STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255095	A. BUILDING _____ B. WING _____	10/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF LAUREL	935 WEST DR LAUREL, MS 39440

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey from 10/28/19 through 10/31/19. During the survey, the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements of participation. The SA cited deficiencies at F656, F677, F686, F697, F812, and F880. The facility was licensed for 120 beds, with a census of 108 at the time of survey.	F 000		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		11/22/19

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

Electronically Signed | 11/22/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 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 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, interview, record review, and policy review, the facility failed to implement the care plan for two (2) of 22 residents reviewed, Resident #6, as evidenced by not providing toenail care for Resident #6 and not providing pain medication during treatment for Resident #15, per the care plan. Findings include: Record review of the facility's "Quality of Care" policy, dated November 2017, revealed each resident shall receive optimal care to attain and/or maintain the highest possible mental physical functional status as determined by the comprehensive assessment and person-centered plan of care. Resident #15 Review of Resident #15's care plan initiated 7/31/19, revealed a potential for pain related to a	F 656	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. 1. Care plans for resident number 6 and resident number 15 were reviewed in detailed by the Assistant Director of Nursing on 11/5/2019. A comprehensive care plan addressing pain related to wound care has been put in place for each resident receiving treatments or procedures that could potentially reflect pain by the Assistant Director of Nursing on 11/5/2019. The Director of Nursing performed an assessment of residents number 6 and resident number 15 with no adverse affects found on October 31,	

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F 656	Continued From page 2 stage 4 ulcer to the coccyx. Interventions included to administer pain medications as ordered. Review of the current Physician Orders, revealed orders for Resident #15's Sacral stage 4 wound to be cleaned with normal saline, pat dry, pack with 1/2 strength Dakins soaked kerlix, and cover with border gauze dressing daily and as needed. Resident #15 had orders for Tramadol HCL 100 milligram (mg) every six (6) hours for pain routinely, with orders for Tylenol with Codeine #3 orally every 12 hours (ordered 10/4/19), as needed for pain. Observation on 10/28/19 at 11:04 AM, revealed Registered Nurse (RN) #1 initiated care to Resident #15's stage 4 wound with normal saline. Resident #15 started crying, holding onto the bed rail saying that it hurt. The nurse said, "I'm almost finished." RN #1 proceeded to measure the 3.0 centimeter (cm) x 3.0 cm x 5.0 cm sacral wound. RN #1 packed the wound with 4 x 4 gauze, soaked in half strength Dakin's solution. RN #1 applied sure prep around peri area and foam gauze. RN #1 did not stop the treatment or offer the resident any pain medication during the treatment. In an interview during wound care, on 10/28/19 at 11:04 AM, RN #1 said Resident #15 cries all the time, even if she gets pain medication. RN #1 said the resident was medicated at 6:00 AM with Tramadol and was not due any more pain medicine until 12:00 PM. During an interview on 10/31/2019 at 9:30 AM, the Director of Nursing (DON) confirmed RN #1 failed to address Resident #15's pain during	F 656	2019. 2. All residents receiving wound care and toenail care have the potential to be affected by this practice. 3. Licensed Practical Nurses and Registered Nurses were in serviced on October 31, 2019 by Director of Nursing specifically on our facilities comprehensive care plan policies to include but not limited to the residents unique characteristics, strengths, and needs including those residents with wounds and treatments. This in-service also included pain assessment before, during, and after wound care treatments as well as toenail care. 4. Director of Nursing along with Assistant Director of Nursing will perform care plan audits on residents who have wound care orders for treatments twice weekly for four weeks and then weekly for four weeks, these will be documented on the facility flow sheet. These care plan audits began on 11/5/2019. Flow sheets containing monitoring and audits for pain management and toenail care will be brought to the Quality Assessment and Assurance Committee by the Director of Nursing. Any deficient practices found will have an improvement plan initiated. Recommendations will be made if warranted. The Quality Assessment and Assurance Committee will meet at least Quarterly to ensure pain management was appropriate for wound care as well as toenail care being provided when needed.	

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F 656	Continued From page 3	F 656		

wound care, by not stopping the wound care and offering more pain medication. The DON said RN #1 should have asked the nurse to give Resident #15 the Tylenol #3 with Codeine, that was ordered as needed (and care planned) before finishing the wound care.

Resident #6
Review of the Comprehensive Care Plan, dated 2/22/11, revealed Resident #6 had a care plan to check/trim toe nails weekly, to be done by the Registered Nurse (RN).

