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	255161	A. BUILDING _____ B. WING _____	03/03/2022

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NMMC BALDWYN NURSING FACILITY	739 4TH STREET SOUTH BALDWYN, MS 38824

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and a facility reported incident (FRI) investigation CI MS# 18470 at the facility from 2/28/22 through 3/3/22. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid regulations for participation. The SA cited deficiencies at F550, F644, F656, F657, F677, and F679. The complaint, CI MS# 18470 concerning a resident on resident was not substantiated and no deficiciencies were cited. The facility had a census of 100 at the time of the survey and held a license for 107 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		4/22/22

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

Electronically Signed | 03/23/2022

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observations, staff interviews, and record reviews, the facility failed to protect the dignity of a resident which was evident when a privacy bag was not placed over a foley catheter bag for one (1) of six (6) residents reviewed with a foley catheter. Resident #90. Resident #90 Dignity Review of the facility policy titled, "Urinary Procedures," with an approval date of 09/2019, an issued date of 12/9/2000, and a last modified date of 04/01/2021, revealed "It is the Policy of (Facility Name) to ensure that urinary procedures are performed appropriately."	F 550	1) On 3/04/22 resident number 90 catheter bag was covered as required by Director of Nursing (DON). 2) All residents with catheters have the potential for the same deficient practice. All residents with catheters were rounded on starting 3/4/22 and completed this date to ensure catheters are covered as required, rounded by the Nursing Leadership. 3) All employees will be in-serviced starting by 4/1/22 by the Clinical Educator and completed by 4/22/22. This will be to ensure the proper covering of catheter bags as applied to residents' rights. The Urinary Procedures Policy was updated on 3/17/2022 by Director of Nursing	

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F 550	Continued From page 2 An observation, on 02/28/22 at 11:24 AM, revealed that Resident #90 did not have a privacy bag that covered her foley catheter bag. Resident #90's foley catheter bag hung on the side of her hospital bed that faced the entry door to Resident #90's room, with the clear side of the foley catheter bag facing the entry door, that allowed the urine drainage to be visible to all other residents, staff, and visitors, that passed Resident #90's room when the door was opened, and was visible to everyone who entered Resident #90's room. An observation on 03/1/22 at 03:32 PM, revealed Resident #90 did not have a privacy bag over the foley catheter bag. Resident #90's foley catheter bag was hung on the side of the hospital bed that faced the entry door to Resident #90's room. The clear side of the bag faced the entry door to Resident #90's room and the urine drainage was visible to everyone who passed Resident #90's room, when the door was opened, and was visible to everyone who entered Resident #90's room. An interview and observation, on 03/1/2022 at 03:41 PM, with the Licensed Practical Nurse (LPN)#1, confirmed Resident #90's foley catheter bag did not have a privacy bag covering it. LPN #1 confirmed that Resident #90's foley catheter bag was visible to everyone that passed Resident #90's entry door, when the door the was opened, and was visible to everyone that entered Resident #90's room. LPN #1 confirmed that there should have been a privacy bag over the foley catheter bag and a privacy bag not being placed over the foley catheter bag could have caused a dignity issue for Resident #90.	F 550	(DON), to include the use of a privacy bag or pillowcase. The Nursing Leadership Team started rounds on 3/04/22 with all residents with catheters to ensure that these bags are covered. Weekly for one month (March), then every two weeks for one month (April), once monthly (May) and will continue these rounds as required. 4) The results based from verbal exit from the State Survey Team was reported to the Quality Assurance and Performance Improvement (QAPI) Committee on 3/4/22. These rounds/results along with the written statement of deficiencies report (CMS-2567) were up for review at our QAPI follow-up meeting on 3/25/22. Recommendations from this committee were implemented as required and will be monitored until compliance is achieved and will be reviewed on the April 19, 2022 QAPI Meeting and on-going.	

