bathing revealed, Resident #2 did not receive bathing for eight (8) days in May 2021, eight (8) days in June 2021, eight (8) days in July 2021, and three (3) days in September 2021 from 9/1/2021 to 09/23/2021. The report revealed in the month August 2021 resident received showers but not on the scheduled days.

Record review of Resident #2's Detail Admission/Discharge Report revealed Resident #2 was admitted to the facility on 1/17/20, discharged 7/15/21 to the hospital and readmitted to the facility on 7/23/21.

Record review of the Face Sheet with an admission date of 7/23/21 revealed Resident #2 had diagnoses of Unspecified abnormalities of gait and mobility, Personal history of COVID-19, Flaccid hemiplegia affecting left nondominant side, Difficulty in walking, Obstructive and reflux uropathy, Muscle weakness, Diabetes mellitus with diabetic neuropathy, Neuromuscular dysfunction of bladder, and Cerebral infarction.

Record review of Resident #2 ' s Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 08/05/21 Section C revealed Resident #2 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated cognitively intact. Section G of the MDS revealed Resident #2 required extensive assistance of two-person assist with bed mobility and transfers, and one-person assist with

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F 585	Continued From page 7 dressing, toileting, and personal hygiene. Section H of the MDS revealed Resident #2 had an indwelling catheter and frequently incontinent of bowel. Record review of Resident #2's Care Plan with a Problem Onset date of 01/24/2020 revealed, "Problem/Need: INCONT(incontinent)/SKIN I am incont. of bowel & I have a hx (history) of skin breakdown. I have limited mobility, right hemiparesis, decreased balance, decreased safety awareness ...Approaches ...Sponge bath, shower as scheduled ...Provide Incontinence care per perineal care policy as needed ...Assist with toileting/changing q2hrs (every two hours) ..." Record review of Resident #2's Care Plan with a Problem Onset date of 01/24/2020 revealed, "Problem/Need: I need extensive assistance with ADL's, transfers, and toileting r/t (related to) my limited mobility, left side hemiplegia, left hand contracture, and lack of coordination ...Approaches ...Toilet/incont. care q2 hrs & prn (as needed) using skin barriers as needed ...Provide AM & PM care ensuring all needs met daily to maintain proper appearance, hygiene, well groomed ..." Record review of facility's "SHOWERING SCHEDULE (ALL HALLWAYS)" on facility letterhead revealed Resident #2 resided in a room that would be scheduled for a shower on Tuesday, Thursday, and Saturday.	F 585		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F 600		11/23/21

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F 600	Continued From page 8 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and facility policy review the facility failed to provide incontinent care in a timely manner and ensure a pressure reducing cushion was in use resulting in the occurrence of a Stage I pressure injury for one (1) of 14 sampled residents reviewed for abuse and neglect. Resident #5. Findings include: Record review of the facility's policy "Abuse, Neglect, and Exploitation/Misappropriation Policy" with a revised date of 03/19/2020 revealed, "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions:..."Neglect" means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical	F 600	1. Resident #5 was provided incontinent care, a pressure relieving cushion was placed in her wheel chair, and treatment and assessment of pressure injury was initiated, by the director of nursing and quality assurance nurse on 09/23/2021. 2. All residents are at risk for this deficient practice. 3. An incontinence care log was implemented for both units on 10/28/2021. The incontinence care log includes: Resident name, room number, soiled, unsoiled, how many briefs, how many pads, pressure reducing device in use, assigned staff member, resolution, nurse name, date, time, supervisor notified. The certified nurse assistant will be notified of resident incontinence care issues. The medication nurse will be responsible to provide incontinence checks with each med pass throughout each shift and	

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F 600	Continued From page 9 harm, pain, mental anguish, or emotional distress...Policy Explanation and Compliance Guidelines:1.c. Include training of new and existing staff on activities that constitute abuse, neglect...The components of the facility abuse prohibition plan are discussed herein: I. Screening ... II. Employee Training A. New employees will be educated on abuse, neglect, exploitation, and misappropriation of resident property during initial orientation. B. Existing staff will receive annual education through planned in-services and as needed ...III. Prevention of abuse, neglect, and exploitation ... IV. Identification of Abuse, Neglect, and Exploitation ... V. Investigation of Alleged Abuse, Neglect, and Exploitation ...VI. Protection of Resident ...VII. Reporting/Response ...VIII Actions ..." During an observation and interview on 09/23/21 at 1:20 PM, Resident #5 explained she was gotten up around 4:00 AM by night shift. She explained she was soaked all morning until right before lunch and had dried bowel movement (BM) on her. She explained now after sitting too long in her wheelchair, soaked in urine and BM with no cushion, she now has redness and maybe a sore on her buttocks. She explained she has not received a shower since Tuesday. She reported when the Certified Nursing Assistant (CNA) did clean her up before lunch, her buttocks felt rough and raw. She explained I also got up yesterday at 4:00 AM and sat up all day in the wheelchair soaked in urine. She reported this happens frequently. State Survey Agency (SSA) noted a strong smell of urine in the room. On 09/23/21 at 1:30 PM, the SSA asked the	F 600	document findings and resolution on the incontinence care log. The medication nurse will be responsible to notify the certified nursing assistant of any resident's with incontinence and supervise the corrective action. The charge nurse will monitor logs for completion and verify resolutions daily. The incontinence log will be brought to the daily interdisciplinary meeting for discussion and resolution beginning on 11/1/2021 and will end on 02/01/2022. A directed in-service training on Activities of Daily Living Policy, Abuse, Neglect, and Exploitation/Misappropriation Policy, and Use of Support Surfaces Policy was given by Mississippi Gulf Coast Community College Registered Nursing instructor for all current staff beginning 11/06/2021 and will be completed on 11/08/2021. After completion of the Directed in-service, the staff development nurse will in-service all new staff members and contracted personnel during the orientation process, on Activities of Daily Living Policy, Abuse neglect, and exploitation/misappropriation Policy and Use of Support Surfaces Policy, by the staff development nurse, beginning 11/09/2021. 4. To ensure improvements are sustained the quality assurance nurse will audit all incontinence logs weekly beginning 11/08/2021. The audit and logs will be presented for review at the monthly quality assurance meeting starting on 11/16/2021 to make recommendations and changes as needed and will end on	

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F 600	Continued From page 10 Director of Nursing (DON) if she would do an incontinent check with Resident #5. As soon as the DON entered Resident #5's side of the room, Resident #5 began telling the DON about how she sat up in the wheelchair in a soaked brief with urine all day yesterday and today with dried BM. She explained to the DON how her bottom felt rough and raw. SSA observed the DON do an incontinent check on Resident #5 and observed two (2) briefs on the resident and the brief was soaked. The DON and SSA observed moderate redness to both buttocks and an area to the left buttock was red and non-blanchable. There was a strong smell of urine noted in the room. During an interview on 09/23/21 at 1:50 PM, with CNA #3, she explained Resident #5 was up today when she started her shift. She explained the resident had been up in wheelchair all morning and she put her to bed just before lunch. When asked had she checked Resident #5 for incontinence at any time this morning, she explained no. When asked if the resident had dried BM on her when she went to change her, she explained Resident #5 had a little dried BM up near her back when she changed her and she noticed resident's buttocks were really red. When asked did she put two (2) briefs on Resident #5 after cleaning her up, she explained she did. When asked if applying two (2) briefs on a resident or not checking a resident for incontinence for over two (2) hours could cause harm or be neglect, CNA #3 did not reply. On 09/23/21 at 2:30 PM, during an interview with Registered Nurse (RN) #1, 400/500-Hall Nurse Supervisor, she explained CNA #3 did report to her right before lunch that Resident #5's bottom was red. She explained she did go look at	F 600	02/01/2022. 5. All corrective action will be completed by 11/23/2021.	

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Resident #5's bottom with the DON. When asked what she observed when she assessed Resident #5, she explained both of the resident's buttocks were red and on the left buttock there was a non-blanchable area around the buttock cheek.

On 09/24/21 at 11:10 AM, during a phone interview with the Nurse Practitioner (NP), when asked regarding what could double briefs on a resident or not providing incontinent care at least every two (2) hours cause with a resident, the NP explained both situations could cause tissue breakdown due to the moisture and could lead to a pressure wound.

On 09/24/21 at 12:00 PM, during an interview with DON, when asked regarding the incident of her finding Resident #5 with two (2) briefs on, she confirmed there were two (2) briefs on Resident #5 and explained that is never acceptable in the building. When asked if a resident is left for long periods of time incontinent and/or double briefed could that be considered neglect, she replied, "It could." When asked to describe what she observed on Resident #5 when she removed the two briefs, she explained the resident's buttocks were severely red and there was one non-blanchable area to the resident's left buttock.

On 09/27/2021 at 12:30 PM, during a phone interview with RN #1, when asked regarding a CNA applying two (2) briefs on a resident, she explained that is not allowed in the facility. When asked if this could be considered neglect and if there could be any negative outcome, she explained it could cause skin breakdown.

Record review of Resident #5's Face Sheet revealed the facility admitted Resident #5 on

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07/15/21 with the diagnoses of Hemiplegia following Cerebral infarction affecting left nondominant side, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Muscle Weakness, and Fibromyalgia.

Record review of Resident #5's Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/22/21, Section C revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated Resident #5 had moderate cognitive impairment. Section G of the MDS revealed Resident #5 required extensive assistance of two-person assist for bed mobility, transfers, dressing, toilet use, and personal hygiene. Section H revealed Resident #5 was always incontinent of bowel and bladder.

Record review of Resident #5's Physician Orders for September 2021 revealed an order with a start date of 7/16/21 for "Pressure reducing chair cushion for wheelchair in place and functioning properly, check q (every) day (gel cushion)" and a new order dated 09/23/21 to "Cleanse both buttocks with wound cleanser/normal saline, pat dry, apply barrier cream and cover with silicone bordered dressing daily and as needed."