Observation on 10/28/19 at 4:21 PM, revealed Resident #6 lying supine in bed, with feet uncovered. Resident #6's toenails were long, thick, and yellow, with dried blood on the left great toe.

During an interview on 10/28/19 at 4:23 PM, Resident #6 stated the Podiatrist normally comes to see him in his room. Resident #6 stated he had reminded the nurse for a month that he needed the Podiatrist to come cut his toenails.

Interview on 10/31/19 at 10:55 AM, with the Director of Nursing (DON), confirmed Resident #6's toe nails were long, with thickened yellow toe nails on both feet and should be trimmed.

Interview on 10/31/19 at 11:07 AM, with License Practical Nurse (LPN #1), revealed she does body audits on Resident #6 weekly. LPN #1 said she had noticed the long thick yellow toe nails and had informed the Treatment Nurse the resident's toenails needed to be cut, but did not inform the DON that the resident's nails weren't cut.

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F 656	Continued From page 4 Review of a "Podiatry Note" revealed Resident #6 was seen by a Podiatrist on 9/23/2017. The note revealed Resident #6's nails were elongated, deformed, and thickened, with fungus nail plates which were yellow. The podiatrist trimmed the resident's toenails and recommended Resident #6 be seen again, as needed, per physicians order, or sooner, if adverse changes in foot condition or foot status.	F 656		
F 677 SS=D	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 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based observation, staff interview, record review, and facility policy review, the facility failed to provide toenail care for (1) one of (22) residents observed for Activities of Daily (ADL) care, Resident #6. Findings Include: Record review of the facility's "Quality of Care" policy, dated November 2017, revealed each resident's care is tailored to the functional status and needs they may have. At the time of bath, all residents shall also receive, if applicable, nail care. Observation on 10/28/19 at 4:21 PM, revealed Resident #6 lying supine in bed, with feet uncovered. Resident #6's toenails were long, thick, and yellow, with dried blood on the left great	F 677	By submitting the enclosed material, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. 1. Director of Nursing cleaned and clipped Resident #6 toenails on 10/31/2019 at 4:00pm and obtained an order for podiatry consultation on 11/1/2019 at 4:39pm. Registered Nurse Supervisors began and completed a body audit of all residents fingernails and toenails on 10/31/2019 and trimmed/filed them as needed. At the time of the audit the census was 111 with 4 resident in the hospital. 60 residents received toenail trimming/filing. All residents care plans were reviewed by the	11/22/19

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F 677	Continued From page 5 toe. During an interview on 10/28/19 at 4:23 PM, Resident #6 stated the Podiatrist normally comes in to see him in his room. Resident #6 stated he had reminded the nurses for a month that he needed the Podiatrist to cut his toenails. Interview on 10/31/19 at 10:55 AM, with the Director of Nursing (DON), confirmed Resident #6's toenails were long, with thickened yellow nails on both feet. The DON said the nurses on the floor were responsible for doing body audits weekly and the CNA's were suppose to notify the nurse when the resident's toenails needed to be cut. The DON also stated the facility had signed a contract with a Podiatrist, but he decided not to accept the position. Interview on 10/31/19 at 11:07 AM, with License Practical Nurse (LPN) #1, revealed she does body audits on Resident #6 weekly. LPN #1 said she had noticed the long thick yellow toenails and had informed the Treatment Nurse the resident's toenails needed to be cut. LPN #1 said she did not notify the DON the resident's nails had not been cut. LPN #1 stated she did mention to the DON that Resident #6 needed to see a Podiatrist. Review of the facility's "Weekly Body Audit Roster", dated 10/1/2019 through 10/30/2019, revealed Resident #6 received body audits on 10/2/2019, 10/9/2019, 10/16/2019, 10/23/2019, and 10/30/2019, which revealed no new skin issues. Review of a "Podiatry Note" revealed Resident #6 was seen by a Podiatrist on 9/23/2017. The note revealed Resident #6's nails were elongated,	F 677	Director of Nursing and the Assistant Director of Nursing on 11/5/2019 and confirmed that toenail/fingernail care is present. 2. All residents have the potential to be affected by this practice. 3. In service was conducted by the Director of Nursing in regards to fingernail/toenail care monitoring for all staff on 11/1/2019. This in service included location of toenail/fingernail care on the kiosk for Certified Nursing Assistants as well. 4. Director of Nursing along with Assistant Director of Nursing will perform checks on ten random residents three times weekly for four weeks and then once a week for four weeks to monitor for toenail/fingernail care ,these will be documented on the facility flow sheets. These random checks started on 11/4/2019. All flow sheets which contain the monitoring and audits regarding toenail care will be brought to the Quality Assessment and Assurance Committee by the Director of Nursing. Any deficient practices regarding toenail care will have a plan initiated and recommendations will be made if warranted. The Quality Assessment and Assurance Committee will meet at least Quarterly.	

