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	255093	A. BUILDING _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF BILOXI	2279 ATKINSON ROAD BILOXI, MS 39531

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Survey Agency (SSA) conducted an annual recertification along with a two (2) Complaint Investigations (CI), MS #18546 and CI MS #18547 from 03/06/2022 through 03/11/2022. During the survey, the SSA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SSA cited F567, F584, F604, F657, F679, F689, F690, F758, F812 and F880 during the survey. The SSA substantiated CI MS #18546 related medication diversion and cited F609 and F610 and CI MS #18547 related to the palatability of food and cited F804. The census at the time of the survey was 133 with a bed capacity of 180. The SSA returned to the facility on 3/16/22 to investigate CI MS #18593. The SSA did not substantiate the complaint regarding abuse.	F 000		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.	F 567		4/27/22

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

Electronically Signed | 04/02/2022

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 567	Continued From page 1 (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interviews, facility policy review and record reviews, the facility failed to ensure residents had ready and reasonable access to personal funds for four (4) of 32 sampled residents. Resident #19, Resident #23, Resident #46, and Resident #77. Findings include: Record review of the facility policy Resident Trust Fund Policy and Agreement dated 10/17/2007 revealed it did not address the amount eligible to be withdrawn on the same day as a request for	F 567	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law. 1. This Facility cannot retroactively correct the deficiency. 2. All residents in the facility who have	

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F 567	Continued From page 2 funds. Resident #46 On 03/6/22 at 12:22 PM, in an interview with Resident #46, she stated she has a trust fund account, but she is not able to get her money on the weekends because the business office is closed. She stated that she must get any money she wants for the weekend by Friday. Record review of Resident #46's "Admission Record" revealed a most recent admission date of 9/24/21, with diagnosis of Type 2 Diabetes Mellitus and Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris. Record review of Resident #46 Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/23/21 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicate cognitively intact. Resident #77 On 3/8/22 at 4:08 PM, in an interview with Resident #77, he stated he cannot get money from his trust fund on the weekend because the Business Office Manager (BOM) told him he cannot get money on the weekend because she is not there. He was never told to tell the nurse to call the BOM and she would come give him money on the weekend. Record review of Resident #77 "Admission Record" for Resident #77, revealed the most recent admission date of 10/1/2019, with diagnoses including Pressure Ulcer of Left Buttock Stage 4, Pressure Ulcer of Right Buttock	F 567	funds managed by the Facility have the potential to be affected by this practice. 3. An in-service was initiated by the Business Office Manager (BOM) and Administrator with staff regarding residents assessing funds on the weekends on 04/01/22 and completed on 04/08/22. Residents were informed of procedures to access funds on the weekend by The Life Connection Coordinator (LCC) that was completed on 03/31/22. On Friday's, beginning 04/01/22, The BOM will bring an envelope with funds to be made available for the residents who have funds managed by the facility to the Central Unit to be locked in the nurse cart. The BOM will provide a list of residents who the facility manages funds for, the amount of funds available for each resident, and sheets to complete any transactions. The BOM will give this to the Nurse on the Central Unit to be kept locked in the cart for the weekend and have the nurse sign off for it. The envelope will be picked up and reviewed by the BOM following the weekend. The BOM will interview two (2) resident weekly for 4 weeks, then monthly for three (3) months to ensure the Residents are able to access funds on the weekends beginning on 04/04/22 and ending on 07/01/22. 4. The BOM will report findings to the	

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F 567	Continued From page 3 Stage 4, and Neuromuscular Dysfunction of Bladder, unspecified. Record review of Resident #77's Quarterly MDS with an ARD of 1/17/2022 revealed a BIMS of 15, which indicated he is cognitively intact. Resident #23 On 3/10/22 at 11:10 AM, in an interview with Resident #23, she stated she is unable to get money from her trust account on weekends and the BOM had told her that if she does not get her money by Friday, then she would have to wait until Monday. She had never been told that the BOM would come to the facility and give her money on a weekend. Record review of the "Admission Record" for Resident #23, revealed an original admission date of 11/22/2019 and recent date of 4/21/21 with diagnoses including Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris and Essential Hypertension. Record review of Resident #23's Quarterly MDS with an ARD of 12/7/21 revealed a BIMS score of 15, which indicated she is cognitively intact. Resident #19 On 3/10/22 at 11:20 AM, in an interview with Resident #19, she stated she was told she could not get money on the weekend because nobody is here. The BOM had told her if she needs money for the weekend, to get it on Friday. She stated she was never told to have a nurse to call the BOM to come to the facility and give them money on the weekend.	F 567	facility's Quality Assurance Performance Improvement (QAPI) committee meeting monthly to monitor compliance for a period of three (3) months to end on 07/01/22. The first Quality Assurance Performance Improvement (QAPI) meeting to review findings will be held in April 2022. If the Quality Assurance team identifies non-compliance, the interdisciplinary team will review policies and procedures and submit solutions and/or changes to make as needed and complete further in-service education.	

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F 567	Continued From page 4 Record review of the "Admission Record" for Resident #19, revealed the facility admitted her on 7/1/2019, with diagnoses including of Type 2 Diabetes Mellitus and Essential Primary Hypertension. Record review of Resident #19's Quarterly MDS with ARD of 12/3/21 revealed a BIMS score of 12, which indicated she is moderately cognitively impaired. 03/08/22 at 2:18 PM, in an interview with the Business Office Manager (BOM), she stated that if residents need money on weekends, they can call her, and she will come to the facility and give residents money out of their trust fund account. She confirmed that she has been the BOM since 2019 and she has never had to come to the facility on a weekend to give money to a resident. She stated," I guess we need to start back putting money on the cart" because they used to keep money on the cart four (4) to five (5) years ago, before she became the BOM. On 3/10/22 at 10:15 AM, in an interview with Administrator, she stated that residents should be able to get their money seven (7) days a week. On 3/10/22 at 3:05 PM, in an interview with the Administrator, she stated that the nurse would have to call and the BOM would come to the facility to give resident's their money on a weekend.	F 567		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F 584		4/27/22

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The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.