Record review of Resident #5's two (2) Wound Assessment Reports dated 09/23/21 revealed irritation/excoriation to left buttock that appeared red or darker pink, moderate irritation, with measurements 9.5 cm (centimeters) length x 4.0 cm width and Stage one (1) Pressure Ulcer to left buttock, left outer aspect of the excoriation, with measurements 2.0 cm length x 3.0 cm width. Both areas were identified on 9/23/21.

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F 600	Continued From page 13 Record review of Resident #5 ' s Care Plan, undated, revealed "Problem: (Formal Name) needs assist with ADLs r/t CVA w/(with) left non-dominant hemiparesis ...Interventions: Toilet/incont care q 2 hrs & PRN using skin barriers as needed, Observe for skin breakdown/redness during care & report to nurse qs (every shift) ...Provide AM & PM care ensuring all needs are met daily to maintain proper appearance, hygiene, well groomed ..." Record review of Resident #5 ' s Care Plan, undated, revealed "Problem: Resident is at risk for skin breakdown r/t decreased functional mobility, diabetes, left sided hemiparesis, incont of B&B (bowel and bladder) ...Interventions ...Pressure reducing cushion chair ...Sponge bath/Shower on designated days ... Record review of Resident #5 ' s Care Plan, onset date 9/23/2021, revealed "Problem: I have acquired a pressure area and have areas of excoriation and redness ....1.) Left buttock-irritation/excoriation, 2.) Left buttock-non-blanchable stage I, 3.) Right buttock-irritation/excoriation ...Interventions: Treatment as ordered ...Provide pressure relief to areas: mattress, cushion ...Provide incontinent care every 2 hours and prn (as needed) ..." Record review of facility's in-service titled, "Abuse, Neglect, and Exploitation Policies" dated 12/20 revealed CNA #3's signature.	F 600		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse,	F 602		11/23/21

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F 602	Continued From page 14 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and facility policy review the facility failed to protect four (4) residents rights to be free from misappropriation of property as evidence by diversion of medication for four (4) of seven (7) residents medication administration reviewed. Resident #8, Resident #10, Resident #11, and Resident #12. Findings Include: Review of the facility's "Drug Diversion Policy and Response" dated 03/19/20 revealed the purpose to provide guidelines for the identification, reporting, and investigation of suspected drug diversion by Lakeview Nursing Center, employees, patients, and visitors. The facility's policy reveals the prevention of drug diversion is essential to the safety of Lakeview Nursing Center patients an in the individual responsibility of every Lakeview Nursing Center Policies. Employees are required to report known or suspected incidents of drug diversion by employees, patients, and visitors. All suspected incidents of drug diversion will be thoroughly investigated, and drug test will be conducted. Suspicion of drug diversion may arise from a variety of circumstances, including but not limited to a witness incident of probable drug diversion, behaviors that man indicate an impaired individual, suspicious activity identified during routine monitoring and/or proactive surveillance,	F 602	1. Resident #8 was monitored on 08/13/2021, for non-verbal cues for pain and interviewed by nursing for complaints of pain, the resident denies any pain. Resident #10 was interviewed on 08/13/2021, for complaints of pain, the resident denies any pain. Resident #11 was interviewed on 08/13/2021, for complaints of pain, the resident denies any pain. Resident #12 was monitored and interviewed on 08/13/2021, for non-verbal cues for pain and complaints of pain, the resident denies any pain. The nurse that was suspected of misappropriation of resident medications was suspended on 08/13/2021 and after an investigation was terminated by the director of nursing on 8/16/2021. 2. All residents are at risk for this deficient practice. 3. The DON and quality assurance nurse will audit all narcotic books beginning on 10/28/2021 for as needed narcotics documented in the medication administration record and blue narcotic sheets for nurse signatures, and will complete the audit on 11/8/2021. The DON and quality assurance nurse will conduct audits of narcotics books	

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F 602	Continued From page 15 self-disclosure of drug diversion by an individual, notification of suspected drug diversion from an external source, The Quality Assurance Department will manage investigation of all reports of suspected drug diversions, and conduct an Emergency Quality Assurance Meeting. The Lakeview leadership will receive prompt notification of incidents of probable drug diversion. Drug diversion is grounds for corrective action. In most cases the expected outcome will be termination of employment or corrective action deemed appropriate by the administration of Lakeview, Medical Director and Pharmacy Director. Review of the facility's, "Drug Administration Policy," revised 03/2019 reveal the purpose is to ensure proper medication administration, documentation, tracking, and disposal of routine and controlled substances. Drugs are signed in by the nurse when delivered. Controlled medications are signed in by two (2) nurses when delivered. All drugs are given by physician's orders. These are recorded on electronic medication administration record (eMAR), which is used as orders. The eMAR should reflect the written physician's order. There is a stock bin on each medication cart for resident medications. It is the medication nurse responsibility, the license nurse dispensing the drug to check the eMARS for orders, find correct card, punch pills into the medication cup. The nurse will give to the appropriate resident, initial on the eMAR. If there is a discrepancy the licensed nurse must call the Medical Doctor immediately for clarification order. Physicians' orders written daily and must be promptly recorded on the eMAR or paper copy correctly. The resident representative will be notified, and documentation of this procedure	F 602	beginning on 11/8/2021 for as needed narcotics documented in the medication administration record and blue narcotic sheets for nurse signatures twice a week, and will end on 02/01/2022. A directed in-service training on Abuse, Neglect, and Exploitation/Misappropriation Policy, Blue narcotic sheets, Drug diversion policy & response, Controlled medication Policy, and Drug Administration Policy was given by Mississippi Gulf Coast Community College Registered Nursing instructor for all current staff beginning 11/06/2021 and will be completed on 11/08/2021. After completion of directed in-service, the staff development nurse will in- service all new staff and contracted personnel, during the orientation process on Abuse, Neglect, and Exploitation/Misappropriation Policy, Blue narcotic sheets, Drug diversion policy & response, Controlled medication Policy, and Drug Administration Policy beginning on 11/09/2021. 4. The narcotic book audits will be maintained and monitored for completion by Quality Assurance Nurse beginning on 11/9/2021 and will end on 02/01/2022. To ensure improvements are sustained quality assurance nurse will review all narcotic audits logs weekly beginning on 11/08/2021 and will present the logs for review at the monthly Quality Assurance meeting starting on 11/16/2021 to make recommendations and changes as needed, and will end on 02/01/2022.	

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F 602	Continued From page 16 happens at this time. Review of the facility's, "Controlled Medication Policy", revised 3/19/20 reveal the purpose to track and trend-controlled medications coming into and out of the facility by pharmacy representatives and employees and to monitor and prevent any altering, tampering and misappropriation of controlled medications within the facility. The facility policy reveals upon receiving, removal, or destruction of any controlled medications in the facility. Two (2) or more, license nurses must verify by count and signage, using the pharmacy manifest sheets, narcotic count sheet, and controlled destruction log. The administration documentation of controlled medications by licensed nurses that administer controlled medication will document administration in the following areas: Medication Administration Record (MAR) and resident narcotic record book. If the facility suspects an inaccurate controlled medications count: The nurse relinquishing keys and the nurse accepting the keys will: recount the medication, search the medication cart to see if the medicine spilled out or was misplaced, see if any other resident received the same medication on the shift. If so, was the medication accidently taken from the wrong container, complete the incident report and notify immediate supervisor and/or Director of Nursing (DON). The DON will then notify: The Administrator, Pharmacy consultant, and quality assurance department to begin an investigation. (Refer to: Drug Diversion Policy & response) Depending upon the results of the investigation, the following employee action may be taken: a written reprimand may be issued, the employee may be allowed to work under supervision (the supervision will observe the distribution of all	F 602	5. All corrective action will be completed on 11/23/2021.	

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narcotics), the employee may be allowed to work but not carry the keys, the employee may be suspended or terminated.

Resident #8

Record review of Resident #8's Face Sheet revealed the resident was admitted to the facility on 3/24/2017, with the diagnoses that included Osteomyelitis, Hypertension, Neuromuscular Dysfunction of Bladder, and Pain.

Record review of the significant change Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 07/06/21 revealed Resident#8 had a Brief Interview for Mental Status (BIMS) score of 8 that indicated Resident #8 has moderate cognitive impairment.

Review of the facility's, "Physicians Orders", July 2021 revealed Resident #8 had an order start date of 12/13/17 for Norco-10-325 milligrams (mg) by mouth (po) every 4 hours (hrs) as needed for pain.

Record review of the Controlled Drug Record and Medication Administration Record for 7/1/21 revealed LPN #1 signed out an extra Norco (hydrocodone-acetaminophen) 10-325 mg at 10:32 PM. The nurse did not document the extra dose as administered on the Medication Administration Record (MAR). Record review of the meeting notes from the facility Emergency Meeting for the investigation of possible drug diversion by LPN #1 dated 8/17/21 revealed there is no documentation of the doctor ordering an extra dose of medication for break through pain on the nurses' notes.

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Resident #10

Record review of Resident #10's Face Sheet revealed the resident was admitted to the facility on 3/21/2018, with diagnoses that included Major Depressive Disorder, Cerebral Infarction, and Muscle Weakness.

Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/05/21 revealed Resident#10 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated Resident #10 is cognitively intact.

Review of the facility's, "Physicians Orders", dated August 2021, revealed Resident #10 had an order for Norco 10-325 mg orally every 4 hours as needed for pain.

Record review of the facility's, "Controled Drug Record", dated 8/9/21 revealed LPN #1 signed out a Norco 10-325 mg tablet at 7:00 AM, 11:00 AM, 15:00 (3:00 PM) and 19:53 (7:53PM). LPN #1 did not document those medications on the MARS. A Norco was signed out at 15:00 (3PM) and LPN #1 signed out a Norco 10-325 mg tablet at 15:25.There were no additional orders written to administer an extra dose.

