STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255232	A. BUILDING _____ B. WING _____	03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE REHABILITATION AND HEALTHCARE CENTER	302 ALCORN DRIVE CORINTH, MS 38834

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey along with complaint investigations (CI) MS #18507, CI MS #18508, CI MS #18506 and CI MS #18270 at the facility from 3/21/22 to 3/24/22. During the survey, the SA determined that the facilty was not in compliance with the requirements of participation in Medicare and Medicaid. The SA did not substantiate CI MS #18507 related to abuse with no citations related to the complaint. The SA substantiated CI MS #18508 related to a nurse working with a suspended license and cited F839 related to qualified staff. The SA substantiated CI MS #18270 related to Activities of Daily Living (ADL) assistance and cited F677 and F725 was cited related to insufficient nursing staff. CI MS #18506 was substantiated and cited F677 related to ADL assistance. The SA also cited F645 related to coordination and assessment for a level 2 Pre Admission Screening Process, F646 related to identifying a significant change for Preadmission Screening and Resident Review, F656 related to development and implementation of a comprehensive care plan, F658 related to services provided to meet professional standards, F692 related to nutrition and hydration, and F812 related to food procurement. The facility had a census of 72 at the time of the survey and held a license for 95 beds.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals	F 645		4/29/22

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

Electronically Signed | 04/15/2022

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F 645	Continued From page 1 with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the	F 645		

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F 645	Continued From page 2 preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and facility policy review, the facility failed to answer questions accurately, on a Preadmission Screening (PAS) Summary and Physician Certification, (Level I PAS), to generate a request for a psychiatric assessment to be completed, for a resident with active psychiatric diagnoses, to determine the need for a Preadmission Screening and Resident Review (PASRR) Level II, for one (1) of three (3) residents reviewed for not having a PASRR Level II. Resident #9 Findings Include	F 645	Preparation and submission of this plan of correction by Cornerstone Rehabilitation and Healthcare Center, Corinth, MS does not constitute an admission of agreement by the provider of the truth or the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is submitted and prepared solely pursuant to the requirements under the federal and state laws.	

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F 645	Continued From page 3 Review of the facility policy titled, " A1500 Preadmission Screening and Resident Review (PASRR)," Adopted from Minimum Data Set (MDS) 3.0 RAI 2018 Case mix, revised on 7/18/18 and Reviewed on 8/11/20, revealed, "Health-related Quality of Life - All individuals who are admitted to a Medicaid certified nursing facility must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), "mental retardation" (MR) in federal regulation/developmental disability (DD), or related conditions regardless of the resident's method of payment." Record review of Resident #9's "Admission Record," revealed a nursing facility admission date of 6/17/19. The "Diagnosis Report" revealed the admission diagnoses of Schizophrenia Unspecified, Major Depressive Disorder Single Episode Unspecified, and Major Depressive Disorder Recurrent Unspecified, all with an onset date of 6/17/19. Record review of the "PAS SUMMARY AND PHYSICIAN CERTIFICATION," (Level I PAS), that indicated a PAS date, for submission, of 08/30/2019, completed for Resident #9, 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?" The Level I PAS also revealed the answer, "yes," to the question that asked, "Person is in need of nursing care for terminal illness." Record review of the "Order Summary Report," for a physician's admission order dated 6/17/19 (discontinued), revealed a physician's order that	F 645	1. On 3/24/2022, a significant change Level 1 (PASRR) Preadmission Screening and Resident Review was completed by Social Services for Resident # 9 related to Huntington's Disease and Schizophrenia. 2. 72 Residents had the potential to be affected. 3. Social Service Director and Business Office Manager were in serviced on 3/24/2022 by Administrator, appropriate coding of psychiatric diagnosis with significant changes on resident following PAS (Preadmission Screening)Instruction Manual from the Division of Medicaid and Maximus Inservice on Understanding the PASRR Process. On 3/25/2022, Audit completed on all current 59 residents with an active psychiatric diagnosis and psychotropic medications by Social Services, to ensure Level 2 (PAS) Preadmission Screening was completed. On 3/28/2022, Social Services and Business Office Manager completed an audit of PASRRs Level 1 that was submitted in the last ninety days, checking that diagnosis was accurately coded in relation to major mental diagnosis; no other issues were identified. 4. Effective 3/28/2022, Social Service Director and Business Office Manager conducted audits on monitoring Diagnosis or psychotropic medication on current	