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F 677	Continued From page 6 deformed, and thickened, with fungus nail plates, which were yellow. The Podiatrist trimmed the resident's toenails and recommended Resident #6 be seen again, as needed, per physicians order, or sooner, if adverse changes in foot condition or foot status. A review of Resident #6's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/09/2019, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had no cognitive impairment.	F 677		
F 686 SS=G	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 by: Based on observation, interview, record review, and policy review, the facility failed to ensure pressure ulcer treatment was provided in a manner to allow the resident to be as pain free as possible during the care. This affected one (1) of six (6) resident wound care observations,	F 686	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations, We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our	11/22/19

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F 686	Continued From page 7 Resident #15, as evidenced by the resident crying and holding on to the bed rail during the wound care of the pressure ulcer. The nurse did not stop the care and/or offer additional pain medication. Findings include: A review of the facility's "Guidelines for Pain Management of Wounds", dated January 2014, revealed: The staff should perform routine pressure ulcer pain assessments with dressing changes and periodically as consistent with the individual's wishes. If consistent with treatment plan, provide opioids and/or non-steroidal anti-inflammatory drugs 30 minutes prior to dressing changes or procedures and afterward. Utilize dressings less likely to require less frequent dressing changes (hydrocolloids, hydrogel alginates, polymeric membrane foams, foam, soft silicone dressings). Please note gauze dressings are more likely to cause pain. Systemic treatment for pressure ulcer pain: Oral administration of drugs in the following order: Step one: non-opioids (aspirin, acetaminophen and nonsteriodal anti-inflammatory drugs), systemic local anesthetics and topical anesthetics). Step two: If pain is persisting or increasing give mild opioids (codeine), plus if necessary non episodes and or adjuvant. Step Three: If pain is persisting or increasing give opioids for moderate to severe pain (morphine), plus if necessary non-opioid and/or adjuvant (step 1 medications and morphine, discontinue step 2). Observation of Resident #15's wound care, on 10/28/19 at 11:04 AM, revealed Registered Nurse (RN) #1 cleaned the resident's stage 4 pressure ulcer wound with normal saline. Resident #15	F 686	regulatory obligations. 1. Director of Nursing performed a head to toe assessment on Resident 15 with no adverse affects found on October 31, 2019. Medical Director, came to visit with Resident number 15 on November 1, 2019 in regards to pain with new orders obtained. New order was for Acetaminophen-cod#3 tablet give one tablet by mouth two times a day for pain and Neurontin 100mg give one capsule by mouth three times a day for pain. Medical Records Nurse completed audit on all residents receiving treatments including wound care to ensure that pain scales were incorporated on the treatment administration record, this was completed on 11/5/2019. 2. All residents receiving wound care have the potential to be affected by this practice. 3. Licensed Practical Nurses and Registered Nurses were in serviced specifically on our facility's policy regarding pain control during each treatment including wound care. This in service was held on November 1, 2019 and conducted by the Director of Nursing. 4. Director of Nursing and Assistant Director of Nursing will perform observations of wound care two times weekly for four weeks, then once weekly for four weeks to ensure pain guidelines and policies are adhered to. These observations were initiated on 11/1/2019.	