Record review of the facility's "Controlled Drug Record", dated 8/15/21, revealed LPN #1 signed out a Norco 10-325 mg tablet at 07:58 AM and at 15:06 (3:06 PM). Neither of these were not documented on the MAR.

Record review of the August 2021 Physician Orders revealed there were orders for an extra dose.

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Resident #11

Record review of Resident #11's Face Sheet revealed the facility admitted the resident on 7/26/2021, with diagnoses that included Displaced Oblique FX (fracture) shaft of the left femur, Nondisplaced Unspecified Condyle Fracture lower end right femur,and Osteoporosis.

Record review of the admission MDS with an ARD of 08/02/21 revealed Resident#11 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated Resident #11 is cognitively intact.

Record review of the facility's, "Physicians Orders", dated August 2021 with a start date of 7/30/21 revealed Resident #11 had a order for Ativan 0.5 mg po at bedtime (anxiety).

Record review of the facility's "Control Drug Record", dated August 12, 2021, revealed LPN #1 signed out two Ativan 0.5 mg tablets at 21:58 (9:58 PM).

Record review of the MAR for 8/12/21 revealed the extra tablet was not documented as administered.

Record review of the nurse's notes for 8/12/21 revealed no documentation of an extra dose of Ativan being administered to Resident #11.

Record review of the August 2021 Physicians Orders revealed there was not an order written for the second tablet.

Resident #12

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Record review of the Face Sheet revealed Resident #12 was admitted to the facility on 8/01/2010, with diagnoses that included Osteoporosis without current pathological fractures, Heart Failure and Major Depressive Disorder.

Record review of the admission MDS with an ARD of 07/16/21, revealed Resident#12 had a Brief Interview for Mental Status (BIMS) score of 10 that indicated Resident #12 had moderate cognitive impairment.

Record review of the facility's, "Physicians Orders", for August 2021 revealed Resident #12 was ordered (Norco) 5-325 mg po two times a day (BID) as needed for pain.

Record review of the facility's, "Controlled Drug Record" dated 8/9/21 revealed a Norco 5-325 mg was signed out by LPN #1 at 18:20 (6:20 PM) and 22:17 (10:17 PM).

Record review of the August 2021 MAR revealed no documentation that the medication signed out by LPN #1 at 22:17 was administered to Resident #12

Record review of the facility's, Controlled Drug Record", dated 8/11/21 revealed a Norco 5-325 mg was signed out 23:47 (11:47PM) by LPN #1.

Record review revealed there was no documentation on the August 2021 MAR that the the medication signed out LPN #1 at 23:47 was administered to Resident #12.

Record review of the August 2021 Physician

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Orders revealed there was not an additional order for the extra doses.

Record review of the facility's "Controlled Drug Record"dated 8/12/21 revealed a Norco 5-325 mg was signed out by LPN #1 at 17:03 (5:03 PM).

Record review of the August 2021 MAR revealed no documentation that Resident #12 was administered the medication that was signed out by LPN #1 at 17:03.

During an interview on 9/21/21 at 09:00 AM, with the Director of Nursing (DON) confirmed LPN #1 failed to follow the facility policy during Medication Administration. The DON said nobody was holding the staff accountable for not following the facility policies. The DON said the Quality Assurance Department notified her that LPN #1 might be diverting medication. The facility immediately started an investigation. The DON said LPN #1 was drug tested at the facility. The results were negative. The DON said she did not know the test should have been sent out to the lab. The nurse was suspended on 8/16/21 and terminated on 8/19/21. The DON said she reported the alleged diversion to the State Licensing Agency, Attorney General's Office (AG) and the State Board of Nursing. A Quality Assurance Performance Improvement meeting was held 8/17/21.

Interview on 9/22/21 at 2:00 PM, with the Medical Doctor (MD) revealed he complained to the Assistant Director of Nursing (ADON) stating that LPN #1 is giving the residents narcotics without an order and keeps coming to him after she has given the residents the medication. The MD said

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when he looks at the physician's order and nurse's notes, the nurse has not written the orders. The doctor said the nurse became suspicious to him and he felt like the facility needed to know. The MD said he talked to the nurse about this several times.

Interview on 9/22/21 at 3:15 PM, with the Pharmacy Consultant confirmed LPN #1 was not following the facility policy when administering narcotic medication. The Consultant said he noticed LPN #1 was giving a lot of extra pain medication and antianxiety drugs that is not documented on the MAR. The Consultant said LPN #1 would document it on the narcotic sheets but would not document it on the MARS or write physicians orders for extra medication that was pulled from the narcotic packets. The Consultant also said the nurse did not document why the residents needed the extra medicine. The Consultant said he talked to the ADON about the alleged diversion. The Consultant said when he talked to LPN #1 about the medication, she would look at him as if he was not there. The Consultant said he can guarantee the medication was pulled from the narcotic packets, but he cannot guarantee the residents got the medication because it is not documented on the MAR.

Interview on 9/22/21 at 3:30 PM, with Registered Nurse (RN) #2 confirmed LPN #1 failed to follow the facility policy. RN #2 said the ADON reported to her that the MD had concerns about LPN #1 diverting medication. RN #2 said she immediately started an investigation. The DON counseled LPN #1 and suspended her on 8/13/21. The QA team met on 8/17/21 and recommended on-going medication cart audits per pharmacist and to in-service staff on administering narcotics

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correctly. QA is to monitor narcotic books periodically and give report at the doctors meeting. QA is to monitor narcotic sheets when completed daily. RN #2 said LPN #1 was counseled last year by another DON on not documenting medication on the MAR. RN #2 said she reported to the Administrator and DON that LPN #1 had stopped for a while and in May of 2021 during her monthly narcotic sheet checks she noticed LPN #1 started back pulling narcotics without documenting. RN #2 said the investigation revealed the residents received their routine medication but was unable to determine if the residents received the extra medication pulled from the narcotic medication logs. The residents that are alert and cognitively intact said they did not receive any extra medication from LPN #1. LPN #1 documented the routine narcotics but did not document extra medications that were pulled from the narcotic packet. RN #2 said the Administrator and DON tried to offer LPN#1 a charge nurse position because they could not prove LPN #1 was diverting the medication. The Administrator told LPN #1 that she would have to do better with documenting narcotics when giving them to the residents.

Interview on 9/23/21 at 10:00 AM, with Resident #10 who is alert and oriented and is able to make her needs known, confirmed she has not had any breakthrough pain. Resident #10 said her routine pain medicine is enough for her and that she has not had any pain or asked for any extra pain medication.

Interview on 9/23/21 at 10:30 AM, with Resident #11 confirmed she has not had any problems with anxiety. Resident #11 said she has not asked any of the nurses for extra anxiety medication.

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F 602	Continued From page 24 Interview on 9/23/21 at 11:00 AM, with LPN #1 said she has been really depressed and worked a lot of shifts. LPN #1 also said she was overwhelmed because of her bills and is working all the time. LPN #1 said she does not remember pulling the narcotics from the packet without orders. LPN #1 said the facility did not show her the medication that was missing. LPN #1 said she has been a nurse for 30 years and has never had a problem with giving medication. LPN #1 said she might have forgotten to document some of the medication on the MAR at times because she worked so many shifts, however the residents did receive their medication. LPN #1 said she knows that in nursing school the instructor teaches "if it's not documented then it wasn't done." LPN #1 said she can't prove the Residents got their medication but, "I can assure you they received their medication." Record review of the Employee Termination Report for LPN#1 revealed the last day worked was 8/15/21. LPN#1 was suspended on 8/16/21 pending investigation. Record review of the Employee Counceling Notice dated 8/19/21 revealed a discharge date of 8/19/21. The nature of the offense was "LPN was found to be giving narcotic medication without MD order to do so".	F 602		
F 656 SS=D	. Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		11/23/21

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

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F 656	Continued From page 26 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review and facility policy review the facility failed to follow the comprehensive care plan regarding Activities of Daily Living (ADLs) for three (3) of 14 care plans reviewed. Resident #2, #5, #10. Findings include: Review of the facility's, "Comprehensive Care Plan Policy", dated 3/20/2020 revealed, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident consistent with resident rights, that incluses measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment...8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of the roles and responsibilities for carrying out the interventions, initially and when changes are made." Resident #2 On 09/21/21 at 12:00 PM, during an interview, Resident #2 explained once he gets up the staff does not check him until he asks to be checked and he tells them he has had a bowel movement. He stated he has had to wait for hours to be changed. On 09/21/21 at 2:35 PM, during an interview with Resident #2, he explained he has been sitting up	F 656	1. The care plan for resident #2 was reviewed by the director of nursing and quality assurance on 09/23/2021. No revisions were needed. The care plan for resident #5 was reviewed by the director of nursing and quality assurance on 09/23/2021. No revisions were needed. The care plan for resident #10 was reviewed by the director of nursing and quality assurance on 09/23/2021. No revisions were needed. 2. All residents are at risk for this deficient practice. 3. An Incontinent care log was implemented on 10/28/2021. The Incontinent care log will include: Resident name, room #, soiled, unsoiled, how many briefs, how many pads, pressure reducing device in use, assigned staff member, resolution, nurse name, date, time, supervisor notified. The certified nurse assistant will be notified of resident incontinence care issues. The medication nurse will be responsible to provide incontinence checks with each med pass throughout each shift and document findings and resolution on the incontinence care log. The medication nurse will be responsible to notify the	