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F 645	Continued From page 4 noted "I certify that post-hospital Nursing Facility/Skilled Nursing Facility (NF/SNF) services are required to be given on an in-patient basis because of the resident's need for skilled nursing or rehab care on a continuing basis for the condition(s) which required an in-patient hospital admission prior to transfer to the NF/SNF under the attending services of (physician's name)." Record review of the "Summary of Findings Report," dated 06/17/19, from an older History and Physical (H&P) dated 12/26/18 from the state mental health agency that completed the psychiatric assessment to determine the need for a Level II screening, for Resident #9, revealed "You were ruled out from further assessments through the PASRR Program: There is not sufficient evidence of Serious Mental Illness." The "Summary of Findings Report" did not contain psychiatric documentation from Resident #9's nursing facility admission that began 6/17/19. The "Summary of Findings Report" noted, "Psychiatric History: The submitted H&P dated 12/26/2018 does not document a psychiatric diagnosis as the newest admission to the facility does that is dated 06/17/19. Due to an absence of a psychiatric diagnosis on the H&P with symptoms/behaviors, (Resident #9's proper name) may benefit from an initial psychiatric evaluation for clarification of diagnosis and treatment planning." Record review of the response letter titled, "PASRR NOTICE OF EXEMPTION FROM PASRR," from the state mental health agency that completed the psychiatric assessment to determine the need for a Level II screening for Resident #9, revealed, "Based on the PASRR evaluation completed for you, you do not meet the criteria for serious mental illness or a	F 645	residents three (3) times weekly for two (2) weeks, then weekly for (3) three months. A report of audit findings will be reviewed by the Administrator and brought to Quality Assurance/Performance Improvement Committee meeting for review and recommendations monthly for four (4) months, starting on April 21,2022. The Social Services, Business Office and Administrator are responsible for compliance.	

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F 645	Continued From page 5	F 645		

developmental condition and therefore not subject to PASRR requirements at this time."

An interview on 3/23/22 at 03:59 PM, with Social Services, revealed the copy of the Level II PASRR "Summary of Findings Report" and the response letter titled, "PASRR NOTICE OF EXEMPTION FROM PASRR," received from the state mental health agency that assessed Resident #9 for need of a Level II Screening, was accepted by the nursing facility as the completed Level II assessment for Resident #9's nursing facility admission dated 6/17/19. Social Services confirmed the psychiatric diagnoses documentation that was on the "Summary of Findings Report" was not accurate and that the diagnosis was pulled from an older H&P and that it was not the psychiatric diagnoses documentation from Resident #9's nursing facility admission dated 06/17/19, and that there were incorrect answers to the questions on the "PAS SUMMARY AND PHYSICIAN CERTIFICATION," Level I PAS, that asked, "Person is in need of nursing care for terminal illness? Person has a diagnosis of a major mental illness? Person has a recent history of a mental illness?"

An interview on 3/24/22 at 1:00 PM, with the Administrator, confirmed Resident #9 was possibly at risk of not benefiting from adequate mental health treatment(s), in the nursing facility, from possible recommendations of mental health treatment(s) and/or intervention(s), that would have been based on possible recommendations made by the state mental health agency responsible for completion of the Level II Screening, due to the Level I PAS not being completed accurately for Resident #9.

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F 646	Continued From page 6	F 646		
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record reviews, facility policy review, and staff interviews, the facility failed to complete a Change in Status Request Form, for submission to the state mental health agency, to generate a request for a resident assessment to determine the need for a Preadmission Screening and Resident Review (PASRR) Level II Screening, for a resident who had two physical changes and a Change in Status Forms were not completed or submitted for 1 (one) of 3 (three) residents reviewed for not having a PASRR Level II. Resident #61 Findings Include Review of the facility policy titled, "A1500 Preadmission Screening and Resident Review (PASRR)," Adopted from Minimum Data Set (MDS) 3.0 RAI 2018 Case mix, revised on 7/18/18 and reviewed on 8/11/20, revealed, "Health-related Quality of Life - A resident with mental illness (MI) or intellectual disability/developmental disability (ID/DD), the nursing home is required to notify the State mental health authority, intellectual disability or developmental disability authority (depending on which operates in their State) in order to notify them of the resident's change in status. Section	F 646	1. On 3/28/2022, a significant change Level 2 (PASRR) Preadmission Screening and Resident Review was completed and submitted by Social Services on Resident #61. 2. 72 Residents had the potential to be affected. 3. On 3/24/2022 by the Administrator, Social Service Director, Business Office Manager, and MDS (Minimum Data Set) nurses #1 and #2 were in serviced on requirements qualifying a significant change following (PAS) Preadmission Assessment Screening Instruction Manual from the Division of Medicaid and Maximus Inservice on Understanding the PASRR Process. On 3/28/2022, the Social Services and Business Office Manager completed an audit of PASRRs Level 1 that was submitted in the last ninety days, checking that diagnosis was accurately coded who had significant changes in relation to major mental diagnosis; no other issues were identified.	4/29/22