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F 550	Continued From page 3	F 550		

An interview, on 3/2/2022 at 08:54 AM, with the Director of Nursing (DON), revealed privacy bags are only placed over a foley catheter bag when a resident was taken out of the room. The DON stated the facility policy did not state that a privacy bag had to be placed over a foley catheter bag when a resident remained in their room, but confirmed he understood how Resident #90 could have had dignity issues, due to the foley catheter bag being hung on the side of the bed facing the entry door to Resident #90's room and was visible to everyone that passed, when the door was opened, and was visible to everyone that visited the room. The DON confirmed Resident #90 should have had a privacy bag placed over the foley catheter bag.

An interview, on 3/3/22 at 09:30 AM, with the DON, revealed the in-service with staff regarding usage of a privacy bag over a foley catheter bag was done with each individual employee, at time of hire and the in-service was done again yearly. DON revealed these in-services are not done in a group setting.

Record review, of the individual employee in-service titled, "Facility Specific Handout Every Resident - Every Time," dated 12/11/2018, revealed, "Providing Excellent Resident Care, 5. Catheters: Use privacy bag to cover drainage bag while resident is out of room."

Record review, of the Active Orders Report, revealed a physician's order for an indwelling urinary catheter, dated 10/22/2021.

Resident #90 was admitted to this facility on 10/22/21, with a diagnosis of Other Cystostomy Status. Record review, of the most recent

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F 550	Continued From page 4 Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/25/2022, for Resident #90, revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating Resident #90 had moderately impaired cognition.	F 550		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review, and staff interviews, the facility failed to submit a Change in Status Request Form for evaluation of need for a Preadmission Screening and Resident Review (PASRR), Level Two (II) Screening, for a resident with new major mental illness diagnoses and new physician's orders for psychiatric medications, as evidenced by, a Change in	F 644	1. Resident number 63 had an appointment with Geri-psych nurse practitioner for evaluation on 3/10/22. A Preadmission Screening and Resident Review (PASARR) Level II was submitted on 3/22/22 to the appropriate system agency for review. On receipt of correspondence from the appropriate	4/22/22

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F 644	Continued From page 5 Status Request form not being submitted for one (1) of two (2) residents reviewed for no PASRR II with diagnosis. Resident #63 Review of the facility policy titled, "Coordination with PASARR Program," with a last review date of 05/05/2020, revealed, "Rationale: To ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level two II resident review. b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR." Findings include: Record review was attempted for review of the Change in Status Request Form submission, for Resident #63, for evaluation of need for a Preadmission and Resident Review (PASRR), Level Two (II) Screening, due to the new major mental illness diagnoses and new psychiatric medications, that were ordered after completion of the initial Pre-Admission Screening (PAS), revealed there was not a Change in Status Request Form in Resident #63's medical record. An interview, on 3/1/22 at 04:06 PM, with the Social Worker (SW), confirmed that the Change in Status Request Form was not submitted to evaluate for the need of a PASRR, Level II Screening, for Resident #63. The SW revealed	F 644	agency the facility will act as required. 2. All residents have the potential to be affected by this practice. All residents' charts were audited on 3/21/22, by Social Services Director to assess for possible significant changes within the last year. Upon audit, five residents were found to have a significant change. Social Services Director submitted these significant changes to appropriate system agency on 3/22/22. On receipt of correspondence from the appropriate agency the facility will act as required. 3. An in-service education was conducted on 3/17/22 by Quality Outcomes Coordinator (QOC) with Leadership Team. The Clinical Educator will in-service all direct care staff starting by 4/1/22 and complete in-services by 4/22/22. These in-services address the significance of referring to Social Services all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. 4. Social Services Director will screen (5) residents' charts weekly for one month (March) starting 3/28/22, then every two weeks for one month (April), and once monthly (May) for possible significant changes. The results based from verbal exit from the State Survey Team was reported to the Quality Assurance and Performance Improvement (QAPI)	