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F 656	Continued From page 27 all day and has not been changed and reported that somedays it may take hours before he gets changed. During an interview on 09/22/21 10:35 AM, with Resident #2 when asked regarding the care at the facility, he explained he has had a problem with the care several times since he has been at the facility. He explained he did file grievances with the facility regarding care and his friends did too. He explained care did get a little better but still occurred. He explained the nurses won't or don't check behind the CNAs to make sure they do their job. He explained the facility has had shorter staff and at times it would take all day to change him after a bowel movement. He further explained sometimes he does not get showers or baths and has waited three (3) weeks at a time for a shower. He stated, "I probably would not have gotten my shower yesterday if you weren't here to watch." He explained he is scheduled for showers on Tuesday, Thursday, and Saturdays and reported usually gets at least one shower a week. Record review of Resident #2's Detail Admission/Discharge Report revealed the facility initially admitted Resident #2 on 01/17/20 and discharged on 07/15/21 and readmitted to the facility on 07/23/21. Record review of the Face Sheet with an admission date of 7/23/21 revealed Resident #2 had diagnoses of Unspecified abnormalities of gait and mobility, Personal history of COVID-19, Flaccid hemiplegia affecting left nondominant side, Difficulty in walking, Obstructive and Reflux Uropathy, Muscle weakness, Diabetes mellitus with diabetic neuropathy, Neuromuscular	F 656	certified nursing assistant of any resident's with incontinence and supervise the corrective action. The charge nurse will monitor logs for completion and verify resolutions daily. The incontinence log will be brought to the daily interdisciplinary meeting daily for daily discussion and resolution beginning on 11/1/2021 and will end on 02/01/2022. A Bathing Record log will be added to the current assignment book on 10/28/2021. The bathing record log will include: Room numbers column, shower, bed bath, or refused column, and certified nurse assistant and nurse signature column. The assigned certified nursing assistant will document if a shower or bath provided and will sign for verification. The medication nurse will be notified of completion or refusal of showers. The medication nurse will sign for verification and document refusals in the nurse's notes. The charge nurse will monitor the Bathing Record for completion of daily assigned Baths and sign they are completed for the shift. A directed in-service training on Activities of Daily Living Policy, Bathing a Resident Policy, and Comprehensive Care Plan Policy was given by Mississippi Gulf Coast Community College Registered Nursing instructor for all current staff beginning 11/06/2021 and will be completed on 11/08/2021. After completion of directed in-service, the	

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F 656	Continued From page 28 dysfunction of bladder, and Cerebral infarction. Record review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/05/21, Section C revealed Resident #2 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated Resident #2 was cognitively intact. Section G of the MDS revealed Resident #2 required extensive assistance of two-person assist with bed mobility and transfers, and one-person assist with dressing, toileting, and personal hygiene. Section H of the MDS revealed Resident #2 had an indwelling catheter and frequently incontinent of bowel. Record review of Resident #2's Care Plan with a Problem Onset date of 01/24/2020 revealed, "Problem/Need: INCONT(incontinent)/SKIN I am incont. Of bowel & I have a hx (history) of skin breakdown. I have limited mobility, right hemiparesis, decreased balance, decreased safety awareness ...Approaches ...Sponge bath, shower as scheduled ...Provide Incontinence care per perineal care policy as needed ...Assist with toileting/changing q2hrs (every two hours) ..." Record review of Resident #2's Care Plan with a Problem Onset date of 01/24/2020 revealed, "Problem/Need: I need extensive assistance with ADL's, transfers, and toileting r/t (related to) my limited mobility, left side hemiplegia, left hand contracture, and lack of coordination ...Approaches ...Toilet/incont. Care q2 hrs & prn (as needed) using skin barriers as needed ...Provide AM & PM care ensuring all needs met daily to maintain proper appearance, hygiene, well groomed ..."	F 656	staff development nurse will in-service all new facility nursing staff and contract personnel, during the orientation process on Activities of Daily Living Policy, Bathing a Resident Policy, and Comprehensive Care plan Policy beginning 11/09/2021. 4. The charge nurse will maintain and monitor the shower and incontinence logs for completion and resolution daily. The incontinence log will be brought to the daily interdisciplinary meeting daily for daily discussion and resolution beginning on 11/1/2021 and will end on 02/01/2022. To ensure improvements are sustained quality assurance nurse will review all incontinence and shower logs weekly beginning on 11/08/2021. The audit and logs will be presented for review at the monthly quality assurance meeting starting on 11/16/2021 to make recommendations and changes as needed and will end on 02/01/2022. 5. All corrective action will be completed on 11/23/2021.	

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Record review of facility's "SHOWERING SCHEDULE (ALL HALLWAYS)" on facility letterhead revealed Resident #2 resided in a room that would be scheduled for a shower on Tuesday, Thursday, and Saturday.

Record review of Resident #2's Section G - Functional Status Report for bathing revealed, Resident #2 did not receive bathing for eight (8) days in May 2021, eight (8) days in June 2021, eight (8) days in July 2021, and three (3) days in September 2021 up to 09/23/2021. The report revealed in the month August 2021 resident received showers but not on the scheduled days.

Resident #5

On 09/21/21 at 11:30 AM, during an interview Resident #5, she explained she has had her ups and downs with the care, including incontinent care and showers. When ask to explain, she reported she must wait long periods to get changed and has gone days without a shower.

On 09/21/21 at 11:35 AM, observed incontinent care on Resident #5 by CNA #1. Observed strong smell of urine and resident's brief very soaked and incontinent pad wet.

On 09/21/21 at 2:05 PM during an interview with Certified Nurse Aide (CNA) #1, she reported honestly sometimes it may take longer than two (2) hours to get to the residents. She explained Resident #5 may have been longer than two (2) hours this morning, but she cannot remember is she had checked resident before peri-care was done with SSA. She further reported Resident #5 receives her showers on Tuesday, Thursday, and Saturday but today she had not been able to give

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resident a shower. She reported she just never got time to shower Resident #5.

Interview on 09/22/21 at 8:45 AM with Resident #5 asked resident regarding shower/bath yesterday, she explained she did not get a bed bath or shower yesterday and sometimes she normally only gets a shower every 3 days and does not get changed frequently or repositioned. She explained she does not know when she is incontinent but does feel when she is soaked.

Observation on 09/22/21 at 2:20 PM Resident #5 sitting in her wheelchair on 100/200 hall with no pressure relieving cushion in wheelchair. She explained she has been up all day and has not been checked for incontinent care.

On 09/22/21 at 4:20 PM observed Resident #5 sitting in her wheelchair in her room, strong smell of urine noted and observed resident's pants soaked with urine. The SSA observed no pressure relieving cushion to Resident #5's wheelchair. During an interview with Resident #5, she explained she has been up in her wheelchair all day since 4:00 AM and not been changed all day. Resident #5 explained she has been waiting for almost two (2) hours to go back to bed.

Interview on 09/22/21 at 4:30 PM with CNA #2, she confirmed Resident #5's pants were soaked in urine when she assisted resident to bed.

On 09/22/21 at 4:35 PM during an interview with Licensed Practical Nurse (LPN) #2, she explained she has never been told her anything about residents not getting showers. She denied following up with resident and CNAs regarding showers/baths because that is the CNAs job.

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Interview on 09/23/21 at 1:20 PM with Resident #5, she explained she was gotten up again around 4:00 AM by night shift. She explained she was soaked all morning until right before lunch and had dried BM on her. She explained now after sitting too long in her wheelchair soaked in urine and BM and had no cushion in her wheelchair, she now has redness and maybe a sore on her buttocks. She explained she never did get a shower since last week. She reported when the CNA did clean her up before lunch, it felt rough and raw. She explained I also got up yesterday at 4:00 AM and sit up all day in the wheelchair soaked in urine. She reported this happens frequently.

On 09/23/24 at 1:30 PM the SSA asks DON if she would check with Resident #5. As soon as DON entered Resident #5's side of the room, Resident #5 began telling DON about how she sat up in the wheelchair in a soaked brief with urine all day yesterday and today with dried BM. She explained to the DON how her bottom felt raw and rough. SSA observed DON do an incontinent check on Resident #5 and observed two (2) briefs on the resident and the brief was soaked. The DON and SSA observed moderate redness to both buttocks and an area to the left buttock red and non-blanchable. There was a strong smell of urine noted in the room.

During an interview on 09/23/21 at 1:50 PM with CNA #3, she explained Resident #5 was up today when she started her shift. She explained resident had been up in wheelchair all morning long and she put her to bed just before lunch. When asked had she checked Resident #5 for incontinence at any time this morning, she

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explained no. When asked if resident had dried BM on her when she went to change her, she explained Resident #5 had a little dried BM up near her back when she changed her and she noticed resident's buttocks were really red. When asked did she put two (2) briefs on Resident #5 after cleaning her up, she explained she did. When asked if applying two (2) briefs on a resident or not checking a resident for incontinence for over two (2) hours could cause harm or be neglect, no reply given.

During an interview on 09/24/21 at 11:20 AM with CNA #2, she explained she did not give Resident #5 a shower on 09/22/21 and resident did not receive a shower that evening or any other evening this week.

On 09/24/21 at 12:00 PM during an interview with DON, she confirmed Resident #5 had two (2) briefs on and explained that is never acceptable in the building. When asked if a resident is left for long periods of time incontinent and/or double briefed could that be considered neglect, she replied, "It could." When asked to describe what she observed on Resident #5 when she removed the two briefs, she explained the resident's buttocks were severely red and there was one non-blanchable area to resident's left buttock.

On 09/27/2021 at 12:30 PM, during a phone interview with RN #1, when asked regarding a CNA applying two (2) briefs on a resident, she explained that is not allowed in the facility. When asked if this could be considered neglect and if there could be any negative outcome, she explained it could cause skin breakdown.

Record review of Resident #5's Face Sheet

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revealed the facility admitted Resident #5 on 07/15/21 with the diagnoses of Hemiplegia following Cerebral infarction affecting left nondominant side, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Muscle Weakness, and Fibromyalgia.

Record review of Resident #5's Admission MDS with ARD of 07/22/21 Section C revealed Resident #5 had a BIMS score of 12, which indicated cognitively intact. Section G of the MDS revealed Resident #5 required extensive assistance of two-person assist for bed mobility, transfers, dressing, toilet use, and personal hygiene. Section H revealed Resident #5 was always incontinent of bowel and bladder.