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F 646	Continued From page 7 1919(e)(7)(B)(iii) of the Social Security Act requires the notification or referral for a significant change." Record review of the "PREADMISSION SCREENING (PAS) SUMMARY AND PHYSICIAN CERTIFICATION," with a PAS date of 04/18/2017, revealed the answer, "yes," to the questions that asked, "Person is in need of nursing care for terminal illness? Person has a diagnosis of a major mental illness?" Record review of the "Diagnosis Report," for Resident #61, revealed the psychiatric diagnoses of Schizoaffective Disorder, Unspecified and Major Depressive Disorder, Recurrent, Unspecified, both with an onset date of 3/22/17. Record review of the response letter titled, "NOTICE OF NEGATIVE LEVEL I SCREEN OUTCOME," dated 4/19/17, from the mental health authority that assessed the PAS Level I for the requirement of a PASRR Level II, revealed, "The PASRR Level I review Identification Screen, reviewed by (agency name removed), revealed that nursing facility placement is appropriate for you." Record review was attempted to reveal documentation from the state mental health authority that showed the nursing facility received a waiver that noted no PASRR Level II was needed, due to Resident #61 was terminally ill, but it was not available. Record review of a "Physician's Telephone Order," dated 3/20/20, for Resident #61, revealed, "Discharge from Hospice."	F 646	4. Effective 3/28/2022, Social Service Director and Business Office Manager will conduct audits for residents requiring a significant change and criteria for the Level 2 PAS per formed three (3) times weekly for two (2) weeks then weekly times three (3) months. The report of audit findings will be reviewed by the Administrator and brought to the Quality Assurance/Performance Improvement Committee meeting for review and recommendations monthly for four months starting April 21, 2022. The Social Services Director, Business Office Manager, and MDS are responsible for compliance.	

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F 646	Continued From page 8	F 646		

Record review, of a "Physician's Telephone Order," dated 8/16/21, revealed, "Admit to (hospice agency name removed)."

Record review was attempted of the Significant Change in Status Request Forms, for Resident #61, for review of the recommendations, from the state mental health agency, regarding the need of a psychiatric assessment to determine the need for a Preadmission Screening and Resident Review (PASRR) Level II for Resident #61, for the physical changes in status, with hospice services, that were discontinued on 03/20/20, and hospice services that resumed on 08/16/21. The Significant Change in Status Request Forms were not located.

An interview with Social Services on 03/23/22 at 3:59 PM, revealed her confirmation that she did not complete or submit the two Change in Status Request Forms for Resident #61, when the hospice services were discontinued on 03/20/20, and when the hospice services were resumed on 08/16/21.

An interview on 03/24/22 at 1:00 PM, with the Administrator confirmed Resident #61 was possibly at risk of not benefiting from adequate mental health treatment(s), in the nursing facility, from possible recommendations of mental health treatment(s) and/or intervention(s), that would have been based on possible recommendations made by the state mental health agency responsible for completion of the Level II Screening, due to the Change in Status Request Form was not submitted for Resident #61 when the hospice services were discontinued on 03/20/20. The Administrator also confirmed that the Change in Status Request

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F 646	Continued From page 9 Form should have also been submitted for the resumption of hospice services on 08/16/21 for Resident #61.	F 646		
F 656 SS=D	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 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	F 656		4/29/22