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F 644	Continued From page 6 she had no knowledge of the Change in Status Request Form submission process for an evaluation for the need of a PASRR, Level II Screening, when new major mental illness diagnoses are added to a resident's medical record, and when new psychiatric medications are ordered, by a physician, for a resident after the initial PAS had been completed for admission. An interview, on 3/2/22 at 08:54 AM, with the Director of Nursing (DON), revealed he had no knowledge of the Change in Status Request Form submission process needed to be done when new major mental illness diagnoses are added to the medical record and/or new psychiatric medications are ordered, by a physician, after the original PAS was completed for admission. An interview, on 3/2/22 at 03:00 PM, with the Administrator, revealed he was not aware of a Change in Status Form needed to be submitted for residents, with new major mental illness diagnoses and new orders for psychiatric medications, from a physician, to ensure the appropriate mental health treatment is provided to residents by the facility. The Administrator confirmed Resident #63 should have had a Change in Status Form completed to ensure all psychiatric care needed for Resident #63 was provided. Record review, of the diagnosis list, for Resident #63, revealed chronic diagnoses of Impulsive Personality Disorder, with an entry date of 10/9/19, Emotional Instability (excessive), with an entry date of 12/9/20, and Bipolar Disorder, with a an entry date of 3/3/22. Initial review of the diagnosis list did not reveal the Bipolar Disorder	F 644	Committee on 3/4/22. These rounds/results along with the written statement of deficiencies report (2567) were up for review at our QAPI follow-up meeting on 3/25/22. Recommendations from this committee were implemented as required and will be monitored until compliance is achieved and will be reviewed in the April 19, 2022 QAPI meeting and on-going.	

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F 644	Continued From page 7 diagnosis. Record review, of the Minimum Data Set (MDS) Quarterly Assessment's Active Diagnosis List, with an Assessment Reference Date (ARD) of 1/4/22, revealed Resident # 63's diagnosis of Bipolar Disorder. Record review, of the PAS Summary and Physician Certification, dated 3/4/2016, revealed the answer, no, to the questions that asked, "Person has a diagnosis of a major mental illness; Person has a recent history of a mental illness?" Record review, of the Active Orders Report, for Resident #63, revealed a physician's order for Prozac 80 MG daily, that was prescribed for Borderline Personality Disorder, with a start date of 6/18/2021, for Seroquel 100 MG daily, that was prescribed for Idealization and Emotional Instability and Bipolar Disorder, with a start date of 9/13/21, and Depakote 500 MG daily, that was prescribed for Bipolar Disorder, with a start date 11/25/21. Resident #63 was admitted to this facility on 2/5/16 with a diagnosis of Borderline Personality Disorder. Record review, of the most recent Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/4/22, for Resident #63, revealed a Brief Interview for Mental Status, (BIMS), score of 12, indicating Resident #63 is cognitively intact.	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		4/22/22

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F 656	Continued From page 8 §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 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 9 section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility policy review, and record review the facility failed to develop and implement an activity care plan for one (1) of twenty six care plans reviewed. Resident # 70 Findings Include: Review of the facility policy titled, "Care Plan Policy" revealed under "Procedure" "When developing a comprehensive care plan, the guide lines below should be followed: A comprehensive care plan should be developed for each resident using the results of a comprehensive assessment. All assessment and care plan documentation should be completed as required by both state and federal regulations". An interview on 3/1/22 at 4:20 AM with the activities staff #1 confirmed that activities help residents to maintain their quality of life and makes them feel at home and that we should have care planned for activities. An interview on 3/2/22 at 2:12 PM with the Director of Nurses (DON) confirmed the resident did not have a care plan relating to his activities, but should have had a care plan. Record review of the facility policy titled, "Resident Activities" with a revision date of October 2015 revealed under, "Policy: It is the policy of (Facility Proper Name) that activities designed to meet the interests and physical, mental, and psycho-social well-being of the resident should be provided." The policy revealed	F 656	1. Resident number 70 care plan was reviewed by Activities Coordinator and Social Services Director. An activities care plan was implemented by the Activities Coordinator to include individualized activities to meet his activities preferences. A radio placed in room by the Activities Coordinator and played with his preference of station. 3/2/2022. 2. All residents of the facility have the potential to be affected by this practice. Minimum Data Set (MDS) audited for all resident care plans to ensure comprehensive care plans were in place, on 3/21/2022. All residents are being rounded on by Social Services and Activities to assess for possible need of activities of preference and will be completed by 4/1/22. 3. An in-service education will be conducted by Clinical Educator with all direct care staff started by 4/1/22, addressing the significance of developing and implementing a comprehensive person-centered care plan for each resident, consistent with the residents' rights and the importance of offering residents' preference of activities completed by 4/22/22. 4. Social Services started screening five residents on 3/18/22 and will continue to screen five residents weekly for one month (March), then every two weeks for	