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F 584	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review and facility policy review, the facility failed to maintain and provide a safe and sanitary shower room for Shower Room #1 and Shower Room # 2 and failed to ensure two (2) resident wheelchairs were repaired for two (2) of six (6) days of survey. Findings include: Record review of the facility's policy "Maintenance Service" dated 06/2000, revealed Policy Statement, "It is the policy of this facility that maintenance service be provided to all areas of the building, grounds, and equipment. Procedure 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times; 2. The following functions are performed by maintenance, but are not limited to: a. Maintaining the building in compliance with current federal, state, and local law regulations and guidelines; b. Maintaining the building in good repair and free from hazard; ... j. Providing routinely scheduled maintenance service to all areas ..." Record review of the facility's policy, "Equipment-General use for all Residents", dated June 1, 2000, revealed, "Policy Statement It is the policy of this facility to provide routine equipment for the general use of resident population. Procedure 1. Wheelchairs, walkers, crutches, canes, etc., are maintained by this facility for the general use of all residents ..." Shower Room #1	F 584	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law. 1. Shower Room #1 is no longer in service and was shut down for repairs on 03/07/22. Shower Room # 2 the wall with the hole and loose tiles was repaired on 03/22/22. For both Resident # 57 and Resident # 39 the wheelchair arm cushions were replaced on 03/10/22. 2. All residents in the facility have the potential to be affected by this practice. 3. An in-service was initiated by the Maintenance Director and Maintenance Assistant and provided education to the staff that if they see any environmental issues or anything that maintenance needs to fix, they are to complete a work order in the maintenance work order binder that is located at each nurse station, front office, or kitchen on 03/30/22 and completed on 04/08/22. The Maintenance Director and/or Assistant will make rounds weekly to assess for environmental issues beginning 03/30/22 and ending on 07/01/22 and will document any findings	

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F 584	Continued From page 7 On 03/07/22 at 11:10 AM, an observation revealed Shower Room #1 had an extreme malodorous smell. Shower Room #1 had two shower stalls. There was a rectangle which measured fifty (50) inches by twenty-three (23) inches on the ceiling in the back left corner of the room, sagging and being black in color. There was a one inch by one inch (1x1) crack between the wall and the flooring of the back wall near the back left corner of the room. There was a rusted handrail attached to the wall behind the tub. There was a black discoloration on the tiles in the back left corner of the floor. There were black discolorations on all sides of the tiles on the floor of the two (2) shower stalls. There was dark brown to black discoloration up to the top of the third (3rd) four by four (4x4) inch ceramic tile along the grout along from floor level up all around the whirlpool tub and under the cabinet (previously described) in the back left corner of the room and around the bottom of both shower stalls where the floor and the shower stall walls met. There were tiles pulled away from the wall studs, with the studs exposed and discolored black; the tiles protrude out away from the studs approximately two (2) inches for approximately six by sixteen (6x16) inches four (4) inches from the floor next to the corner of the shower stall. There was no signage posted on the shower room door indicating the shower room was not in operating order. On 03/07/22 at 11:30 AM, an interview with Certified Nursing Assistant (CNA) #1 revealed, she has been using Shower Room #1 every day for showering residents. CNA #1 stated she had told someone about the discolored area of the ceiling and the odor of the shower room a few	F 584	and take immediate corrective action as necessary. 4. The Maintenance Director and/or Assistant will report any adverse environmental findings to the facility's Quality Assurance Performance Improvement (QAPI) committee meeting monthly to monitor compliance for a period of three (3) months to end on 07/01/22. The first Quality Assurance Performance Improvement (QAPI) meeting to review findings will be held in April 2022. If the Quality Assurance team identifies non-compliance, the interdisciplinary team will review policies and procedures and submit solutions and/or changes to make as needed and complete further in-service education.	

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months ago, but she was unable to recall who she had reported it to.

On 03/07/22 at 11:20 AM, an interview with CNA #2 confirmed Shower Room #1 was used every day except on Sundays. CNA #2 revealed Shower Room #1 had an extreme odor.

On 03/07/22 at 11:25 AM, an interview with Housekeeping #1 revealed, she believed the black colored rectangle in the back left corner of the ceiling of the Shower Room #1 hall shower room was "mildew".

On 03/07/22 at 2:00 PM, an interview and observations made with the Maintenance Supervisor, revealed he stated the black discolored area of the ceiling in the back left corner of Shower Room #1, to be microbial growth caused by water damage in the roof.

On 03/07/22 at 2:15 PM, an interview with the Administrator, she confirmed Shower Room #1 had an odor, but she was not aware the staff were utilizing the shower room for showering residents. The Administrator confirmed Shower Room #1's ceiling had the appearance of "mildew". She then closed the shower room until it received repairs.

On 03/09/22 at 2:07 PM, an interview with the Maintenance Supervisor revealed Shower Room #1 is now closed temporarily for maintenance repair.

Shower Room #2

On 03/09/22 at 9:25 AM, an interview with CNA #5 and observation of Shower Room #2, revealed

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that Resident #101 had received a shower today (03/09/22). SA noted there were tiles missing, and there was a large hole in the wall with loose tiles noted on the left side of the room. SA also noted damage around all tiles in the shower room. CNA #5 stated she did not know how long the hole has been in the shower room wall.

On 03/09/22 at 2:00 PM, during an interview with the Maintenance Supervisor, he stated he had just observed Shower Room #2 and the "shower room needs a makeover". He confirmed Shower Room #2 had water damage and there are missing tiles with a hole in the wall with loose tiles. He explained he had replaced the tiles in the shower room before and had to replace all the doorknobs in the shower rooms. There is a maintenance binder located at each nurse's station that includes work orders. He checks the binders at each station and picks up the work orders and completes them as needed. He reported he has not had any work orders for repairs needed to Shower Room #2.

Resident #57

During an observation on 03/07/22 at 11:28 AM of Resident #57's wheelchair with Licensed Practical Nurse (LPN) #4, revealed the right arm rest of the wheelchair was torn and the cushion was protruding out, with jagged irregular edges noted. Bruises and old scars were observed by the SA on Resident #57's right arm.

An interview on 03/07/22 at 11:28 AM with the Resident #57 revealed she has old bruises on her right arm that were caused from the torn, jagged edges of the wheelchair arm rest.

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Record review of the "Admission Record" revealed the facility admitted Resident #57 on 8/27/2013, with the diagnoses that included Hemiplegia and Hemiparesis following Cerebrovascular Disease, Right Hand Contracture and Diabetes Mellitus.

Record review of the Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 1/3/22 revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 12 that indicated Resident #57's cognition is moderately impaired.

Resident # 39

During an observation on 03/07/22 at 11:38 AM, of Resident #39, the SA noted resident's right arm sliding off the right arm rest of the wheelchair. Closer inspection of the wheelchair revealed the right arm rest cushion was missing and only metal was exposed. Resident #39 was wearing a long-sleeved shirt and the material of the shirt resting against the metal, instead of a cushion, caused her arm to slide and require repositioning.

Record review of Resident #39's "Admission Record", revealed the facility admitted her on 10/8/19 with the diagnoses that included Alzheimer Disease and Osteoarthritis.

Record review of the Quarterly MDS with the ARD of 12/20/21, Section C, Item C1000 revealed Resident# 39's cognitive skills were severely impaired.