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F 656	Continued From page 10 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, staff interview, record review and facility policy review the facility failed to develop a comprehensive care plan for a resident who smokes for one (1) of four (4) residents reviewed. Resident #39. Findings Include: Record review of the facility policy titled, "Care Plans, Comprehensive Person-Centered" with a revision date of December 2016 revealed under, "Policy Statement- A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident". The policy revealed under, "Policy Interpretation and Implementation:.. #10-Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process" and "#12- The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment Minimum Data Set (MDS)". On 3/22/22 at 8:30 AM, an observation revealed Resident #39 smoking in the designated smoking	F 656	1. On 3/23/2022 and by MDS (Minimum Data Set) Nurse, Resident #39 had care plans revised to include supervised smoking. 2. Eleven (11) residents that smoke had the potential to be affected. 3. On 3/23/2022, Audits were completely by MDS and Social Services on eleven (11) current residents that smoke to ensure care plans were in place. No changes were required. 4. On 3/25/2022, Inservice was completed by Administrator with MDS and Social Service Director for person-centered Care Plan for each individual resident that smokes. Effective 3/23/2022, MDS and Social Services Director will conduct audits to ensure residents have person-center care plans in place. Audits will be conducted three (3) times weekly for two (2) weeks, then weekly for (3) three months. The report of audit findings will be reviewed by the Administrator weekly and brought to the Quality Assurance/Performance Improvement Committee for review recommendations	

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F 656	Continued From page 11 area supervised by staff. An interview on 3/23/22 at 9:40 AM, with Resident #39 confirmed that he is a smoker and has been smoking since the age of 12. Record review revealed that Resident #39 did not have a care plan for smoking and that he was readmitted to the facility on 11/15/21 with a History and Physical dated 11/15/21 that stated, "Current every day smoker." An Interview on 3/23/22 at 9:50 AM, with the Minimum Data Set (MDS) nurse confirmed that Resident #39 did not have a smoking care plan. She revealed they get their information on developing care plans from referral paperwork and nursing admission charting. The MDS nurse confirmed the hospital referral dated 11/14/21 revealed the resident is a current every day smoker. She confirmed that this information should have triggered a smoking care plan for Resident #39 and that she overlooked it. An interview on 3/23/22 at 10:20 AM, with Director of Nursing (DON) confirmed that all smokers should have a care plan. She revealed that the care plan lets the staff know about safety measures for the resident and this helps prevent the resident from getting burned or other injury. She revealed that the resident had a care plan before he went to the hospital, and it did not get replaced on readmission. The DON confirmed that he should have a care plan for smoking.	F 656	monthly for four (4) months starting on April 21, 2022. The MDS team will be responsible for monitoring and compliance.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		4/29/22

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F 658	Continued From page 12 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review, and record review the facility failed to appropriately administer medications for one (1) of two (2) residents observed for percutaneous endoscopic gastrostomy (PEG) medication administration. Resident #178. Findings include: Review of the facility policy titled, "Administering Medications through an Enteral Tube" revised November 2018, revealed the purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. Steps in the procedure: #12. Administer medication by gravity flow. An observation on 03/22/22 at 9:30 AM, revealed Registered Nurse (RN) #2 administered PEG tube medications to Resident #178. RN #2 crushed and mixed each of the five (5) medications separately in medication cups with water. RN #2 did not administer the medications by gravity flow. She pulled up each medication separately in the 60 cc syringe and pushed the medications into the enteral tube. She pushed the water flushes with a syringe between each medication and after all medications were administered. An interview on 3/24/22 at 11:10 AM, with the Director of Nursing (DON) revealed that PEG medications and anything else given via PEG	F 658	1. On 3/22/2022, Resident #178 was assessed by the (RN) Registered Supervisor for any adverse reactions due to failure to follow facilities policy and procedure for Administering Enteral Medications. No adverse reactions were found. On 3/24/2022, an Inservice was completed by RN #2 by Director of Nurses on Enteral Medication Administration following policy and procedure. 2. Eight (8) current residents with Enteral Tubes have the potential to be affected. 3. Beginning 3/24/2022, Licensed nursing staff were in serviced by Staff Development Coordinator and Assistance Director of Nurses on proper Enteral Medication Administration following policy and procedure with return demonstration. On 4/6/2022 skill evaluation with return demonstration was initiated by Consultant Pharmacist, Staff Development Coordinator and Assistant Director of Nurses on all current licensed nursing staff. All Licensed nurses will be completed with skills evaluation on 4/21/2022. 4. Effective 3/24/2022, Staff Development Coordinator and Assistant Director of Nursing will conduct audits on three (3) nurses three (3) times weekly for two (2)	