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F 656	Continued From page 10 under, "Procedure: #4-Activities should be planned for both individual and group according to the resident level of functioning. Activities should be planned for inside and outside the facility" Record review of the residents face sheet revealed an admission date of 10/11/21 with medical diagnoses that included Alzheimer's disease with late onset. Record review of the Minimum Data Set with an Assessment Reference Date of 01/11/22 revealed a Brief Interview Status of 03 indicating the resident is severely cognitively impaired.	F 656	one month (April) and once monthly (May). The results based from verbal exit from the State Survey Team was reported to the Quality Assurance and Performance Improvement (QAPI) Committee on 3/4/22. These rounds/results along with the written statement of deficiencies report (CMS-2567) were up for review at our QAPI follow-up meeting on 3/25/22 and will be reviewed during the scheduled QAPI meeting on April 19, 2022 . The Recommendations from this committee were implemented as required and will be monitored until compliance is achieved (April 22, 2022).	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		4/22/22

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F 657	Continued From page 11 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review the facility failed to revise care plans for pressure ulcers and tracheostomy care for residents #29 and #45 for two (2) of twenty six resident's care plans reviewed. Resident #29 Respiratory Care 03/02/22 9:30am observed trach care with Respiratory Therapist (RT) suctioned resident and monitored the resident oxygen level while providing care. Record review of the facility care plan for "Risk for Respiratory complications and SOB (shortness of breath)," dated "Problem onset 09/15/20," with a goal and target date of 08/16/21. Interview with the DON on 03/02/22 at 2:10 PM confirmed that the care plan for resident was expired and that the facility has quarterly care plan meetings but that he would have to ask the MDS nurse why she had not updated the resident's care plan. Interview with the MDS nurse, CLPN on 03/02/22	F 657	1. On 3/4/22 Resident number 29 care plan was reviewed and revised by Minimum Data Set (MDS) staff to reflect the resident's current care needs. On 3/4/22 Resident number 45 care plan was reviewed and revised by Minimum Data Set (MDS) staff to reflect the resident's current care needs. 2. All residents of the facility have the potential to be affected by this practice. Minimum Data Set (MDS) staff will audit active resident care plans, to review and ensure all care plans have been reviewed and updated on 03/21/2022. 3. An in-service education was conducted to the Interdisciplinary Team (IDT) by the Quality Outcomes Coordinator (QOC) on 3/17/22 and the Clinical Educator will in-service all direct care staff starting by 4/1/22 and be completed by 4/22/22. These in-services are addressing the significance of reviewing and revising care plans upon Admission, Quarterly, Annually and with changes in resident plan of care. IDT will, review, and revise resident care plan, with every Admission, Quarterly, Annual and Significant change	