During an interview on 03/07/22 at 11:28 AM, with LPN #4, she said she was not aware the left arm rest cushion was torn on Resident #57's

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wheelchair and the scars and bruises were because of the disrepair to the arm rest. LPN #4 confirmed Resident #57 did have scars and bruises to her left arm. She also said she did not know the arm rest cushion was missing on Resident #39's wheelchair and she was going to notify Maintenance that both wheelchairs needed to be repaired.

During an interview on 03/7/22 at 11:55 AM, with Certified Nursing Assistant (CNA) #4, she said she had not noticed the torn cushion on Resident #57's wheelchair left arm rest and the missing cushion Resident #39's wheelchair right arm rest. If she had noticed the issues with the wheelchairs, she would have logged it in the maintenance log or notified the nurse.

During an interview on 3/7/22 at 12:00 PM with CNA #2, she said she did not realize Resident #57 ' s wheelchair armrest was torn, and Resident #39's right arm rest was missing. CNA #2 said the protocol is to log it in the maintenance log.

During an interview on 03/11/22 at 09:12 AM with the Maintenance Director, he stated he was not aware of the cushion being torn on Resident #57's left arm rest wheelchair and the cushion missing from the right arm rest on Resident #39's wheelchair. The staff did not log it in the maintenance log.

During an interview with the Administrator on 3/11/22 at 10:00 AM, she confirmed Resident #39 and Resident #57's wheelchairs needed to be repaired. The Administrator said the staff on this unit is responsible for environmental rounds and the staff should put everything that needs to be

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F 584	Continued From page 12 repaired in the maintenance book. The maintenance log is checked daily.	F 584		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, family and staff	F 604	This plan of correction constitutes a	4/27/22

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F 604	Continued From page 13 interviews, record review and facility policy review, the facility failed to identify the use of a Geri chair with a tray as a physical restraint for one (1) of three (3) residents reviewed. Resident 101. Findings include: Record review of the facility's policy "Physical Restraints" dated August 18,2005 revealed "It is the policy of this facility that our residents have the right to be free from physical restraints not required to treat the residents symptoms. Physical restraints are not to be used for the convenience of the facility ..." A record review of Resident #101's "Admission Record" revealed the facility admitted him on 06/18/2019 with the diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side, Aphasia following other Nontraumatic Intracranial Hemorrhage, Repeated Falls, and Anxiety Disorder, unspecified. A record review of Resident #101's Comprehensive Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/23/22 revealed no Brief Interview for Mental Status (BIMS) was conducted. The Staff Assessment for Mental Status revealed the resident had memory problems and was severely cognitively impaired. A record review of the Comprehensive Care Plan for Resident #101 revealed a "Focus" of "I am at risk for falls/injuries ..." with an "Intervention/Task" that included "Up in Geri-chair with table top for positioning/poor truck control. Every shift for	F 604	written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law. 1. Resident 101 had the tabletop removed by the Director of Nursing (DON) on 03/11/22. 2. All residents in the facility have the potential to be affected by this practice. 3. An in-service was initiated by the DON and provided education to the nursing staff regarding restraints and to report any issues to the DON on 03/31/22 and completed on 04/08/22. The DON completed a 100% audit on all Geri chairs to ensure no other restraints were found; none found. The Occupation Therapist (OT) completed an evaluation on Resident 101 related to positioning on 03/14/22. The Director of Nursing (DON) will audit all geri-chairs weekly for three (3) months to ensure that no other resident gets an unnecessary restraint beginning on 03/28/22 and ending on 07/01/22 and will document any findings and take immediate corrective action as necessary. 4. The DON will report findings to the facility's Quality Assurance Performance	

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F 604	Continued From page 14 when up". A record review of Resident #101 ' s "Order Recap Report" with "Order Date: 08/01/2021 - 03/31/2022" revealed a physician order for "Up in Geri-chair with table top for positioning/poor trunk control. every shift when up" with an order date of 8/10/2021 and end date of 3/11/22. On 03/06/22 at 1:00 PM, the State Survey Agency (SSA) observed Resident #101 in a Geri chair in the hallway, using his left arm to hold on to the handrails and propel himself forward. When the resident reached a doorway in which there were no handrails, he would lean over the side of the chair and reach down to turn the actual wheel and push off the floor with his left hand to propel himself toward the next section of the handrail. The SSA observed that his right arm appeared to be contracted and there was a tray attachment to the front of the Geri chair. At 1:03 PM on 03/06/22, during an interview with LPN #3, who was coming onto the unit, he explained Resident #101 goes up and down the hall in the Geri chair all day. LPN #3 was not sure why Resident #101 was in a Geri chair with tray attached, but he thought it was because Resident #101 had numerous falls in the past. LPN #3 confirmed that Resident #101 usually gets up every day in his Geri chair with the tray attached and will move himself up and down the hallway using the handrails or by using whatever is close by to propel himself. He also reaches down and pushes off the floor to move his chair. He stated the resident eats his meals in his room and usually sits up on the side of the bed. He does not require assistance with meals and LPN #3 confirmed that Resident #101 does not have	F 604	Improvement (QAPI) committee meeting monthly to monitor compliance for a period of three (3) months to end on 07/01/22. The first Quality Assurance Performance Improvement (QAPI) meeting to review findings will be held in April 2022. If the Quality Assurance team identifies non-compliance, the interdisciplinary team will review policies and procedures and submit solutions and/or changes to make as needed and complete further in-service education. 5. Completion date as of 04/27/22.	

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issues related to leaning while sitting on the side of the bed.

On 03/06/22 at 1:25 PM, during an interview with CNA #3, she explained Resident #101 usually does not get up until after lunch, so he doesn't sit all day in the Geri chair with the tray attached. CNA #3 stated Resident #101 had been using the Geri chair and tray for a long time, but she was unable to say exactly how long. She confirmed Resident #101 propels up and down the hallway by using the handrails and reaching down and pushing off the floor. She also confirmed the resident is unable to remove the tray attachment to his chair and requires assistance from staff to remove it. He is unable to use his right arm due to a stroke. She reported he sits up on the side of the bed with no problems.

On 03/06/22 at 2:00 PM, two (2) SSA observed Resident #101 in a Geri chair with the tray attached, pulling on the handrails propelling himself in the hallway.

On 03/07/22 at 10:33 AM, during an interview Resident #101's sister, she explained the resident had been having a lot of falls and was placed in a Geri chair with a tray to prevent falls, but he cannot remove the tray by himself.

On 03/08/22 at 11:25 AM, during an interview with CNA #5, she explained she is not aware of any falls Resident #101 may have had. She confirmed he can sit on the side of his bed, without leaning, and eat his meals. Resident #101 was in a wheelchair for some time when she first started working at the facility and she was not sure why he was changed to a Geri-chair.