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F 686	Continued From page 8 started crying and held on to the bed rail saying that it hurt. RN #1 stated, "I'm almost finished." RN #1 proceeded to measure the 3.0 centimeter (cm) x 3.0 cm x 5.0 cm sacral pressure ulcer, which had a red wound bed and no odor. RN #1 packed the wound with 4 x 4 gauze, soaked in half strength Dakin's solution. RN #1 applied sure prep around peri area and foam gauze. RN #1 did not stop the treatment or offer the resident any pain medication. During an interview on 10/28/19 at 11:04 AM, during the resident's wound care, RN #1 stated Resident #15 cried all the time, even if she had pain medication. RN #1 said the resident was medicated at 6:00 AM, and was not due any more pain medicine until 12:00 PM. He stated Resident #15 was given the routine Tramadol orally at 6:00 AM, for pain. Review of the Physician Orders, dated October 2019, revealed the wound care orders for Resident #15: Wound to be cleaned with normal saline, pat dry, pack with 1/2 strength Dakins soaked kerlix, and cover with border gauze dressing daily and as needed. Resident #15 had routine orders for two (2) 50 milligram (mg) Tramadol HCL tablets orally every six (6) hours for pain routinely, with orders for Tylenol with Codeine #3 orally ever 12 hours, as needed for pain. Review of the Medication Administration Record (MAR), dated October 2019, revealed Resident #15 received Tramadol HCL 100 mg every six (6) hours for pain routinely at 6:00 AM, 12:00 PM, 6:00 PM, and 12:00 AM. The resident had not received Tylenol with Codeine #3 for the month of October 2019, per the MAR.	F 686	All flow sheets containing the observations of wound care will be brought to the facility Quality Assessment and Assurance Committee by the Director of Nursing. Any deficient practices with wound care will have an improvement plan initiated. Recommendations will be made if warranted. The Quality Assessment and Assurance Committee will meet at least Quarterly.	

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F 686	Continued From page 9	F 686		

Review of Resident #15's Pain Assessment, dated 10/17/2019, revealed Resident #15 was unable to verbalize pain, however, she expressed pain through facial grimacing and crying.

Review of the facility's "Wound Assessment Reports", dated 7/16/2019, 8/20/2019, 9/17/2019, and 10/22/2019, revealed Resident #15 complained of pain by moaning, grimacing and crying.

During an interview on 10/30/19 at 11:16 AM, Resident #15's niece confirmed the resident complained of pain to her sacrum all the time. The niece stated she was told by the nurses that they give the resident pain medicine all the time. The niece said it bothers her to hear her aunt cry in pain.

During an interview on 10/30/19 at 4:02 PM, Certified Nursing Assistant (CNA) #1 stated she takes care of Resident #15 on the day shift and the evening shift. She stated Resident #15 cried all the time. She stated the resident said her buttocks hurt whenever staff repositions her. CNA #1 said she reported the resident's complaint of pain to the nurse.

During an interview on 10/30/19 at 4:13 PM, CNA #2 stated she provided care to Resident #15 on evening shift. CNA #2 stated Resident #15 complained of pain to her buttocks all the time when care is provided. CNA #2 stated she reported the resident's pain to the nurse.

During an interview on 10/30/19 at 4:18 PM, the Medical Doctor (MD) confirmed he was not aware Resident #15 complained of pain during wound

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F 686	Continued From page 10 care. The MD said he would address this with the nurses during his visit to the facility. During an interview on 10/31/2019 at 9:30 AM, the Director of Nursing (DON) confirmed RN #1 failed to address Resident #15's pain during treatment of the pressure ulcer. The DON stated she told RN #1 to assess Resident #15's pain prior to providing the wound care. The DON said RN #1 should have asked the Medication Nurse to give Resident #15 the Tylenol #3 with Codeine before finishing the wound care, as it was ordered as needed. A review of Resident #15's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/25/2019, revealed Resident #15 complains of pain with vocal complaints and facial grimacing. The resident's Brief Interview for Mental Status (BIMS) revealed a score of zero (0), which indicated severe cognitive impairment.	F 686		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure a resident was free from pain during wound care for one (1) of six (6) wound care observations, Resident #15, as evidenced by the resident crying and holding on to the bed rail during wound care	F 697	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations, We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our	11/22/19

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	255095	A. BUILDING _____ B. WING _____	10/31/2019

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CARE CENTER OF LAUREL	935 WEST DR LAUREL, MS 39440