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F 657	Continued From page 12 at 2:30 PM confirmed that the resident's care plan have expired and stated, "The care plans should have been updated on 08/30/21 when the resident's quarterly assessment was done but I haven't had any help and we had the care plan meeting but I never went back and updated the care plans I guess." Record review of the facility policy titled, "Care Plan Policy," dated 10/29/20, stated, "When developing a comprehensive care plan, the guidelines below should be followed: Review and revise after each comprehensive assessment." Findings include: Record review of Resident #45's care plan revealed a Pressure Ulcer Care Plan dated 06/01/21 with a goal and target date of 08/03/21 for new skin breakdown/Stage II to coccyx. An interview with the Director of Nursing (DON) on 03/02/22 at 2:10 PM confirmed that they do have monthly and quarterly care plan meetings and verified that the care plans for Resident #45 expired on 08/03/21 and should have been updated with the residents quarterly assessment review in August 2021. An interview, on 03/02/22 at 2:30 PM with the Minimum Data Set (MDS) Nurse revealed that they do conduct quarterly meetings and as needed for significant changes and stated, "Yes, the care plans should have been updated but I have been back there by myself and guess I failed to do so." The MDS Nurse confirmed that she does not bring the actual care plans to the	F 657	assessment by 4/22/22 and on-going. 4. Beginning April 1, 2022, the QOC will audit (5) a sample of care plans (1) time per week for (1) month (April) then, every other week for (1) month (May), then monthly for (1) month (June), to assure the review and revision of care plans has been completed. Beginning April 1, 2022, a new Transmission meeting will be held weekly, to review MDS completion and to validate that each care plan has been reviewed and revised. All findings will be reported to the Quality Assurance and Performance Improvement Committee (QAPI). The results based from verbal exit from the State Survey Team were reported to the Quality Assurance and Performance Improvement (QAPI) Committee on 3/4/22. These results along with the statement of deficiencies (CMS-2567) have been up for review at the QAPI Committee follow-up meeting on 3/25/22 and will be reviewed in the April 19, 2022 QAPI meeting and on-going. Recommendations from this committee were implemented as required, until compliance is achieved .	

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F 657	Continued From page 13 quarterly meetings and she should have so they could have updated them at that time. Record review revealed resident was admitted to the facility on 09/19/18 with diagnoses including Paraplegia, Spinal Stenosis, Type II Diabetes, Morbid Obesity, Osteoporosis and Pressure Ulcer. Record review of the most recent Brief Interview for Mental Status score (BIMS) on 12/21/21 revealed a BIMS Score of 15 indicating resident had full cognitive ability.	F 657		
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 on observation, staff interview, record review, and facility policy review the facility failed to provide facial hair removal for a female resident who was dependent for her activities of daily living as evidenced by visible patches of shiny white hairs on a female resident's chin for one (1) of twenty residents observed. Resident #81. Record review of the facility policy titled, " AM/PM Care" revealed under "Policy: It is the policy of (Facility Name) to promote resident cleanliness by assisting with AM/PM care as appropriate". This policy revealed under "Procedure: Residents should be shaved per preference" Findings include:	F 677	1) On 3/04/22 resident number 81 Activities of Daily Living care was given to remove facial hair and removed by the Charge Nurse. 2) All residents have the potential for the same deficient practice. All other residents rounds were completed on 3/04/22 by the Director of Nursing to ensure Activities of Daily Living (ADL) care is given to prevent ADL care deficiencies, to include facial hair removal. The Policy Title Bathing was updated 3/3/22 by the Director of Nursing, to include shaving of male/female of facial hair should be done with scheduled baths or as needed.	4/22/22