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At 2:20 PM on 03/08/22, SSA observed Resident #101 sitting on the side of his bed. He was not leaning and there were no trunk control problems observed.

On 03/09/22 at 8:25 AM, SSA observed Resident #101 sitting on the side of his bed, feeding himself breakfast with his left hand. Resident was not leaning and appeared to have no problems related to trunk control.

On 03/09/22 9:00 AM, during an interview with the Physical Therapist, he explained the therapy department has never worked with Resident #101 since he has been working at the facility for two and half years.

On 03/09/22 9:25 AM, during an observation and interview with CNA#5, she advised Resident #101 would be getting a shower today. He requires a full body lift for transfers, and he tolerates the transfers well and follows her directions. The SSA observed CNA #6 and CNA #5 transfer Resident #101 to the shower chair. He sat in the shower chair with no problems leaning or issues with controlling the trunk of his body. Resident #101 was transferred back to bed and then to his Geri chair with the tray attached.

On 03/10/22 at 9:30 AM, during an interview with LPN #9/Restorative Nurse, she explained Resident #101 is not on restorative services.

At 9:10 AM on 03/11/22, during an interview with the Administrator, she explained the facility is a restraint-free building, and currently do not have any residents with a restraint. She confirmed she has seen Resident #101 in the Geri chair with the tray attached. She also confirmed that if the

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F 604	Continued From page 17 resident cannot remove the tray by himself, it is a restraint. On 03/11/22 at 9:30 AM, during an interview with Director of Nursing, she explained Resident #101 has been in the Geri chair with the tray since she started in November 2021. SSA shared observations of that the Geri chair with the tray attached that restricted Resident #101 ' s ability to move freely. She confirmed that Resident #101 leans over the side of the chair because he is propelling himself, and not because of poor trunk control as the physician order states. She also confirmed Resident #101 can feed himself while sitting on the side of his bed without issues and she and she knows the resident does not have poor trunk control. The DON stated she is aware of the definition of a restraint and confirmed Resident #101 cannot remove the tray on the Geri-chair and that is considered a restraint. The resident has not received therapy or restorative services recently, and the facility did not implement effective interventions or try other least restrictive measures before using the tray attachment. She said the facility is a "no restraint facility", but admitted the tray is a restraint.	F 604		
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.	F 657		4/27/22

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F 657	Continued From page 18 (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 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 staff interviews, record reviews, and facility policy review, the facility failed to revise the care plan after a resident had a fall for one (1) of thirty (32) residents reviewed for care plans. Resident #13. Findings include: A record review of the facility's policy "Care Plans-Comprehensive" dated June 1, 2000, revealed, "Policy Statement It is the policy of this facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs ... Procedure ... 4. Care plans are revised as changes in the resident's condition dictates..."	F 657	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law. 1. The care plan for Resident # 13 was reviewed and revised on 03/11/22. 2. All residents in the facility have the potential to be affected by this practice. 3. The Director of Nursing (DON) determined the cause of the fall that occurred on 02/27/22 for Resident # 13	

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F 657	Continued From page 19 A record review of the "Progress Notes" by LPN #3 for Resident #13 with an effective date of 2/27/2022 at 2: 49 PM, revealed " ...@ 0810 (8:10 AM) Resident noted on pad by bed on floor. This nurse assessed for injuries. Small amount blood noted at nostril ...This nurse assisted resident back into bed with staff. Left eye swelling noted @ 0830 (8:30 AM). This nurse informed (Proper Name of Physician) and MD stated to monitor resident. The progress note did not address an intervention to prevent the reoccurrence of a fall. A record review of "Progress notes" by the DON for Resident #13 with an effective date of for 2/27/22 at 3:14 PM, revealed " ... Resident noted to be on the fall mat next to bed. Resident assessed with swelling noted to left eye, and small amount of blood noted in left nostril. Vitals obtained. MD notified with orders to monitor resident. Action: Not Applicable Response: Will continue to monitor." The progress note did not address an intervention to prevent the reoccurrence of fall. A record review of the facility's log "Incidents by Incident Type" revealed Resident #13 has had three (3) falls 12/02/21, 12/09/21, and 2/27/22. A record review of Resident #13's Comprehensive Care Plan revealed a care plan "Focus" for "I am at high risk for falls r/t (related to) Confusion, Gait/balance problems with a "Goal" of "The resident will not sustain serious injury through the review date". The "Interventions/Tasks" included "12/2/21 Increase rounds on 11-7 to every 1 hour to anticipate resident's needs" and "12/9/21 Place on the 6 AM get up list to be put in Geri chair". There was no intervention indicated for Resident #13's fall on	F 657	and put interventions in place to reduce the likelihood of another fall and put a note in Point Click Care (PCC) on 03/11/22. An in-service was initiated by the Administrator and provided education to the DON, Assistant Director of Nursing (ADON), and Minimum Data Set (MDS) nurses regarding completing fall interventions and care plans and was completed on 03/30/22. The MDS Nurse completed a 100 % audit on fall care plans for all residents who had sustained a fall from 01/01/21 through 04/01/22 to ensure proper interventions. This audit was completed on 04/01/22. The MDS nurses or DON will audit two (2) residents fall care plans weekly beginning on 04/01/22 and ending on 07/01/22 and will document any findings and take immediate corrective action as necessary. 4. The MDS Nurses and/or DON will report findings of the audit to the facility's Quality Assurance Performance Improvement (QAPI) committee meeting monthly to monitor compliance for a period of three (3) months to end on 07/01/22. The first Quality Assurance Performance Improvement (QAPI) meeting to review findings will be held in April 2022. If the Quality Assurance team identifies non-compliance, the interdisciplinary team will review policies and procedures and submit solutions and/or changes to make as needed and	

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F 657	Continued From page 20 02/27/22. Also, the Care Plan "Focus" was not changed from "risk for falls" although he had actual falls on 12/2/21, 12/9/21, and 2/27/22. At 12:00 PM on 03/09/22, during an interview with LPN #1, she explained the facility uses working care plans and they are updated daily after the daily clinical meeting. She stated that new interventions are added to the care plan with each fall. At 9:00 AM on 03/11/22, during an interview with the Director of Nursing (DON), she explained there was no identification of the root cause of the fall on 2/27/21 and there was no intervention put in to place that would decrease the likelihood for another fall. She stated it just was not done. She also confirmed a revision of the care plan "Focus" was not changed from "at risk" although he had actual falls. On 03/11/22 at 10:00 AM, during an interview with LPN #1, she reported she thought the new intervention for Resident #13's fall on 2/27/22 was a fall mat. However, she was unable to explain how it was a new intervention if the resident was found lying on a fall mat. She confirmed the care plan focus was not changed from "at risk" for falls even though he had actual falls documented.	F 657	complete further in-service education.	
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	F 679		4/27/22