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F 697	Continued From page 11 and the nurse did not stop the care and/or offer additional pain medication. Findings include: A review of the facility's "Guidelines for Pain Management of Wounds", dated January 2014, revealed: The staff should perform routine pressure ulcer pain assessments with dressing changes and periodically as consistent with the individual's wishes. If consistent treatment plan, provide opioids and/or non-steroidal anti-inflammatory drugs 30 minutes prior to dressing changes or procedures and afterward. Utilize dressings less likely to require less frequent dressing changes (hydrocolloids, hydrogel alginates, polymeric membrane foams, foam, soft silicone dressings). Please note gauze dressings are more likely to cause pain. Systemic treatment for pressure ulcer pain: Oral administration of drugs in the following order: Step one: non-opioids (aspirin, acetaminophen and nonsteriodal anti-inflammatory drugs), systemic local anesthetics and topical anesthetics). Step two: If pain is persisting or increasing give mild opioids (codeine), plus if necessary non episodes and or adjuvant. Step Three: If pain is persisting or increasing give opioids for moderate to severe pain (morphine), plus if necessary non-opioid and/or adjuvant (step 1 medications and morphine, discontinue step 2). Observation of wound care, on 10/28/19 at 11:04 AM, with Registered Nurse (RN) #1, revealed the nurse cleaned Resident #15's stage 4 wound with normal saline. Resident #15 started crying, holding onto the bed rail saying that it hurt. The nurse said, "I'm almost finished." RN #1	F 697	regulatory obligations. 1. Director of Nursing performed a head to toe assessment on Resident 15 with no adverse affects found on October 31, 2019. The Medical Director came to visit with Resident number 15 on November 1, 2019 in regards to pain with new orders obtained. New order was for Acetaminophen-cod#3 tablet give one tablet by mouth two times a day for pain and Neurontin 100mg give one capsule by mouth three times a day for pain. Medical Records Nurse completed audit on all residents receiving treatments including wound care to ensure that pain scales were incorporated on the treatment administration record, this was completed on 11/5/2019. 2. All residents receiving wound care have the potential to be affected by this practice. 3. Licensed Practical Nurses and Registered Nurses were in serviced specifically on our facility's policy regarding pain control during each treatment including wound care. This in service was held on November 1, 2019 and conducted by the Director of Nursing. 4. Director of Nursing and Assistant Director of Nursing will perform observations of wound care two times weekly for four weeks, then once weekly for four weeks to ensure pain guidelines and policies are adhered to. These observations were initiated on 11/1/2019.	

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F 697	Continued From page 12 proceeded to measure the 3.0 centimeter (cm) x 3.0 cm x 5.0 cm sacral wound, which had a red wound bed and no odor. RN #1 packed the wound with 4 x 4 gauze, soaked in half strength Dakin's solution. RN #1 applied sure prep around peri area and foam gauze. RN #1 did not stop the treatment or offer the resident any pain medication. During an interview on 10/28/19 at 11:04 AM, during the resident's wound care, RN #1 stated Resident #15 cried all the time, even if she had pain medication. RN #1 said the resident was medicated at 6:00 AM, and was not due any more pain medicine until 12:00 PM. He stated Resident #15 was given the routine Tramadol orally at 6:00 AM, for pain. Review of the Physician Orders, dated October 2019, revealed the wound care orders for Resident #15: Wound to be cleaned with normal saline, pat dry, pack with 1/2 strength Dakins soaked kerlix, and cover with border gauze dressing daily and as needed. Resident #15 had orders for Tramadol HCL 100 milligram (mg) orally every six (6) hours for pain routinely, with orders for Tylenol with Codeine #3 orally ever 12 hours, as needed for pain. Review of the Medication Administration Record (MAR), dated October 2019, revealed Resident #15 received Tramadol HCL 100 mg every six (6) hours for pain routinely at 6:00 AM, 12:00 PM, 6:00 PM, and 12:00 AM. The resident had not received Tylenol with Codeine #3 for the month of October 2019. Review of Resident #15's Pain Assessment, dated 10/17/2019, revealed Resident #15 was	F 697	All flow sheets containing the observations of wound care will be brought to the facility Quality Assessment and Assurance Committee by the Director of Nursing. Any deficient practices with wound care will have an improvement plan initiated. Recommendations will be made if warranted. The Quality Assessment and Assurance Committee will meet at least Quarterly.	

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F 697	Continued From page 13	F 697		

unable to verbalize pain, but expressed pain through facial grimacing and crying.

Review of the facility Wound Assessment Reports, dated 7/16/2019, 8/20/2019, 9/17/2019, and 10/22/2019, revealed Resident #15 complained of pain by moaning, grimacing and crying.

During an interview on 10/30/19 at 11:16 AM, Resident #15's niece confirmed the resident complained of pain to her sacrum all the time. The niece stated the nurses told her that they give the resident pain medicine all the time. The niece said it bothers her to hear her aunt cry in pain.