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F 658	Continued From page 13 should be by gravity flow. The DON confirmed that RN # 2 did not follow the facility policy for medication administration by PEG tube. She stated the facility has provided inservice education on PEG medication administration and used the facility policy to conduct the in-service. A telephone interview on 3/24/22 at 12:15 PM, with RN #2 revealed that she was not aware that she was not supposed to push the medications when administering by a PEG. She stated that she has been a nurse for 13 years and did not know this. She stated that she had not had any in-service education concerning PEG medication administration. A telephone interview on 3/24/22 at 2:30 PM, with the Consultant Pharmacist revealed that gravity flow is preferable. He stated that pushing the medications could force the tube out of place, cause irritation or push air into the stomach. Record review revealed the facility provided an inservice education with a topic titled, "Check Placement of PEG tube and one medication at a time with flush. Administer each medication by gravity flow." The inservice attendance sheet dated 03/07/22 revealed RN #2 was in attendance at this inservice and signed the in-service sheet.	F 658	weeks and weekly for three (3) months to ensure Enteral Medication Administration is completed following policy and procedure. The report of audit findings will be reviewed by the Administrator and bought to the Quality Assurance/Performance Improvement Committee for review and recommendations monthly for four (4) months starting on April 21, 2022. The Director of Nursing will be responsible for monitoring and compliance.	
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	F 677		4/29/22

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F 677	Continued From page 14 by: Based on observation, resident and staff interview, record review and facility policy review the facility failed to provide baths and transfers for a resident that is dependent on staff for their Activities of Daily Living (ADL) for one (1) of 19 residents observed. Resident #44. Findings include: Record review of the facility policy titled, "Activities of Daily Living (ADL), Supporting" with a revision date of "March 2018" revealed under the policy statement, " Residents who are unable to carry out activities of daily living, independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene". On 03/21/22 at 07:33 AM, an interview and observation of Resident #44 revealed she was lying in bed alert, awake and oriented with disheveled, greasy hair. She revealed she was the last on the bath schedule due to having to be lifted with a lift and that she is suppose to have a bath on Mondays but sometimes it gets pushed to Tuesday or not at all. Resident #44 revealed she can't remember the last time she got up in the wheelchair. She has told the staff that she wants to get up, but they will tell me they are short staffed, and that they do not have anyone that is certified to use the lift. We've had days where the only CNA we had were ones that were in training. An interview with Certified Nurse Assistant (CNA) #1 on 3/23/22 at 8:45 AM, revealed that bath days are Monday, Wednesday, and Fridays for even rooms and if the resident is bed bound then they get a bed bath. She has some residents that	F 677	1. On 3/23/2022, Certified Nursing Assistant and Temporary Nurse Aide immediately performed shower with personal hygiene providing out of bed activities on resident #44. On 3/28/2022 and by Staff Development Coordinator staff were educated on providing personal hygiene and Activities of Daily Living (ADL) care according to plan of care. 2. 72 Residents had the potential to be affected in receiving Activity of Daily Living Care. 3. On 03/28/22 current nursing staff were in serviced by Assistant Director of Nurses on completion with documentation of ADL care to include any refusals. On 3/28/2022 and by Medical Records, Staff Development Coordinator and Assistant Director of Nurses current residents care plans and care cards were reviewed to ensure proper bathing and ADL care were reflected. Any residents that were found with concerns were corrected immediately. 4. Beginning 4/3/2022, Audits by Medical Records, Staff Development and Assistant Director of Nurses for review of ADL documentation using Point of care three (3) times a week to ensure compliance for four (4) weeks and then weekly for three (3) months. Beginning April 21, 2022, report of findings will be submitted to the Quality Assurance Performance Improvement for review and	

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F 677	Continued From page 15 refuse a bath but Resident #44 is not one of them. CNA #1 revealed the facility has been short staffed, so some things they do get put off due to not having enough people and confirmed this resident must be lifted with a 2 person assist lift. Record review of documented baths and transfers revealed Resident #44 has had two baths and two transfers between the dates of 3/11/22 through 3/21/22 with no refusals documented. According to the bath schedule for Resident #44 she should have received five baths during that time frame. Record review of the Admission Record revealed she was admitted to the facility on 12/27/21. Record review of the medical diagnoses revealed the following diagnoses: morbid obesity, fusion of spine cervical region and muscle weakness. Record review of Resident #44's most recent accepted Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/4/22, Section C revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicates the resident has moderate cognitive impairment.	F 677	recommendation monthly for three(3)months. The (DON) Director of Nurses is responsible for monitoring and compliance.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		4/29/22