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F 679	Continued From page 21 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 observations, interviews, record reviews, and facility policy review, the facility failed to implement an ongoing resident-centered activities program that incorporates the resident's interests on the memory care unit for three (3) of three (3) residents out of 33 residents on the unit. Residents #57, #64, and #126. Findings include: Review of the facility's policy, "Life connections Program," revised 5/4/21 revealed "The Life Connection Program is based on the comprehensive assessment (Life Story), care plan, and the preferences of each resident to support his or her choice of activities both facility sponsored groups and individual activities as well as independent activities. It is designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident encouraging both independence and interaction in the community... The Life connections Program should be designed as an ongoing resident centered activities program that incorporates the resident's interests, hobbies and cultural preferences which is fundamental to maintaining and/or improving a resident's physical, mental, and psychosocial well-being and independence. Life connections activities maybe schedule seven days a week .... The Life Connections program may consist of individual, small and large group activities based on the comprehensive	F 679	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law. 1. Resident # 57, Resident # 64, and Resident # 126 were reassessed for activity preferences by the Life Connection Coordinator on 04/01/22 and the care plans were updated to include listening to music, dancing, arts and crafts, and outside activities. Independent activities will be provided to these residents when group activities are not scheduled. 2. All residents in the facility have the potential to be affected by this practice. 3. The Administrator completed a one-on-one in-service with the Life Connection Coordinator (LCC) regarding the Facility's policy and procedure related to the Life Connection Program on 03/30/22. An in-service was initiated by the LCC to the activity staff regarding life connection	

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F 679	Continued From page 22 assessment and care plan choice of activities... Specialized activities will be available for residents with cognition impairment and/or intellectual disabilities that are meaningful, failure free and meets their interests ..." Resident #57 Record review of Resident #57's Comprehensive Care Plan revealed "Focus: I participate in activities of interest such as Bingo, whamo, arts and crafts, manicures, exercise, and social time. I enjoy drinking coffee. I also love listening and dancing to music. r/t (related to) Depression, Physical Limitations...Interventions included ...Encourage the resident's participation by inviting resident to activities of interest ..." On 3/6/22 at 2:00 PM, the SA observed Resident #57 lying in bed with head of bed elevated in her room. The room is dark and television playing. Resident #57 said she was in bed because there was nothing else to do and she was bored. Resident #57 said she has an activities calendar, but the facility does not follow the calendar. Record review of the Activities calendar revealed Rummy was scheduled for March 6, 2022, at 2:30 PM. The SA observed the day room at 2:30 PM and there were no activities in progress. Observation on 3/7/22 at 09:00 AM, of Resident #57 in her room seated in her wheelchair drinking coffee and watching television. Resident #57 said there's nothing to do except watch television or smoke. Observation on 3/7/22 at 10:00 AM, of Resident #57 seated in her wheelchair in the day room	F 679	program policy and procedures including following the activity calendars on 03/30/22 and completed on 04/08/22. To ensure the Life Connections Program meets the needs and interests of residents, the LCC will bring the months activity calendars for each unit to the Administrator to review and approve prior to posting in the facility and distributing to the residents that begin on 04/01/22 and end on 07/01/22. The Administrator or Director of Nursing (DON) will monitor to ensure that individualized and group activities are being provided to residents by monitoring two (2) residents weekly beginning on 04/01/22 and ending on 07/01/22 and will document any findings and take immediate corrective action as necessary. 4. The Administrator or Director of Nursing (DON) will report findings to the facility's Quality Assurance Performance Improvement (QAPI) committee meeting monthly to monitor compliance for a period of three (3) months to end on 07/01/22. The first Quality Assurance Performance Improvement (QAPI) meeting to review findings will be held in April 2022. If the Quality Assurance team identifies non-compliance, the interdisciplinary team will review policies and procedures and submit solutions and/or changes to make as needed and complete further in-service education.	

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area with the television on. The resident was not looking at the television.

Observation on 3/7/22 at 2:30 PM, revealed Resident #57 was seated in her wheelchair in the dayroom area with her eyes closed. The television was on with three (3) residents, including Resident #57, seated in front of the television. The Resident did not appear to be watching television and there were no activities in progress.

Review of the March 7, 2022, Activities Calendar for 2:30 PM revealed Brain Games was scheduled, however there was no activity in progress.

On 3/7/22 at 3:30 PM, during a general conversation, Resident #57 expressed she thinks they should have more activities. Resident #57 said she enjoys arts and crafts and enjoyed painting and making things when she was at home, but there's nothing to do here.

Observation and interview on 3/8/22 at 2:00 PM. revealed Resident #57 was seated in her wheelchair in the dayroom with her eyes closed. The Resident stated she doesn't do a whole lot. Resident #57 said she's not interested in what is on the television during the daytime but likes to watch television at night. She said she is not necessarily sleeping when sitting in the dayroom area, but just closes her eyes because there's nothing to do.

Record review of the Admission Record revealed Resident #57 was admitted to the facility on 8/27/2013 with diagnoses that included included Hemiplegia and Hemiparesis and Other

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Recurrent Depressive Disorder.

Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/3/22, Section F revealed It was very important to listen to music, keep up with the news, do favorite activities and go outside to get fresh air when the weather is good. Resident#57 had a Brief Interview for Mental Status (BIMS) score of 12 that indicated Resident #57's cognition is moderately impaired.

Resident #64

Record review of the Comprehensive Care Plan for Resident #64 revealed, "I am dependent on staff for meeting emotional, intellectual, physical, and social needs related to cognitive deficits, and physical limitations. I enjoy being around others, smoking, watching TV, gardening, and being outside..."Encourage ongoing family involvement...Introduce the resident to resident's with similar background, interests and encourage/facilitate interaction..."

Observation on 3/6/22 at 3:30 PM, of Resident #64 standing in the hallway
looking outside of the door. The Resident was not interacting with any
of the residents.

Observation on 3/7/22 at 9:00 AM, revealed Resident #64 walking up and down the hallway asking, "what we gonna do?"

Observation on 3/7/22 at 2:30 PM, revealed Resident #64 walking up and down the hallway.

Record review of the March 7, 2022, Activities

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Calendar revealed "Brain Games" was scheduled at 2:30 PM. There were no activities in progress.

During an observation on 3/7/22 at 3:35 PM, and interview with Resident #64's daughter-in-law revealed Resident #64 enjoys folding clothes and gardening. She wishes the facility would do some one-on-one activities to keep Resident #64 occupied because she is bored. The daughter-in-law said she has talked to the nurses several times about activities.