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F 677	Continued From page 14 An observation on 02/28/22 at 11:27 AM revealed Resident #81 lying in bed with a patch of shiny long white hairs on both sides of her chin. An interview, on 3/1/22 at 3:30 PM with Certified Nurse's Assistant (CNA) #1 revealed the CNAs are responsible for the residents' baths and shaving. CNA #1 revealed the bath schedule for B Hall was Monday, Wednesday and Friday (M, W, F) with odd rooms and Tuesday, Thursday and Saturday (T, TH, SA) for even rooms. CNA #1 revealed that if someone needs shaved and it is not their bath day then she will go ahead and shave them even if it is a woman. An interview, on 3/1/22 at 3:40 PM with Licensed Practical Nurse (LPN) #2 revealed baths and shaving are the responsibility of the CNAs, but if I need to help them I do. An observation and interview, on 3/1/22 at 3:50 PM with CNA #1 and LPN #2 confirmed that the resident was lying in bed with a patch of long shiny white hair on both sides of her chin. LPN #2 revealed the resident was combative at times during care and when she provides care for the resident she always carries someone with her. CNA #1 and LPN #2 confirmed the resident had hair on her chin and needed to be shaved. An interview, on 3/22/22 at 9:15 AM with Registered Nurse (RN #2) revealed that residents are supposed to be shaved with AM/PM care if they need it, even if it is not their bath day and this is the responsibility of the CNA's. An interview, on 3/3/22 at 10:40 AM with the DON revealed that an in-service is completed on hire	F 677	3) Employees will be in-serviced by the Clinical Educator starting by 4/1/22 and completed by 4/22/22 to the proper ADL care for residents to include facial hair removal. The Nursing Leadership Team started rounds the following week (3/7/22) and will round on facility residents to ensure proper ADL care weekly for one month (March), then every two weeks for one month (April), and once monthly (May). 4) The results based from verbal exit from the State Survey Team were reported to the Quality Assurance and Performance Improvement Committee (QAPI) on 3/4/22. These rounds/results along with the written statement of deficiencies report (CMS-2567) were up for review at our QAPI follow-up meeting on 3/25/22. Recommendations from this committee were implemented as required and will be monitored until compliance is achieved on 4/22/2022 and on-going.	

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F 677	Continued From page 15	F 677		

and annually regarding AM/PM care that includes shaving.

An interview, on 3/3/22 at 11:30 AM with the DON revealed that a female resident that had chin hair would probably make them feel bad and if they want shaved, they need to be.

An interview, on 3/3/22 at 11:40 AM with the Administrator revealed that staff may forget about women needing to be shaved and maybe that could be taken care of in a beauty shop visit if they can go. The Administrator revealed shaving women when they need it is something we are going to have to be sure and work on remembering.

Review of the resident's face sheet revealed the resident was admitted 2/8/16 with medical diagnoses that included: Other Reduced Mobility, Dementia with Lewy bodies, Age Related Physical Debility, Muscle weakness.

Review or the residents care plan revealed a care plan for ADL's: Unable to independently perform basic self-care due to hx fall with lt femur fx, dementia, muscle weakness, debility. Review of this care plan revealed the interventions included "Assist daily with hygiene, bathing, toileting, dressing, grooming, and feeding which indicated the responsibility of this intervention is the CNAs.

Record review of the bath roster for the resident from 2/2/22 thru 3/2/22 revealed the resident had 10 partial or complete bed bath's during this time frame.

Record review of the residents AM/PM Care Roster for 2/2/22 thru 3/2/22 revealed the

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F 677	Continued From page 16 resident had not been shaved. Record review of the residents Minimum Data Set with an Assessment Reference Date of 01/04/22 revealed under "Sectional G-Functional Status" "Personal hygiene: support provided; Two+ persons physical assist". Record review revealed that the Minimum Data Set with an Assessment Reference Date of 01/04/22 revealed a Brief Interview of Mental Status of 99 which indicated the resident was severely cognitively impaired.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review the facility failed to provide the activities to meet the resident's needs for one (1) of twenty-six residents. Resident #70. Findings Include:	F 679	1. Resident number 70 care plan was reviewed by Activities Coordinator and Social Services Director. Activities care plan was implemented by the Activities Coordinator and Social Services Director to include individualized activities to meet his activities preferences. A radio placed in room by the Activities Coordinator and played with his preference of station.	4/22/22