During an interview on 10/30/19 at 4:02 PM, Certified Nursing Assistant (CNA) #1 stated she takes care of Resident #15 on day shift and evening shift. She stated Resident #15 cries all the time, stating her buttocks hurt, whenever the staff repositions her. CNA #1 said she reported the resident's complaint of pain to the nurse.

During an interview on 10/30/19 at 4:13 PM, CNA #2 revealed she is Resident #15's care giver on evening shift. CNA #2 stated Resident #15 complains of pain to her buttocks all the time during care. CNA #2 said she reports the resident's pain to the nurse.

During an interview on 10/30/19 at 4:18 PM, the Medical Doctor (MD) confirmed he did not know Resident #15 complained of pain during wound care. The MD said he would address this with the nurses during his visit to the facility.

During an interview on 10/31/2019 at 09:30 AM,

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F 697	Continued From page 14 the Director of Nursing (DON) confirmed RN #1 failed to address Resident #15's pain during wound care, by not stopping the wound care. The DON said she told RN #1 to assess Resident #15's pain prior to providing the wound care. The DON said RN #1 should have asked the Medication Nurse to give Resident #15 the Tylenol #3 with Codeine, that was ordered as needed, before finishing the wound care. A review of Resident #15's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/25/2019, revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident is severely cognitively impaired. The MDS revealed Resident #15 complains of pain with vocal complaints and facial grimacing.	F 697		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		11/22/19

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F 812	Continued From page 15 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and policy review, the facility failed to monitor each of the Medication Storage Room refrigerators for expired food items, incomplete temperature logs, and spills in the bottom of the refrigerators, for three (3) of the (3) Nurse's station Medication Storage Room refrigerators inspected. Findings Include: The facility's "Facility Unit Refrigeration Equipment" policy, revised on 05/2018, revealed the facility will ensure the refrigerated foods are stored outside the food service area through accepted storage practices. The policy noted the temperatures are checked daily by a designated employee, documented on a temperature log, and food items that have passed the "use by" date, or expiration date, are discarded. During an observation, of the refrigerator in the Medication Storage Room (Med Room) located at the North Nurse's station, on 10/30/2019 at 11:30 AM, there were six (6) two-percent (2%) milk cartons and five (5) whole milk cartons with use-by-dates that were past their expiration date. During an observation, on 10/30/2019 at 11:40 AM, of the Patient Care Unit (PCU) Nurse's station Med Room refrigerator, there was one (1) whole milk carton with an expired use-by-date. The refrigerator was also noted to have excessive brown-colored spillage in the bottom.	F 812	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. 1. All three Medication Storage Room refrigerators were inspected and cleaned on 10/31/2019 by the Director of Nursing, Assistant Director of Nursing, along with the Administrator. The Director of Nursing removed 11 cartons of milk and cleaned liquid from the bottom of the refrigerator along with one carton of thickened water. 2. All residents have the potential to be affected by this practice. 3. In service was conducted on 11/1/2019 for all staff by the Director of Nursing specifically for the night shift nurses with responsibility to check the Medication Storage Room refrigerator temps as well as cleanliness and expiration dates nightly. Large refrigerator ordered to replace all Medication Storage Room refrigerators with the plan to place all supplements in a central location. The maintenance supervisor ordered the door for this location on 11/19/2019 and picked up on 12/3/2019. It was installed on 12/6/2019. He ordered refrigerator was ordered on 12/6/2019.	