Observation on 3/7/22 at 3:45 PM, revealed Resident #64 was standing by the door looking out the window. Resident continues to walk up and down the hallway.

Observation on 3/8/22 09:00 AM, revealed Resident #64 walking up and down hallway as she was drinking coffee. Resident #64 was not interacting with the other residents.

Observation on 3/8/22 at 10:30 AM, of Resident #64 walking up and down the hallway mumbling to herself. Resident #64 sat down at table with SA and asked, "What are we doing today?"

Observation on 3/9/22 at 11:00 AM, of Resident #64 sitting in dayroom with her head on the table while the TV was playing.

Observation on 3/9/22 at 2:30 PM, revealed Resident #64 walking up and down the hallway. The Activity Aide took five (5) residents off the

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memory care unit to a gospel concert. Resident #64 remained on the unit walking up and down the hallway.

Record review of the Activity Calendar for March 9, 2022 revealed a gospel concert was scheduled.

During an interview on 3/9/22 at 2:30 PM, the Activity Aide revealed
Resident #64 couldn't go to the concert because she could only take so
many residents and she wanders off.

Record review of the Admission Record revealed Resident #64 was admitted to the facility on 5/28/21 with diagnoses that included Unspecified Dementia with Behavioral Disturbance and Major Depressive Disorder, Recurrent, Unspecified.

Record review of the Quarterly MDS with an ARD of 6/4/21, Section F revealed it is very important to do favorite activities. Resident#64 had a Brief Interview for Mental Status (BIMS) score of 0 that indicated Resident #64 is
severely cognitively impaired.

Resident #126

Record review of the Comprehensive Care Plan revealed to distract Resident #126 from wandering by "offering pleasant diversions, structured
activities, food, conversation, television, book, Resident prefers".

Observation on 03/06/22 at 12:42 PM, of Resident #126 walking and saying
she's bored and she wants a cigarette. The

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resident is hard to redirect
and continued to walk up and down the hallway saying she's about to lose
her mind.

During an interview on 03/06/22 01:22 PM. with Resident #126 revealed
she is bored with nothing to do and she's about to lose her mind.

An observation on 3/6/22 at 2:00 PM, revealed Resident #126 walking around in the dining room stating she was bored and asking, "what are we gonna do here?"

On 3/6/22 at 3:30 PM, an observation of Resident #126 sitting by the nurse's
station crying, stating that she is bored. The nurse stated that "we're
gonna go smoke in a little while just hold on". The resident continues to
sit at the nurses' station fidgety.

Observation on 3/7/22 at 09:30 AM, revealed Resident #126 pacing up and
down the hallway, appears very anxious and fidgety, asking the staff "when are we gonna smoke?" and "Does anybody have any music?"

Observation on 3/7/22 at 10:00 AM, revealed Resident #126 sitting in the dayroom talking to herself, saying "I wish I could go outside". Resident #126
continues to repeat "I wish I could go outside."

Observation on 3/7/22 at 2:30 PM, of Resident #126 revealed Resident
seated in a chair in the dayroom with her eyes closed. The television (TV)

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was playing.

Observation on 3/7/22 3:30 PM, of Resident #126 standing behind the entrance door watching staff and another Resident pacing up and down the hallway. The Resident asked State Agency (SA) for a battery to put in her radio.

During an interview on 3/7/22 at 3:45 PM, with Resident #126 revealed the facility does not have enough activities and she enjoys music and playing games. The Resident said the facility has a calendar, but they do not follow it. Resident #126 said, "it's boring around here," "I'm about to lose my mind."

Observation on 3/9/22 10:00 AM, of Resident #126 sitting in the hallway yelling saying, "what are we gonna do", "there's nothing to do", "I would like to listen to my music", and "does anybody have a battery that I can use for my radio?"

Observation on 3/9/22 at 11:00 AM, of Resident #126 sitting in the dining room talking to herself stating, "I'm about to lose my mind because there's nothing in this facility to do", "I want to go smoke", "They're dead people in this facility", and "I wish we could play cards."

Record review revealed the facility admitted Resident #126 on 8/27/2021, per the "Admission

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Record", with diagnoses that included Unspecified Dementia without behavioral disturbance, Major Depressive Disorder, Anxiety Disorder and Visual and Auditory Hallucinations.

Record review of the Admission MDS with an ARD of 2/8/22, Section F revealed it is very important to listen to music, do things with groups of people, do favorite activities, go outside to get fresh air when the weather is good and practice in religious services or practices. Resident#13 had a Brief Interview of Mental Status (BIMS) score of 13 that indicated Resident #126 is cognitively intact.

During an interview on 3/9/22 at 2:00 PM, with Activity Aide #3, she
confirmed she does follow the activities calendar as scheduled. She
also confirmed it is her responsibility to do activities with the residents
on two halls. She said the residents don't like to participate in the
activities and the residents do not pay attention to the television and
will nod off or close their eyes while up in the Dayroom. She does not ask residents about what activities they enjoy, and she does what is on the schedule the best way she can.

During an interview on 3/9/22 at 2:15 PM, with the Life Connections
Coordinator revealed she is responsible for creating the monthly
activities calendar and she uses the same calendar for the entire
building. She does not make a special calendar for the memory care
unit, but she will "Google" ideas for memory care

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F 679	Continued From page 30 residents because the calendar is not centered toward memory care residents. The coordinator agreed the residents do not have activities of interest. The coordinator said she is responsible for completing the resident activity assessments and care plans and she is aware of the things the residents enjoy related to activities. During an interview on 3/9/22 at 2:30 PM, with License Practical Nurse (LPN) #4, she confirmed the facility does not have enough activities to meet the needs of the resident on the memory care unit. LPN #4 stated that she sometimes buys different activities and brings them to work to help with activities. During an interview on 3/10/22 at 09:00 AM, with the Director of Nursing (DON), she confirmed the facility should do more activities with the residents on the memory care unit. During an interview on 3/10/22 at 09:10 AM, with the Administrator, she confirmed the facility needed to improve their activity program.	F 679		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		4/27/22