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F 692	Continued From page 16 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review the facility failed to provide hydration to a resident as evidenced by no water observed in the resident's room for two (2) of four (4) days of survey observations. Resident #6 Findings Include: Review of the facility policy titled, "Hydration Management," with no revision date revealed under "Standard" that "All residents will be provided with sufficient fluid intake to maintain proper hydration and nutritional status." An observation on 03/21/22 at 09:53 AM, revealed Resident #6 was alert and pleasantly confused. Her eyes appeared sunken, and she asked for water twice while the State Agency (SA) was interviewing her roommate. During this observation, Resident # 6's roommate, Resident #44 revealed that Resident #6 asked for water a lot. This observation revealed there was a half empty cup of water sitting on Resident #6's night	F 692	1. On 3/24/2022, Resident #6 was evaluated for signs and symptoms of dehydration by Licensed Practical Nurse due to facilities policy and procedure for Hydration Management. No signs and symptoms of dehydration were noted. On 3/24/2022 the Nursing staff were verbally in serviced on Hydration Management following policy and procedure by Director of Nursing. 2. Three (3) current residents with thickened liquids had the potential to be affected. 3. Beginning 3/24/2022, Nursing staff were verbally in serviced that residents with thickened liquids have them at bedside within reach by the Director of Nurses. On 3/28/2022, a written in-service was completed with all staff on Hydration and Nutritional Needs by Director of Nurses.	

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F 692	Continued From page 17 stand that appeared to be thickened water but was out of reach of the resident. An observation on 3/22/22 at 9:00 AM, revealed that Resident #6 did not have a glass of water in her room. An observation on 3/23/22 at 8:40 AM, revealed there was no glass of water in Resident #6's room. An interview on 3/23/22 at 8:45 AM, with Certified Nurse Assistant (CNA) #1 revealed that Resident #6 can feed herself, but she has to be assisted to sit up. CNA #1 revealed that when she works she usually feeds her. CNA #1 revealed that the staff try to leave her water on her table, because she can reach it and drink it by herself. An interview on 3/23/22 at 9:05 AM, with Licensed Practical Nurse (LPN) #2 confirmed that monitoring for dry mouth is listed on Resident #6's orders. LPN #2 confirmed that Resident #6 has to have thickened liquids and she revealed that the staff leave her a big cup of thickened liquid on her bedside table for her in the morning, lunch and afternoon. LPN #2 confirmed that the resident can reach her own water and self drink. LPN #2 revealed everyone is responsible for putting water out for the residents, but the nurses are the ones that add the thickening liquid. LPN #2 revealed she put Resident #6 a glass of water in her room this morning. LPN #2 observed and confirmed that the resident did not have any water in her room at that time and stated, "I will take care of this, I'm not sure what is going on." Record review revealed that Resident #6 was admitted to hospice 11/19/21 and all labs and	F 692	4. Beginning 3/28/2022, Medical Records, Staff Development and Assistant Director of Nurses will perform visual checks to ensure thickened liquids are available and in reach to residents requiring thickened liquids, three (3) times weekly, and weekly for three (3) months. A report of findings will be submitted to the Quality Assurance Performance Improvement for review and any recommendations monthly for three months, starting April 21, 2022. The DON (Director of Nurses) is responsible for monitoring and compliance.	

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F 692	Continued From page 18	F 692		

monthly weight monitoring were discontinued per Resident #6's physician.

An observation on 3/24/22 at 9:10 AM of Resident #6 revealed there was a glass of thickened water on her bedside table, but the table was out of reach of the resident.

An interview on 3/24/22 at 9:15 AM, with LPN #2 confirmed the water on the bedside table should always be within reach of the resident, so she can drink it when she wants to. LPN #2 revealed she would send a Hospitality Nurse Aide to push Resident #6's bedside table close enough to the resident so she can reach her water.

An interview on 3/24/22 at 9:30, with the Registered Dietician (RD) revealed that Resident #6 has no limits on the amount of fluid intake she has daily. The RD revealed that for Resident #6's most current weight of 83.2 pounds, the resident should be receiving at least 1300 milliliters (ml) of water per day.