Record review of facility's Daily Assignment log for 400/500 Hall dated for 09/21/21 revealed Resident #5 was to receive a shower on day or evening shift but neither one was initialed nor marked off.

Record review of facility's showering schedule revealed all "B" bedrooms and odd private rooms receive showers on Tuesday, Thursday, and Saturday. Resident #5 resided in a room in the "B" bed and would get bathing on Tuesday, Thursday, and Saturday.

Record review of Resident #5's Physician Orders for September 2021 revealed an order with a start date of 7/16/21 for "Pressure reducing chair cushion for wheelchair in place and functioning properly, check q (every) day (gel cushion)" and a new order dated 09/23/21 to "Cleanse both buttocks with wound cleanser/normal saline, pat dry, apply barrier cream and cover with silicone bordered dressing daily and as needed."

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Record review of Resident #5's Functional Status for Bathing revealed the resident missed four (4) showers for the month of July 2021, three (3) for the month of August, and one (1) shower the month of September.

Record review of Resident #5's Care Plan, undated, revealed "Problem: (Formal Name) needs assist with ADLs r/t CVA w/(with) left non-dominant hemiparesis ...Interventions: Toilet/incont care q 2 hrs & PRN using skin barriers as needed, Observe for skin breakdown/redness during care & report to nurse qs (every shift) ...Provide AM & PM care ensuring all needs are met daily to maintain proper appearance, hygiene, well groomed ..."

Record review of Resident #5's Care Plan, undated, revealed "Problem: Resident is at risk for skin breakdown r/t decreased functional mobility, diabetes, left sided hemiparesis, incont of B&B (bowel and bladder) ...Interventions ...Pressure reducing cushion chair ...Sponge bath/Shower on designated days ...

Record review of Resident #5's Care Plan, onset date 9/23/2021, revealed "Problem: I have acquired a pressure area and have areas of excoriation and redness ....1.) Left buttock-irritation/excoriation, 2.) Left buttock-non-blanchable stage I, 3.) Right buttock-irritation/excoriation ...Interventions: Treatment as ordered ...Provide pressure relief to areas: mattress, cushion ...Provide incontinent care every 2 hours and prn (as needed) ..."

Resident #10

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On 09/22/21 at 8:30 AM, in an interview with Resident #10, she explained sometimes she is lucky to get a shower once a week. She reported she needs assistance for showers.

During an interview with Resident #10 on 09/23/21 at 1:20 PM she reported she is lucky to receive a shower once a week.

Record review of Resident #10's Section G - Functional Status report provided by the facility from 6/24/21 - 9/22/21 revealed the acivity of bathing was coded "8" which indicates "activity did not occur" from 6/24/21 through 7/8/21, 7/13/21 through 9/9/21 and 9/11/21 through 9/21/21. The report revealed Resident #10 received "bathing" on 7/9/21, 7/12/21, 9/10/21 and 9/22/21.

During an interview with DON on 09/24/21 at 12:00 PM reviewed Resident #10's bathing documentation with DON, she explained she cannot explain why there is no documentation for bathing. She explained if there is no documentation, then it did not occur.

Record review of Resident #10's Face Sheet revealed the facility admitted Resident #10 on 03/21/2018 with the diagnoses of cerebral infarction, major depressive disorder, anxiety disorder, hemiplegia following cerebral infarction affecting left nondominant side, difficulty in walking, and muscle weakness.

Record review of Resident #10's Quarterly MDS with ARD of 08/05/21 Section C revealed Resident #10 had a BIMS score of 15, which indicated cognitively intact. Section G of the MDS revealed Resident #10 required extensive

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F 656	Continued From page 36 assistance of one-person assist for transfers and toileting and limited assistance of one-person for personal hygiene. Section G of the assessment bathing section revealed in the seven (7) day look back the activity did not occur. Section H of the MDS revealed Resident #10 if frequently incontinent of bladder and always continent of bowel. Record review of Resident #10's Care Plan with a Problem Onset date of 03/21/2018 revealed, "Problem/Need: INCONT(incontinent)/SKIN I am frequently incontinent of bladder, often decline showers, have decreased mobility, and require assist with care ...Approaches ...Sponge bath, shower as scheduled ...Promote and encourage good hygiene practices ..." On 09/24/21 at 1:30 PM during an interview with the Minimum Data Set (MDS) nurse, LPN #4, she explained she does the care plans and the MDS for each resident. She explained when resident's care plan is in place, she expects the staff to follow care plans. She reported all resident's care plans are individualized and follow resident's physician orders. She further explained is there is any change in the resident, the care plans are up-dated as needed and this also includes ADL care. During an interview on 9/23/21 at 11:00 AM with RN #3 said she expects the staff to follow the care plan.	F 656		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		11/23/21

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F 677	Continued From page 37 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff, family, and resident interviews, record reviews, and facility policy review the facility failed to provide Activities of Daily Living (ADL) care as evidenced by failure to provide baths and incontinent care for three (3) of five (5) residents reviewed for ADLs. Residents #2, #5, and #10. Findings include: Record review of the facility's policy "Activities of Daily Living (ADLs)" with a date reviewed/revised of 03/20/2020 revealed, "Policy: The facility will ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. This includes the resident's ability to: 1. Bathe, dress, and groom..Policy Explanation and Compliance Guidelines: ....3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene ....5. The facility will maintain individual objectives of the care plan and periodic review and evaluation." Record review of facility's policy "Bathing a Resident" date reviewed/ revised of 03/03/2020 revealed, "Policy: It is the practice of this facility to assist residents with bathing to maintain proper hygiene...Schedule: Residents may request a shower and be scheduled for the shift to be showered. Report any resident, that refuses a shower, to the Charge nurse or the Medication Nurse, for documentation..."	F 677	1. Resident #2 was given incontinent care on 09/22/2021 and given a shower by certified nursing assistant on 09/23/2021. Resident #5 was given incontinent care on 09/22/2021 and given a shower on 09/23/2021 by director of nursing and quality assurance nurse. Resident #10 was given a shower by certified nursing assistant on 09/23/2021. 2. All residents are at risk for this deficient practice. 3. An Incontinent care log was implemented on 10/28/2021. The Incontinent care log will include: Resident name, room #, soiled, unsoiled, how many briefs, how many pads, pressure reducing device in use, assigned staff member, resolution, nurse name, date, time, supervisor notified. The certified nurse assistant will be notified of resident incontinence care issues. The medication nurse will be responsible to provide incontinence checks with each med pass throughout each shift and document findings and resolution on the incontinence care log. The medication nurse will be responsible to notify the certified nursing assistant of any resident's with incontinence and supervise the corrective action.	

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F 677	Continued From page 38 In an interview on 09/21/21 at 12:00 PM, Resident #2 reported once he gets up the staff does not check him until he asks to be checked and he tells them he has had a bowel movement. He explained he has had to wait for hours to be changed. Interview on 09/21/21 at 2:35 PM, Resident #2, explained he has been sitting up all day and has not been changed and reported that some days it may take hours before he gets changed. On 09/22/21 at 10:35 AM, during an interview with Resident #2 when asked regarding the care at the facility, he explained he has had a problem with the care several times since he has been at the facility. He explained he did file grievances with the facility regarding care and his friends did too. He explained care did get a little better but the problem still occurred. He explained the nurses won't or don't check behind the Certified Nursing Assistants (CNAs) to make sure they do their job. He explained the facility have had shorter staff and at times it would take all day to change him after a bowel movement. He further explained sometimes he does not get showers or baths and has waited 3 weeks at a time for a shower. He stated, "I probably would not have gotten my shower yesterday if you weren't here to watch." He explained he is scheduled for showers on Tuesday, Thursday, and Saturdays and reported he usually gets only one shower a week. On 09/23/21 at 12:45 PM, during a phone interview with the complainant regarding Resident #2, she explained she had received a phone call from Resident #2 on 09/02/21 around 5:00 PM complaining he had a bowel movement on him	F 677	The charge nurse will monitor logs for completion and verify resolutions daily. The incontinence log will be brought to the daily interdisciplinary meeting daily for daily discussion and resolution beginning on 11/1/2021 and will end on 02/01/2022. A Bathing Record log will be added to the current assignment book on 10/28/2021. The bathing record log will include: Room numbers column, shower, bed bath, or refused column, and certified nurse assistant and nurse signature. The assigned certified nursing assistant will document if a shower or bath provided and will sign for verification. The medication nurse will be notified of completion or refusal of showers. The medication nurse will sign for verification and document refusals in the nurse's notes. The charge nurse will monitor the Bathing Record for completion of daily assigned Baths and sign they are completed for the shift. A directed in-service training on Activities of Daily Living Policy, Bathing a Resident Policy, and Comprehensive Care Plan Policy was given by Mississippi Gulf Coast Community College Registered Nursing instructor for all current staff beginning 11/06/2021 and will be completed on 11/08/2021. After completion of directed in-service, the staff development nurse will in-service all new facility nursing staff and contract personnel, during the orientation process on Activities of Daily Living Policy, Bathing a Resident Policy, and Comprehensive	

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F 677	Continued From page 39 since earlier that morning and not received a shower. Record review of Resident #2's Detail Admission/Discharge Report revealed the facility initially admitted Resident #2 on 01/17/20 and discharged on 07/15/21 and readmitted to the facility on 07/23/21. Record review of the Face Sheet with an admission date of 7/23/21 revealed Resident #2 had diagnoses of Unspecified abnormalities of gait and mobility, Personal history of COVID-19, Flaccid hemiplegia affecting left nondominant side, Difficulty in walking, Obstructive and reflux uropathy, Muscle weakness, Diabetes mellitus with diabetic neuropathy, Neuromuscular dysfunction of bladder, and Cerebral infarction. Record review of Resident #2's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 08/05/21 Section C revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #2 was cognitively intact. Section G of the MDS revealed Resident #2 required extensive assistance of two-person assist with bed mobility and transfers, and one-person assist with dressing, toileting, and personal hygiene. Section H of the MDS revealed Resident #2 had an indwelling catheter and frequently incontinent of bowel. Record review of Resident #2's Care Plan with a Problem Onset date of 01/24/2020 revealed, "Problem/Need: INCONT(incontinent)/SKIN I am incont. of bowel & I have a hx (history) of skin breakdown. I have limited mobility, right hemiparesis, decreased balance, decreased	F 677	Care plan Policy beginning 11/09/2021. 4. The charge nurse will monitor the shower and incontinence logs and bring to the daily interdisciplinary meeting for discussion and resolution beginning on 11/01/2021 and will end on 02/01/2022. To ensure improvements are sustained quality assurance nurse will review all incontinence and shower logs weekly beginning on 11/8/2021. The audit and logs will be presented for review at the monthly quality assurance meeting starting on 11/16/2021 to make recommendations and changes as needed and will end on 02/01/2022. 3. All corrective action will be completed on 11/23/2021.	