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F 689	Continued From page 31 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to reassess the resident fall risk, determine the root cause of a fall, address the risk factors for the fall, and implement an intervention to reduce the likelihood of another fall for (1) of three (3) residents reviewed for falls. Resident #13. Findings include: A record review of the facility's policy "Fall Risk Management" (undated), " ...residents will be assessed for fall risk potential, interventions will be implemented ...and interventions will be re-evaluated for effectiveness ... Procedures ...1. A fall risk assessment needs to be completed on admission, after each fall, and quarterly. 2. Follow guide of Fall evaluation. 3. Update the care plan with Fall risk and inventions. Interventions ... interventions should be appropriate to the resident's cognitive and physical abilities with the root cause of falls considered." On 03/06/22 at 01:45 PM, State Survey Agency (SSA) observed Resident #13 from the hallway lying in bed and calling for help. Licensed Practical Nurse (LPN) #3 who was also in the hallway stated to the SSA that he would check on the resident. On 03/06/22 at 1:50 PM, SSA walked into the resident's room. During an observation and an	F 689	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law. 1. The Director of Nursing (DON) determined the cause of the fall that occurred on 02/27/22 for Resident # 13 and put an intervention in place to reduce the likelihood of another fall and put a note in Point Click Care (PCC) on 03/11/22. Resident # 13 was reassessed for fall risk on 04/02/22. 2. All residents in the facility have the potential to be affected by this practice. 3. An in-service was initiated by the Administrator and provided education to the DON, Assistant Director of Nursing (ADON), and Minimum Data Set (MDS) nurses regarding completing fall interventions and care plans and was completed on 03/30/22. The MDS Nurse completed a 100 % audit on fall assessments and care plans for all residents who had sustained a fall from 01/01/21 through 04/01/22 to ensure	

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F 689	Continued From page 32 interview with the resident, the SSA observed Resident #13 to have fading bruises, which had discolorations of brown, green, yellow, and red to the left orbital area. Resident #13 explained he doesn't know what happened and thinks he might have fallen. At 2:00 PM on 03/06/22, during an interview with Certified Nursing Assistant (CNA) #3, she explained Resident #13 had the black eye when she returned on Monday, 2/28/22, and was told by other staff that the resident had fallen out of the bed. On 03/06/22 at 2:20 PM, during an interview with LPN #3, he explained Resident #13 had fallen last Sunday, 2/27/22, around 8:00 AM. The resident was found on his fall mat on the floor, and he sustained a raised contusion above his left eye. He notified the physician of the fall and received orders to monitor the resident. On 03/08/21 at 1:00 PM, during an interview with CNA #5, she explained on Sunday, 2/27/22, in the morning while she was making rounds, Resident #13's roommate came out of the room and told her the resident had fallen. When she went into the room, Resident #13 had fallen on the floor onto the fall pad and was lying on his left side. A record review of the facility's log "Incidents by Incident Type" revealed Resident #13 had a fall on 2/27/22. A record review of the facility's report of the fall, revealed, "#2232 Fall Date: 2/27/2022 15:03 (3:03 PM) Resident: (Proper Name of Resident #13) ...Incident Description: Resident noted on floor mat beside bed. Small amount of blood	F 689	proper interventions were in place. This audit was completed on 04/01/22. Falls are discussed during meeting daily. 4. The MDS nurses or DON will audit two (2) residents fall assessments and care plans weekly beginning on 04/01/22 and ending on 07/01/22 and will document any findings and take immediate corrective action as necessary. The DON and/or MDS nurses will report audit findings to the facility's Quality Assurance Performance Improvement (QAPI) committee meeting monthly to monitor compliance for a period of three (3) months to end on 07/01/22. The first Quality Assurance Performance Improvement (QAPI) meeting to review findings will be held in April 2022. If the Quality Assurance team identifies non-compliance, the interdisciplinary team will review policies and procedures and submit solutions and/or changes to make as needed and complete further in-service education. 5. Completion date as of 04/27/22.	

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noted in nostril @ 0800 (8:00 AM). Residents left eye swollen @ 0830 (8:30 AM). Notified (Proper Name of Physician) and he stated to monitor resident ...Injuries Observed at Time of Incident ...No injuries observed at time of incident ...Injuries Report Post Incident ...No injuries Observed Post Incident ...Witnesses ...No Witnesses found ...Agencies/People Notified ...No Notifications found." Resident's Mental Status, Level of Pain, Predisposing Environmental Factors, Predisposing Physiological Factors, and Predisposing Situation Factors were not checked which indicated the nurse did not address the risk factors for the fall. The fall report did not include an intervention that was implemented to prevent the reoccurrence of a fall.

A record review of the "CES Quarterly Evaluation Bundle (Clinical) - V-11" revealed "Section 2: Fall Risk Evaluation", was completed for Resident #13 on 2/24/22 in which his "Score" was listed as "13" and "Category" was listed as "Moderate Risk". This was the last Fall Risk Evaluation noted in the medical chart which indicated the facility did not reassess the resident fall risk after Resident #13's fall that occurred on 2/27/22.

A record review of the "Progress Notes" by LPN #3 for Resident #13 with an effective date of 2/27/2022 at 2: 49 PM, revealed " ...@ 0810 (8:10 AM) Resident noted on pad by bed on floor. This nurse assessed for injuries. Small amount blood noted at nostril ...This nurse assisted resident back into bed with staff. Left eye swelling noted @ 0830 (8:30 AM). This nurse informed (Proper Name of Physician) and MD stated to monitor resident." The progress note did not address an intervention to prevent the reoccurrence of a fall.

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F 689	Continued From page 34	F 689		

A record review of "Progress Notes" by the Director of Nursing (DON) for Resident #13 with an effective date of 2/27/22 at 3:14 PM, revealed, " ... Resident noted to be on the fall mat next to bed. Resident assessed with swelling noted to left eye, and small amount of blood noted in left nostril. Vitals obtained. MD notified with orders to monitor resident. Action: Not Applicable Response: Will continue to monitor." The progress note did not address an intervention to prevent the reoccurrence of a fall.

At 9:00 AM on 03/11/22, during an interview with the Director of Nursing (DON), she explained Resident #13 had fallen on the fall mat on 02/27/22. She reported she does not remember why or how Resident #13 fell and does not remember the root cause of the fall. The DON reviewed the fall incident report for Resident #13 dated 02/27/22 and confirmed the report is incomplete because it did not indicate the risk factors and mental status of the resident. There was no identification of the root cause of the fall and there was no intervention put in place that would decrease the likelihood for another fall. She stated it just was not done. The nurse did notify the physician and the DON regarding the fall on 02/27/22, but no investigation of the root cause of the fall or a revision of the care plan was completed. The DON also confirmed there was no fall risk assessment completed after the fall on 02/27/22.