An interview on 3/24/22 at 2:08 PM, with the Administrator, the Assistant Director of Nursing (ADON) and the Director of Nursing (DON) revealed the CNA's are not taught how to add thickener and the Administrator revealed that she does not recall CNA's ever adding thickener to liquids. The Administrator revealed that it is the responsibility of the nurses to provide Resident #6 with her thickened water.

Record review of the Admission Record revealed Resident #6 was admitted to the facility on 10/25/18 with the following diagnoses: Dysphagia, Constipation, Personal history of urinary tract infections and Senile Degeneration

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F 692	Continued From page 19 of the brain. Record review of Resident #6's "Nutrition-fluids" for the past 30 days revealed that Resident #6's daily fluid intake ranged from 360 ml to 960 ml for a 24 hours period. Record review of Resident #6's Electronic Medical Record (EMAR) and Electronic Treatment Record (ETAR) for the dates of 3/1/22 through 3/23/22 revealed there was a task titled, "Interventions Anti-Psychotic Every Shift #7 Give Fluid," and was initialed by nursing staff every day. Record review of Resident #6's physicians order dated 12/17/21 revealed the following order; Regular diet Pureed texture, Honey Thickened consistency, Double portions (every) Q meal with no straws, sippy cup with each meal, Magic Cup three times a day (tid) with meals, provide fortified foods on each meal tray daily, Ice Cream on lunch & supper trays for 60 days. Record review of Resident #6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/29/21, Section G, revealed the resident needed extensive assistance with drinking. Record review of Resident #6's MDS with an ARD of 12/29/21 revealed Resident #6's Brief Interview for Mental Status Score (BIMS) of 99, which indicates that the resident was unable to complete the interview.	F 692		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		4/29/22

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F 812	Continued From page 20 §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 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review the facility failed to properly store, label and date foods in the refrigerator and freezer for one (1) of two (2) kitchen tours. Findings include: Review of the facility policy titled, "Food Storage: Cold Foods" revised 9/2017, revealed per policy statement, All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated will be appropriately stored in accordance with guidelines of the FDA (Food and Drug Administration) food code. Procedure #5 revealed all foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination.	F 812	1. On 3/21/2022 Dietary Staff/Manager immediately discarded the unlabeled foods and juices and cleaned the bottom of the refrigerator. On 3/21/2022, Dietary Manager in serviced dietary staff on proper procedure for labeling, dating and storage of foods and juices. 2. 72 residents had the potential to be affected. 3. Beginning 3/28/2022, Dietary Manager and Administrator in serviced all dietary staff on proper procedure for labeling, dating and storage of foods and juices. 4. Effective 3/28/2022, Dietary Manager and Infection Preventionist will conduct	

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F 812	Continued From page 21 An observation of the standup freezer revealed an open, undated one fourth full bag of French fries. An observation of the refrigerator revealed nine (9) cups of fruit cocktail, 21 glasses of milk, six (6) serving bowls of lettuce, three (3) glasses of orange juice, one (1) glass of soy milk not dated or labeled and five and one half (5 1/2) boiled eggs in a bag opened, not dated and unlabeled. A large hunk of whitish colored meat wrapped in plastic wrap, unlabeled and undated. There was a ten-pound tube of ground beef on the second shelf from the bottom and a box of pork thawing on the bottom shelf of the refrigerator not in a container. Observed the bottom of the refrigerator covered with pink-red fluid. An interview on 3/21/22 at 8:35 AM, with the Dietary Manager (DM) revealed that any food in the freezer that has been opened should be labeled and all foods in the refrigerator should be labeled and dated. The DM stated that food should be labeled and dated to prevent the possibility of spoilage and causing illness. The DM stated that the meat should be in a container when thawing to prevent contaminating everything. The DM stated that the hunk of meat was turkey used the day before. She confirmed it should be labeled and dated. An interview, on 3/24/22 at 1:50 PM with the Administrator (ADM) confirmed that foods in the freezer and refrigerator should be labeled and dated. She stated that if they are not the food could be spoiled. She stated, as for the meat thawing, she could not imagine this. The ADM who also serves as the Infection Preventionist stated they have not had any outbreaks related to gastrointestinal issues.	F 812	audits on kitchen sanitation, labeling and storage three (3) times weekly and weekly thereafter. The report of the audits will be reviewed by the Administrator and brought to the Quality Assurance Performance Improvement Committee for review and recommendations monthly for four (4) months starting on April 21, 2022.	

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