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safety awareness ...Approaches ...Sponge bath, shower as scheduled ...Provide Incontinence care per perineal care policy as needed ...Assist with toileting/changing q2hrs (every two hours) ..."

Record review of Resident #2's Care Plan with a Problem Onset date of 01/24/2020 revealed, "Problem/Need: I need extensive assistance with ADL's, transfers, and toileting r/t (related to) my limited mobility, left side hemiplegia, left hand contracture, and lack of coordination ...Approaches ...Toilet/incont. care q2 hrs & prn (as needed) using skin barriers as needed ...Provide AM & PM care ensuring all needs met daily to maintain proper appearance, hygiene, well groomed ..."

Record review of facility's "SHOWERING SCHEDULE (ALL HALLWAYS)" on facility letterhead revealed Resident #2 resided in a room that would be scheduled for a shower on Tuesday, Thursday, and Saturday.

Record review of Resident #2's Section G - Functional Status report for bathing revealed, Resident #2 did not receive bathing for eight (8) days in May 2021, eight (8) days in June 2021, eight (8) days in July 2021, and three (3) days in September 2021 up to 09/23/2021. The report revealed in the month August 2021 resident received showers but not on the scheduled days.

Resident #5

On 09/21/21 at 11:30 AM, during an interview Resident #5, she explained she has had her ups and downs with the care, including incontinent care and showers. She reported she must wait

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long periods to get changed and has gone days without a shower.

On 09/21/21 at 11:35 AM, observed incontinent care on Resident #5 by Certified Nurse Aide (CNA) #1. Observed strong smell of urine and resident's brief very soaked and the incontinent pad was wet.

On 09/21/21 at 2:05 PM, during an interview with CNA #1, she reported honestly sometimes it may take longer than two (2) hours to get to the residents. She explained Resident #5 may have been longer than two (2) hours this morning, but she cannot remember if she had checked the resident before peri-care was done with the State Survey Agency (SSA). She further reported Resident #5 receives her showers on Tuesday, Thursday, and Saturday but today she had not been able to give the resident a shower. When asked why Resident #5 did not get a shower, she reported she just never got time to shower Resident #5.

Interview on 09/22/21 at 8:45 AM, with Resident #5 when asked the resident regarding a shower/bath yesterday, she explained she did not get a bed bath or shower yesterday and she normally only gets a shower every 3 days and does not get changed frequently.

On 09/22/21 at 2:20 PM, observed Resident #5 sitting in her wheelchair on the 100/200 hall with no pressure relieving cushion in her wheelchair. She explained she has been up all day and has not been checked for incontinent care.

Observation and interview on 09/22/21 at 4:20 PM, observed Resident #5 sitting in her

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wheelchair in her room with a strong smell of urine noted. Observed Resident #5's pants soaked with urine. The SSA observed no pressure relieving cushion to Resident #5's wheelchair. Resident #5 explained she has been up in her wheelchair all day since 4:00 AM and not been changed all day. Resident #5 explained she has been waiting for almost two (2) hours to go back to bed.

Interview on 09/22/21 at 4:30 PM, with CNA #2, confirmed Resident #5's pants were soaked in urine when she assisted the resident back to bed.

On 09/22/21 at 4:35 PM, during an interview with Licensed Practical Nurse (LPN) #2, she explained she has never been told her anything about residents not getting showers. She explained the CNAs discuss among each other during shift change regarding residents and baths/showers. She explained she never follows up with resident and CNAs regarding showers/baths because that is the CNAs job.

Interview on 09/23/21 at 1:20 PM, with Resident #5, she explained she was gotten up again around 4:00 AM by night shift. She explained she was soaked all morning until right before lunch and had dried bowel movement (BM) on her. She explained now after sitting too long in her wheelchair soaked in urine and BM and had no cushion in her wheelchair, she now has redness and maybe a sore on her buttocks. She explained she never did get a shower since last week. She explained I also got up yesterday at 4:00 AM and sat up all day in the wheelchair soaked in urine. She reported this happens frequently.

On 09/23/24 at 1:30 PM the SSA asked the DON

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is she would do a random incontinent check with Resident #5. As soon as the DON entered Resident #5's side of the room, Resident #5 began telling the DON about getting up at 4:00 AM for two (2) mornings in a row and how she sat up in the wheelchair in a soaked brief with urine all day yesterday and today with dried BM. SSA observed the DON do an incontinent check on Resident #5 and observed two (2) briefs on the resident and brief soaked. The DON and SSA observed moderate redness to both buttocks and an area to the left buttock red and non-blanchable. There was a strong smell of urine noted in the room.

On 09/23/21 at 1:40 PM, during an interview with LPN #3, he explained he was informed Tuesday that Resident #5 did not get a shower on day shift and reported he did not chart resident refused because Resident #5 was to get shower on evening shift.

During an interview on 09/23/21 at 1:50 PM, with CNA #3, she explained Resident #5 was up today when she started her shift. She explained resident had been up in wheelchair all morning long and she put her to bed just before lunch. When asked had she checked Resident #5 for incontinence at any time this morning, she explained no because resident went to smoke, and she got busy doing her other residents. When asked if resident had dried BM on her when she went to change her CNA #3 explained Resident #5 had a little dried BM up near her back when she changed her, and she noticed resident's buttocks were really red. When asked if she put two (2) briefs on Resident #5 after cleaning her up, she explained she did.

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On 09/23/21 at 2:30 PM, during an interview with Registered Nurse (RN) #1, when asked what she observed when she assessed Resident #5, she explained both of resident's buttock were red and on the left buttock there was a non-blanchable area around the buttock cheek.

On 09/24/21 at 11:10 AM, during a phone interview with the Nurse Practitioner, when asked regarding what could double briefs on a resident or not doing incontinent care at least every two (2) hours cause, she explained both situations could cause tissue breakdown due to the moisture and could lead to a pressure wound.

During an interview on 09/24/21 at 11:20 AM, with CNA #2 she explained she did not give Resident #5 a shower on 09/22/21 and Resident #5 did not receive a shower that evening or any other evening this week.

On 09/24/21 at 12:00 PM, during an interview with DON when asked regarding the incident of her finding Resident #5 with two (2) briefs on, she explained that is never acceptable in the building. When asked if a resident is left for long periods of time incontinent and/or double briefed could that be considered neglect, she replied, "It could." When asked to describe what she observed on Resident #5 when she removed the two briefs, she explained the resident's buttocks were severely red and there was one non-blanchable area to resident's left buttock.

On 09/27/2021 at 12:30 PM, during a phone interview with RN #1, when asked regarding a CNA applying two (2) briefs on a resident, she explained that is not allowed in the facility. When asked if this could be considered neglect and if

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there could be any negative outcome, she explained it could cause skin breakdown.

Record review of Resident #5's Face Sheet revealed the facility admitted Resident #5 on 07/15/21with diagnoses of Hemiplegia following Cerebral infarction affecting left nondominant side, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Muscle weakness, and Fibromyalgia.

Record review of Resident #5's Admission MDS with ARD of 07/22/21 Section C revealed Resident #5 had a BIMS score of 12 which indicated Resident #5 had moderate cognitive impairment. Section G of the MDS revealed Resident #5 required extensive assistance of two-person assist for bed mobility, transfers, dressing, toilet use, and personal hygiene. Section H revealed Resident #5 was always incontinent of bowel and bladder.

Record review of facility's Daily Assignment log for 400/500 Hall dated for 09/21/21 revealed Resident #5 was to receive a shower on day or evening shift but neither one was initialed nor marked off.

Record review of Resident #5's Wound Assessment Reports dated 09/23/21 revealed an irritation to left buttock with measurements 9.5 cm x 4.0 cm and Stage one (1) pressure ulcer to the left buttock with measurements 2.0 cm x 3.0 cm.

Record review of Resident #5's Section G - Functional Status report for Bathing revealed the resident missed four (4) showers for the month of July 2021, three (3) for the month of August, and one (1) shower the month of September.

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Record review of facility's showering schedule revealed all "B" bedrooms and odd private rooms receive showers on Tuesday, Thursday, and Saturday. Resident #5 resided in a room in the "B" bed and would get bathing on Tuesday, Thursday, and Saturday.

Record review of Resident #5 ' s Care Plan, undated, revealed "Problem: (Formal Name) needs assist with ADLs r/t CVA w/(with) left non-dominant hemiparesis ...Interventions: Toilet/incont care q 2 hrs & PRN using skin barriers as needed, Observe for skin breakdown/redness during care & report to nurse qs (every shift) ...Provide AM & PM care ensuring all needs are met daily to maintain proper appearance, hygiene, well groomed ..."