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F 679	Continued From page 17 Record review of the facility policy titled, "Resident Activities" with a revision date of October 2015 revealed under, "Policy: It is the policy of (Facility Name) that activities designed to meet the interests and physical, mental, and psycho-social well-being of the resident should be provided." The policy revealed under, "Procedure: #4-Activities should be planned for both individual and group according to the resident level of functioning. Activities should be planned for inside and outside the facility" An observation on 2/28/22 at 10:15 AM revealed the resident lying in bed, eyes closed, lights off and blinds closed. An interview on 02/28/22 at 10:55 AM with the resident revealed he is blind. The resident stated, "I can see shadows" When asked if the staff provides any activities for him, he stated, "They don't do a damn thing," the resident revealed they do not bring activities to my room, no music or anything. An observation on 3/1/22 at 9:00 AM revealed the resident lying in bed, lights off and blinds closed, no TV was observed on the resident's side of the room and no radio. The observation revealed the resident does not have a roommate and the TV on the other side of the room was off. An interview on 3/1/22 at 4:00 PM with Activities staff #1 revealed she has been with the facility as activities director for 3 years. The Activities staff #1 revealed that she develops a monthly calendar of activities and those that cannot attend group activities get in room visits 2-3 times per week. The Activities staff #1 revealed that her assistants usually completes the in room visits	F 679	3/2/2022. 2. All residents of the facility have the potential to be affected by this practice. Activities and Minimum Data Set (MDS) audited to ensure comprehensive care plans were in place, including activities and completed on 3/21/2022. All residents are being rounded on by Social Services Director and Activities Coordinator starting 3/18/22 to assess for possible need of activities of preferences to be completed by 4/22/22. 3. An in-service education will be conducted by Clinical Educator, starting by 4/1/22, with all direct care staff, addressing the significance of developing and implementing a comprehensive person-centered care plan for each resident, consistent with the residents' rights and the importance of offering activities of preference. This is to be completed by 4/22/22. 4. Social Services Director started screening residents on 3/18/22 and will continue to screen (5) residents weekly for one month (March), then every two weeks for one month (April) and once monthly (May). The results based from verbal exit from the State Survey Team were reported to the Quality Assurance and Performance Improvement Committee (QAPI) on 3/4/22. These results along with the written deficiency report (CMS-2567) have been up for review at our QAPI Committee follow-up meeting on 3/25/22	

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F 679	Continued From page 18 based on the resident's interest, they document it on an activities log and she reviews it quarterly. The Activities staff #1 revealed that she could not find the activity log for December 2021. An observation on 3/1/22 at 4:05 PM of the activity log revealed that the resident had not attended any group activities since admission on 10/11/21 and had six (6) in room visits. The observation revealed the residents in room visits were on 11/16/21, 11/18/21, 11/20/21, 1/21/22, 1/26/22 and 2/21/22. An interview on 3/1/22 at 4:12 PM with the Activities staff #1 revealed she stated, "We could do better by him." An observation on 3/1/22 at 4:15 PM of the resident's activity assessment on admission 10/11/2021 revealed under "current activity preference and interest survey" that the resident was interested in any type of TV, western movies, gospel, and blues music, enjoys sitting outside, van rides, music club, Bible, church services, church specials and gospel singings. An interview on 3/1/22 at 4:20 PM with the Activities staff #1 revealed that the resident needed a TV, and we could get him some music. The activities staff #1 stated, "The nurses could turn the TV on in his room to the music channel." The activities staff #1 confirmed that activities are to help residents to maintain their quality of life and makes them feel at home, but when they do not have activities they could feel depressed. An interview on 3/3/22 at 11:59 AM with the Administrator revealed that each resident should have activities based on their interest to help with	F 679	and will be reviewed at the April 19, 2022 QAPI meeting and on-going. Recommendations from this committee were implemented as required and will continue to monitor as needed until compliance is achieved.	

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F 679	Continued From page 19 their quality of life. He revealed that the resident could use a radio. Record review of the resident's face sheet revealed an admission date of 10/11/21 with medical diagnoses that included Alzheimer's disease with late onset. Record review of the residents History and Physical with a date of service 10/11/21 indicated the resident was "legally blind" under "Chief Complaints." Record review of the Minimum Data Set with an Assessment Reference Date of revealed a Brief Interview Status (BIMS) of 03 indicating the resident is severely cognitively impaired.	F 679		