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F 812	Continued From page 16 During an observation, on 10/30/2019 at 11:50 AM, of the South/South Central Nurse's station Med Room refrigerator, there was one (1) 2% milk carton, three (3) whole milk cartons, and one (1) container of honey-thickened water with an expired use-by-date. Review of the temperature refrigerator logs from each of the Nursing stations Medication Storage rooms, revealed that there were multiple dates for October 2019, in which no record of the unit's refrigerator temperatures had been documented; 13 for October 2019 and 22 for September 2019, for the North Nursing Unit; 11 for October 2019 for the PCU Unit; and one (1) for the South Nursing Unit for October 2019. During an interview on 10/30/19 at 11:35 AM, Licensed Practical Nurse (LPN) #1 confirmed there were six (6) cartons of 2% milk and five (5) cartons of whole milk, past the use-by-date, in the refrigerator in the Med Room. LPN #1 stated she is the floor nurse for the North Nurse's station, but it is the night nurse that is supposed to check the unit refrigerators and record the refrigerator's temperatures on the temperature log. LPN #1 confirmed there were multiple dates that the temperatures were not written on the temperature log for the month of October 2019. During an interview on 10/30/19 at 11:45 AM, LPN #2 confirmed one (1) carton of whole milk had a past use-by date and should have been discarded. LPN #2 confirmed there were spills in the bottom of the refrigerator that needed to be cleaned. LPN #2 stated she is the floor nurse for the Personal Care Unit, but the night nurse on the unit, is the person responsible for checking for expired foods in the refrigerator and documenting	F 812	4. Director of Nursing along with Assistant Director of Nursing will monitor all Medication Storage Room refrigerators three times weekly for four weeks and then weekly for four weeks to monitor for cleanliness, expired items, and completed temperature logs. This monitoring began on 10/31/2019. All flow sheets containing documentation of the monitoring will be brought to the facility Quality Assessment and Assurance Committee by the Director of Nursing. Any deficient practices will have a quality improvement plan initiated. Recommendations will be made if warranted. The Quality Assessment and Assurance Committee will meet at least Quarterly.	

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F 812	Continued From page 17 the temperatures on the temperature log. LPN #2 confirmed there were a lot of missing dates on the temp log. LPN #2 stated the milk products in the unit refrigerators are for resident use only. During an interview on 10/30/19 at 11:55 AM, LPN #3 confirmed three (3) cartons of whole milk, one (1) carton of 2% milk, and one (1) four (4) ounce (Oz) container of honey thickened water, had a past use-by expiration date. LPN #3 confirmed these food items should have been thrown away. During an interview on 10/30/19 at 12:20 PM, the facility's Administrator confirmed all food items stored in the unit refrigerators with expired use-by dates, should be discarded. The Administrator stated the night nurses are delegated to check each unit refrigerator, remove the expired food items, and record the refrigerator temperatures on the temperature log. The Administrator stated the food items in the unit refrigerators are for resident use only. During an interview, on 10/31/19 at 10:50 AM, the Director of Nursing (DON) confirmed any food products beyond the use-by dates, should be discarded. The DON stated the night shift nurse from all three (3) nursing stations are responsible for cleaning, checking the food items inside the unit refrigerator, and document the temperatures on the temperature logs. The DON stated the milk and thickened waters are stored in the unit refrigerator in order to give to the residents as ordered or needed.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		11/22/19

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F 880	Continued From page 18 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 19 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of the facility policy, revealed the facility failed to handle linens in a manner to prevent the possible spread of infection for one (1) of three (3) days of survey. Findings include: Review of the facility's "Infection Control Linen Handling" policy, dated 6/14 , revealed: Deposit soiled linen immediately into the soiled linen hamper and replace the cover.	F 880	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. 1. Staff Development Infection Control Licensed Practical Nurse performed a complete audit of residents rooms to ensure there was no linen on floors on	

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F 880	Continued From page 20 Observation and interview on 10/30/19 at 4:00 PM, soiled linens were observed on the floor in a resident's room on the Personal Care Unit (PCU). Certified Nursing Assistant (CNA) #3 stated, when asked why the soiled linens were on the floor, "Cause I just took them off the bed and I did not have a bag."	F 880	10/31/2019. Linen was found on the floor of one residents room during this audit, CNA was reminded of policy and lined was removed from the floor and taken to laundry. Staff Development Infection Control Licensed Practical Nurse also educated staff on the location of bags used for linen on 10/31/2019. 2. All resident have the potential to be affected by this practice. 3. In service was conducted by the Director of Nursing on 11/1/2019 for all staff with specifics on resident linen disposal with linen not allowed on the floor and should be placed in a bag. 4. Staff Development Infection Control Licensed Practical Nurse initiated visits to include monitoring of residents rooms by one random hall three times weekly for four weeks and then weekly for four weeks to inspect for linen on the floors of residents rooms, these will be documented on the facility flow sheets. These visits began on 11/1/2019. All flow sheets containing documentation of visits and monitoring of residents rooms will be brought to the facility Quality Assessment and Assurance Committee by the Director of Nursing. If any deficient practices are found an improvement plan will be initiated. Recommendations will be made if warranted. The Quality Assessment and Assurance Committee will meet at least Quarterly.	

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 11/20/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 000	Initial Comments ********** Survey conducted on 11/01/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

Electronically Signed | 11/20/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.