Record review of Resident #5 ' s Care Plan, undated, revealed "Problem: Resident is at risk for skin breakdown r/t decreased functional mobility, diabetes, left sided hemiparesis, incont of B&B (bowel and bladder) ...Interventions ...Pressure reducing cushion chair ...Sponge bath/Shower on designated days ...

Record review of Resident #5 ' s Care Plan, onset date 9/23/2021, revealed "Problem: I have acquired a pressure area and have areas of excoriation and redness ....1.) Left buttock-irritation/excoriation, 2.) Left buttock-non-blanchable stage I, 3.) Right buttock-irritation/excoriation ...Interventions: Treatment as ordered ...Provide pressure relief to areas: mattress, cushion ...Provide incontinent care every 2 hours and prn (as needed) ..."

Resident #10

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F 677	Continued From page 47	F 677		

On 09/22/21 at 8:30 AM, in an interview with Resident #10, she explained sometimes she is lucky to get a shower once a week. She reported she needs assistance for showers.

Record review of Resident #10's Section G - Functional Status report provided by the facility from 6/24/21 - 9/22/21 revealed the acivity of bathing was coded "8" which indicates "activity did not occur" from 6/24/21 through 7/8/21, 7/13/21 through 9/9/21 and 9/11/21 through 9/21/21. The report revealed Resident #10 received "bathing" on 7/9/21, 7/12/21, 9/10/21 and 9/22/21.

During an interview with the DON on 09/24/21 at 12:00 PM, reviewed Resident #10's bathing documentation with the DON, she stated she can not explain why there is no documentation for bathing. She explained if there is no documentation, then it did not occur.

Record review of Resident #10's Face Sheet revealed the facility admitted Resident #10 on 03/21/2018 with the diagnoses of Cerebral Infarction, Major Depressive Disorder, Anxiety disorder, Hemiplegia following Cerebral Infarction affecting left nondominant side, Difficulty in walking, and Muscle weakness.

Record review of Resident #10's Quarterly MDS with ARD of 08/05/21 Section C revealed Resident #10 had a BIMS score of 15, which indicated Resident #10 was cognitively intact. Section G of the MDS revealed Resident #10 required extensive assistance of one-person assist for transfers and toileting and limited assistance of one-person for personal hygiene. Section G of the assessment bathing section

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F 677	Continued From page 48 revealed in the seven (7) day look back the activity did not occur. Section H of the MDS revealed Resident #10 is frequently incontinent of bladder and always continent of bowel. Record review of facility's showering schedule revealed all "A" bedrooms and even private rooms receive showers on Monday, Wednesday, and Friday. Resident #5 resided in an "A" bed and would receive showers on Monday, Wednesday, and Fridays. Record review of Resident #10's Care Plan with a Problem Onset date of 03/21/2018 revealed, "Problem/Need: INCONT(incontinent)/SKIN I am frequently incontinent of bladder, often decline showers, have decreased mobility, and require assist with care ...Approaches ...Sponge bath, shower as scheduled ...Promote and encourage good hygiene practices ..."	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		11/23/21

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F 686	Continued From page 49 by: Based on observation, staff interview, and record review the facility failed to prevent the occurrence of an avoidable pressure ulcer for one (1) of five (5) residents observed for wound care. Resident #5 Findings include: On 09/21/21 at 11:30 AM, during an interview with Resident #5, she explained she has had her ups and downs with the care, including incontinent care. She reported she must wait long periods to get changed. On 09/21/21 at 11:35 AM, observed incontinent care on Resident #5 by Certified Nurse Aide (CNA) #1. Observed strong smell of urine and resident's brief very saturated and the incontinent pad beneath the resident was wet. On 09/21/21 at 2:05 PM, during an interview with CNA #1, she reported, "honestly sometimes it may take longer than two (2) hours to get to the residents." She explained Resident #5 may have been longer than two (2) hours this morning, but she cannot remember if she had checked the resident before peri-care was done with the State Survey Agency (SSA). Interview on 09/22/21 at 8:45 AM, with Resident #5 reported she does not get her incontinent brief changed frequently. Observation on 09/22/21 at 2:20 PM, revealed Resident #5 sitting in her wheelchair on the100/200 hall with no pressure relieving cushion in her wheelchair. She explained she has been up all day and has not been checked	F 686	1. Resident #5 was given incontinent care on 09/22/2021 and treatment was provided for the Stage 1 pressure ulcer on 09/22/2021 by director of nursing and quality assurance nurse. 2. All residents are at risk for this deficient practice. 3. The director of nursing, charge nurse, and medication nurse, performed body audits on all residents in the facility and treatments will be initiated per physician orders if any injury is identified, beginning on 09/30/2021 and completed on 10/05/2021. The director of nursing and quality assurance nurse will complete the pressure ulcer risk assessment on all residents on 11/8/2021 and any identified preventative measures and will complete on 11/9/2021. The charge nurses will monitor the pressure ulcer risk assessments and complete quarterly beginning 11/10/2021. An incontinence care log was implemented for both units on 10/28/2021. The incontinence care log includes: Resident name, room number, soiled, unsoiled, how many briefs, how many pads, pressure reducing device in use, assigned staff member, resolution, nurse name, date, time, supervisor notified. The certified nurse assistant will be notified of resident incontinence care issues. The medication nurse will be responsible to provide incontinence checks with each	

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F 686	Continued From page 50	F 686		

for incontinence or had not been provided incontinent care.

Observation and interview on 09/22/21 at 4:20 PM, observed Resident #5 sitting in her wheelchair in her room with a strong smell of urine noted. Observed Resident #5's pants soaked with urine. The SSA observed there was not a pressure relieving cushion to Resident #5's wheelchair. During an interview with Resident #5, she explained she has been up in her wheelchair all day since 4:00 AM and not been changed all day. Resident #5 explained she has been waiting for almost two (2) hours to go back to bed.

Interview on 09/22/21 at 4:30 PM, with CNA #2, she confirmed Resident #5's pants were soaked in urine when she assisted the resident back to bed.

Interview on 09/23/21 at 1:20 PM, with Resident #5, she explained she was gotten up around 4:00 AM by the night shift. She explained she was soaked all morning until right before lunch and had dried bowel movement (BM) on her. She explained now after sitting too long in her wheelchair soaked in urine and BM and had no cushion in her wheelchair, she now has redness and maybe a sore on her buttocks. She reported when the CNA did clean her up before lunch, her buttocks, felt rough and raw. She explained I also got up yesterday at 4:00 AM and sit up all day in the wheelchair soaked in urine. She reported this happens frequently.

On 09/23/24 at 1:30 PM the SSA asked the Director of Nurses (DON) to do an incontinent check with Resident #5. She stated that she sat up in the wheelchair in a soaked brief with urine

med pass throughout each shift and document findings and resolution on the incontinence care log. The medication nurse will be responsible to notify the certified nursing assistant of any resident's with incontinence and supervise the corrective action.
The charge nurse will monitor logs for completion and verify resolutions daily. The incontinence log will be brought to the daily interdisciplinary meeting for discussion and resolution beginning on 11/1/2021 and will end on 02/01/2022.

A directed in-service training on At Risk for Pressure Ulcer Assessment policy, Body Audit Policy, Pressure Injury Prevention Guidelines Policy, and Pressure Injury Prevention and Management with pre- and post-test was given by Mississippi Gulf Coast Community College Registered nursing instructor for all current staff beginning 11/06/2021 and will be completed on 11/08/2021.

After completion of directed in-service, the staff development nurse will in-service all new staff members and contracted personnel during the orientation process, on At Risk for Pressure Ulcer Assessment Policy, Body Audit Policy, Pressure Injury Prevention Guidelines Policy, and Pressure Injury Prevention and Management with pre- and post-test, beginning 11/09/2021

4. Quality Assurance (QA) nurse will monitor in-services and training on pressure Injuries for completion weekly beginning 11/9/2022 and will end on

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F 686	Continued From page 51 all day yesterday and today with dried BM on her. She explained to the DON how her bottom felt when the CNA cleaned her up. SSA observed the DON do an incontinent check on Resident #5 and observed two (2) briefs on the resident and the brief was soaked. The DON and SSA observed moderate redness to both buttocks and an area to the left buttock was red and non-blanchable. There was a strong smell of urine noted in the room. During an interview on 09/23/21 at 1:50 PM with CNA #3, she explained Resident #5 was up today when she started her shift. She explained resident had been up in the wheelchair all morning long and she put her to bed just before lunch. When asked had she checked Resident #5 for incontinence at any time this morning, she explained "no" because Resident #5 went to smoke, and she got busy doing her other residents. When asked if Resident #5 had dried BM on her when she went to change her, she explained Resident #5 had a little dried BM up near her back when she changed her. She stated she noticed the resident's buttocks were really red. When asked did she put two (2) briefs on Resident #5 after cleaning her up, she explained she did. When asked if applying two briefs on a resident or not checking a resident for incontinence for over two hours could cause harm, CNA #3 did not reply. On 09/23/21 at 2:30 PM, during an interview with Registered Nurse (RN) #1, when asked what she observed when she assessed Resident #5, she explained both of the resident's buttocks were red and on the left buttock there was a non-blanchable area around the buttock cheek.	F 686	02/01/2022. To ensure improvements are sustained quality assurance nurse will review all pressure ulcer risk assessments and body audits for completion and present for review at the monthly QA meeting starting on 11/16/2021 to make recommendations and changes as needed, weekly for one (1) month, bi-monthly for one (1) month, and monthly and will end on 02/01/2022. To ensure improvements are sustained the quality assurance nurse will audit all incontinence logs weekly beginning 11/08/2021. The audit and logs will be presented for review at the monthly quality assurance meeting starting on 11/16/2021 to make recommendations and changes as needed and will end on 02/01/2022. 5. All corrective action will be completed by 11/23/2021.	

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On 09/24/21 at 11:10 AM, during a phone interview with the Nurse Practitioner (NP), when asked what could double briefs on a resident or not providing incontinent care at least every two (2) hours cause with a resident, the NP explained both situations could cause tissue breakdown due to the moisture and could lead to a pressure wound.

On 09/24/21 at 12:00 PM, during an interview with the DON, when asked regarding the incident of her finding Resident #5 with two (2) briefs on, she explained that is never acceptable in the building. When asked to describe what she observed on Resident #5's skin when she removed the two briefs, she explained the resident's buttocks were severely red and there was one non-blanchable area to resident's left buttock.

On 09/27/2021 at 12:30 PM, during a phone interview with RN #1, when asked regarding a CNA applying two (2) briefs on a resident, she explained that is not allowed in the facility. When asked if there could be any negative outcome, she explained it could cause skin breakdown.

Record review of Resident #5's Physician Orders September 2021 revealed an order with a start date of 7/16/21 for "Pressure reducing chair cushion for wheelchair in place and functioning properly, check q (every) day (gel cushion)" and a new order dated 09/23/21 to "Cleanse both buttocks with wound cleanser/normal saline, pat dry, apply barrier cream and cover with silicone bordered dressing daily and as needed."

Record review of Resident #5's Nurse Progress note revealed the DON assessed Resident #5 on

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09/24/21 and observed 2.0 centimeters (cm) x 3.0 cm non-blanchable Stage one (I) to left buttock ..."

Record review of Resident #5's two (2) Wound Assessment Reports dated 09/23/21 revealed irritation/excoriation to left buttock that appeared red or darker pink, moderate irritation, with measurements 9.5 cm (centimeters) length x 4.0 cm width and Stage one (1) Pressure Ulcer to left buttock, left outer aspect of the excoriation, with measurements 2.0 cm length x 3.0 cm width. Both areas were identified on 9/23/21.

Record review of Resident #5's Care Plan, undated, revealed "Problem: (Formal Name) needs assist with ADLs r/t CVA w/(with) left non-dominant hemiparesis ...Interventions: Toilet/incont care q 2 hrs & PRN using skin barriers as needed, Observe for skin breakdown/redness during care & report to nurse qs (every shift) ...Provide AM & PM care ensuring all needs are met daily to maintain proper appearance, hygiene, well groomed ..."

Record review of Resident #5's Care Plan, undated, revealed "Problem: Resident is at risk for skin breakdown r/t decreased functional mobility, diabetes, left sided hemiparesis, incont of B&B (bowel and bladder) ...Interventions ...Pressure reducing cushion chair ...Sponge bath/Shower on designated days ...

Record review of Resident #5's Care Plan, onset date 9/23/2021, revealed "Problem: I have acquired a pressure area and have areas of excoriation and redness ....1.) Left buttock-irritation/excoriation, 2.) Left buttock-non-blanchable stage I, 3.) Right

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F 686	Continued From page 54 buttock-irritation/excoriation ...Interventions: Treatment as ordered ...Provide pressure relief to areas: mattress, cushion ...Provide incontinent care every 2 hours and prn (as needed) ..." Record review of Resident #5's Face Sheet revealed the facility admitted Resident #5 on 07/15/21with diagnoses of Hemiplegia following Cerebral infarction affecting left nondominant side, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Muscle weakness, and Fibromyalgia. Record review of Resident #5's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/22/21 Section C revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated Resident #5 had moderate cognitive impairment. Section G of the MDS revealed Resident #5 required extensive assistance of two-person assist for bed mobility, transfers, dressing, toilet use, and personal hygiene. Section H revealed Resident #5 was always incontinent of bowel and bladder.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and	F 689	1. Resident #1 was removed from the	11/23/21

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F 689	Continued From page 55 facility policy review the facility failed to protect the residents from ant bites for two (2) of five (5) residents reviewed for ant bites. Resident #1, Resident #7. Findings include: Review of the facility's policy, "Accidents and Supervision", dated 12/09/2020 revealed the resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes identifying hazards and risks, evaluating and analyzing hazards and risks, implementing interventions to reduce hazards and risks, monitoring for effectiveness and modifying interventions when necessary. The environment refers to any environment or area in the facility that is frequented by or accessible to residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas, and activity areas. Review of the facility's policy titled, "Accident-Incident Reports", dated 12/09/20 revealed an accident/incident report should be completed by assigned nurses and an investigation should be initiated to determine all contributing factors. During an interview on 09/20/21 at 2:45 PM, with the Administrator revealed the facility uses a local pest control service that comes to the facility monthly. The Administrator said the pest control sprays for all pest with different pesticides. The facility had some ant problems after the last big storm and called for services right away.	F 689	room and a body audit and treatment to injured areas was provided 09/10/2021 by nursing. The resident was moved to a different room free of pest. Pest control was called to facility to treat the infested room on 9/10/2021 and arrived at 0900 on 9/10/2021 and treated the room and surrounding areas. Resident #7 was removed from the room and showered by nursing staff on 04/30/2021. A body audit was performed during the shower and treatment to the wound was conducted. The resident was moved to a different room free of pest. Pest control was called to facility to treat the infested room on 4/30/2021 and arrived in the morning of 5/1/2021 and treated the room and surrounding areas. 2. All residents are at risk for this deficient practice. 3. External pest control increased in-door and out-door pest treatments to twice a month and as needed starting on 9/27/2021 and will end on 02/01/2022. The facility maintenance increased pest control in-door and out-door treatments to once monthly and as needed starting on 10/5/2021 and will end on 02/01/2022. A directed in-service training on Accidents and Supervision Policy was given by Mississippi Gulf Coast Community College Registered nursing instructor for all current staff beginning 11/06/2021 and will be completed on 11/08/2021. After completion of directed in-service, the staff development nurse, will in-service all new staff and contracted personnel on Accidents and Supervision Policy	

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F 689	Continued From page 56 Record review of Pest Control invoices dated 8/13/21 and 9/14/21 revealed the facility used a local Pest Control company. On 9/14/21, the invoice indicated "Targeted issues: Ants, Targeted areas: Interior". Review of the facility's, "Quality Assurance Performance Improvement meeting", dated 4/30/21 revealed the interdisciplinary team discussed the ants in the building and what has been done to keep them out. The recommendation was for maintenance to investigate and treat. Resident #1 Record review of the facility's," Resident Incident Report", dated 9/10/21 revealed a Certified Nursing Assistant (CNA) notified a nurse that Resident #1 was complaining of itching and had ants crawling in his bed. The nurse and CNA assisted the Resident out of the bed into the wheelchair. Resident #1 was inspected for injury. Resident #1 had several raised areas and redness noted to his right arm and right elbow. Resident #1 was transferred to another room. The Medical Doctor (MD) was notified. Review of the facility's, "Body Audit Form", dated 9/10/21, revealed Resident #1 had raised red areas to the right arm. Interview on 9/21/21 at 10:00 AM, with Licensed Practical Nurse (LPN)#5 confirmed a CNA came to her reporting Resident #1 had ants in his bed crawling on him. LPN #5 said Resident #1 had several raised dime size red areas to the right arm and redness noted to the inner aspect of the right elbow. LPN #5 removed Resident #1 from	F 689	beginning on 11/09/2021 and will be completed on 11/08/2021. 4. The maintenance supervisor will maintain and monitor external and internal pest control logs weekly to begin 10/05/2021 and will end on 02/01/2022. To ensure improvements are sustained quality assurance nurse will review pest control log book bi-weekly beginning on 11/01/2021 for completion and present for review at the monthly quality assurance meeting starting on 11/16/2021 to make recommendations and changes as needed and will end on 02/01/2022. 5. All corrective action will be completed on 11/23/2021.	

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his room and notified Maintenance, the Administrator and the Director of Nursing (DON). Resident #1's room was cleaned by housekeeping and sprayed by pest control.

Interview on 9/21/21 at 10:30 AM with Nurse Practitioner (NP) #2 confirmed Resident #1 had small, raised areas to his right arm. NP #2 said she ordered some cortisone cream. Resident #1 did not complain from the incident. NP #2 said the Resident did not remember the ants were in his bed.

Record review of the Face Sheet revealed Resident #1 was admitted on 8/25/2021 with diagnoses that included Chronic Respiratory failure, Chronic Obstructive Pulmonary Disease and Kidney failure.

Resident #7

Record review of the facility's," Resident Incident Report", dated 4/30/21 at 04:30 AM, revealed Resident #7 was noted with ants in his bed, on him and in the wound bed. The facility gave the Resident a bath and cleansed the wound, applied new dressing and changed Resident #7 to another room.

Record review of the facility's, "Nurses Notes", dated 4/30/21 revealed Resident #7 was noted in his room with ants in his bed and on him. Resident #7's dressing was removed from the wound on the sacrum. Ants were noted in the wound bed. The wound had a foul odor with green, black drainage. The wound bed was dark green and black tissue necrotic with tunnelling. Resident #7 was bathed and the dressing was changed. Resident #7 was moved to another

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	C 09/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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room. The Medical Doctor (MD), Administrator, Director of Nursing (DON), and Maintenance were notified.

During an interview 9/21/21 at 11:00 AM, with the Medical Director (MD) confirmed he was told about the ants in Resident #7's wound. The MD said the ants did not contribute to the residents wound being infected or getting the worse. The MD said Resident #7's wound was really bad when he was admitted. Resident #7's co-mobilities caused his wound to decline. The MD said Resident #7's wound was getting worse prior to the ants. The MD said Resident #7 was a Diabetic and had End Stage Renal failure, and was on dialysis 3 times a week. Resident #7 was also a bilateral amputee and had heart disease.

Record review of the Face Sheet revealed Resident #7 was admitted on 5/12/2021 with diagnoses that included Diabetes Mellitus, Dependence on renal dialysis and Atrial Fibrillation.

Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/05/21 revealed Resident#7 had a Brief Interview for Mental Status (BIMS) score of 15 that indicated Resident #7 is cognitively intact.