On 03/11/22 at 10:00 AM, during an interview with LPN #1, she reported she thought the new intervention for Resident #13's fall on 2/27/22 was a fall mat. However, she was unable to explain how it was a new intervention if the resident was

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THE PILLARS OF BILOXI	2279 ATKINSON ROAD BILOXI, MS 39531

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 35 found lying on a fall mat. LPN #1 confirmed she was the person who completed the fall report for on 02/27/22, but she was not Resident #13's assigned nurse. She had only helped by entering the information into the fall report for LPN #3. She agreed the fall report was incomplete. A record review Resident #13's "Admission Record" revealed the facility admitted Resident #13 on 11/24/21 and has current diagnoses including Unqualified Visual Loss one eye, Contusion of other part of head, and Alcohol Abuse. A record review of Resident #13's Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/30/21 revealed he had Brief Interview for Mental Status (BIMS) score of 4 which indicated he is severely cognitively impaired.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 690		4/27/22

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F 690	Continued From page 36 catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review the facility failed to clean the suprapubic catheter tubing in a manner to prevent urinary tract infections for one (1) of five (5) catheter care observations. Resident #77. Findings Include: Record review of the facility 's policy, "Catheter Care Suprapubic", dated 8/25/2014, revealed " ...Steps in the Procedure ...6 ...Wash the outer part of the catheter tube with soap and water ..." On 3/9/22 at 2:30 PM, during an observation of suprapubic catheter care being performed by Licensed Practical Nurse #2 (LPN), she failed to clean the catheter tubing.	F 690	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law. 1. Resident # 77 was assessed by the Director of Nursing (DON) to rule out any signs or symptoms of infection related to suprapubic catheter care on 03/11/22. There were no signs or symptoms noted. The DON completed a one-on-one in-service with Licensed Practical Nurse (LPN) # 2 regarding catheter care on 03/11/22.	

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F 690	Continued From page 37 On 3/9/22 at 3:45 PM, in an interview with LPN #2, she stated she should have cleaned the suprapubic catheter tubing and her actions could have caused the Resident to acquire an infection. On 3/9/22 at 4:23 PM, in an interview with the Director of Nursing (DON), she confirmed the nurse should have cleaned the catheter tubing during care. She stated the tubing was still dirty after the nurse performed the catheter care, and that is an infection control issue. Record review of Resident #77's "Admission Record" revealed the facility originally admitted him on 4/19/2017 and the facility readmitted him on 10/1/2019. He had a diagnosis of Paraplegia and Neuromuscular Dysfunction of Bladder, unspecified. Record review of Resident #77's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/17/2022 revealed a Brief Mental Status (BIMS) score of 15, which indicated he is cognitively intact. Record review of the "Order Summary Report" with "Active Orders As Of: 03/09/2022" for Resident #77 revealed a physician order with an order date of 10/15/2019 to "Clean supra pubic cath (catheter) with soap and H2O (water) q (every) shift and prn as needed".	F 690	2. All residents in the facility who require catheter care have the potential to be affected by this practice. 3. An in-service was initiated by the DON to all Licensed Nurses regarding catheter care policy and procedure on 03/30/22 and is to be completed on 04/08/22. The Director of Nursing (DON) and/or Assistant Director of Nursing (ADON) will check off on all Licensed Nurses regarding catheter care beginning on 3/12/22 and is to be completed by 04/08/22 and at least annually thereafter. The Facility will maintain documentation of competencies in each employee's record. The DON and/or Assistant Director of Nursing (ADON) will observe two (2) nurses provide catheter care weekly beginning on 04/01/22 and ending on 07/01/22 and will document any findings and take immediate corrective action as necessary. 4. The DON and/or ADON will report findings to the facility's Quality Assurance Performance Improvement (QAPI) committee meeting monthly to monitor compliance for a period of three (3) months to end on 07/01/22. The first Quality Assurance Performance Improvement (QAPI) meeting to review findings will be held in April 2022. If the Quality Assurance team identifies	

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F 690	Continued From page 38	F 690	non-compliance, the interdisciplinary team will review policies and procedures and submit solutions and/or changes to make as needed and complete further in-service education.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		4/27/22

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F 758	Continued From page 39 in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and facility policy review, the facility failed to re-evaluate the use of a psychotropic medication within 14 days, including documentation of the continued need and duration of the medication for one (1) of four (4) residents reviewed for unnecessary medications. Resident #120. Findings include: A record review of the facility's policy "Psychotropic Medications" with a revision date of 02/15/2018, revealed, "Policy It is the policy of this facility to limit the use of psychotropic medications to only those that are necessary to treat specific conditions that are diagnosed, documented, and agreed on by the physician, IDT (Interdisciplinary Team), and resident or representative ... Procedure ...when any psychotropic medication is ordered the following will occur: PRN (as needed) psychotropic	F 758	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law. 1. Resident # 120 Ativan as needed was discontinued on 03/29/22. 2. All residents in the facility who take psychotropic medications have the potential to be affected by this practice. 3. The Director of Nursing (DON) initiated a 100% audit of all psychotropic medications to ensure that all as needed (PRN) psychotropic orders are re-evaluated within 14 days and obtain	

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F 758	Continued From page 40	F 758		

medications will have a 14-day period of administration time. If the prescribing MD/NP (Medical Doctor/Nurse Practitioner) orders to continue the medication beyond 14 days, the MD/NP will document rationale and the duration of the medication in the clinical record ..."

A record review of Resident #120's "Admission Record" revealed the facility re-admitted Resident #120 on 11/16/21, with diagnoses including Major Depressive Disorder, Recurrent, Severe with Psychotic Symptoms and Anxiety Disorder.

A record review of Resident #120's "Orders Summary Report" with "Active Orders as of 3/9/2022", revealed he had an active physician order, dated 12/16/2021, for "Ativan tablet 1 mg (milligram) Give 1 tablet by mouth every 08 hours as needed for agitation related Major Depressive Disorder, Recurrent, and Severe with Psychotic Symptoms". There was no specific duration indicated on the physician order.

A clinical record review for Resident #120 revealed there were no physician notations or rationale found related to the PRN Ativan order or the continued need and appropriateness of the medication. The need for medication use was not re-evaluated on 12/29/21 which was 14 days after the start date of 12/16/21 for the PRN Ativan physician's order. The physician order was active for 72 days without physician re-evaluation.

A record review of Resident #120's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 02/04/22, revealed he had a Brief Interview for Mental Status score of 09, which indicated moderate cognitive impairment. Section N revealed Resident #120

required documentation on 03/30/22 to end on 04/08/22. Any findings that are found to be out of compliance will be addressed immediately.

The DON will audit three (3) resident charts weekly for 4 weeks, then monthly for three (3) months to ensure the Facility remains in compliance with re-evaluating PRN psychotropic orders within 14 days and obtain required documentation beginning on 03/30/22 and ending on 07/01/22.

4. The DON will report findings to the facility's Quality Assurance Performance Improvement (QAPI) committee meeting monthly to monitor compliance for a period of three (3) months to end on 07/01/22. The first Quality Assurance Performance Improvement (QAPI) meeting to review findings will be held in April 2022. If the Quality Assurance team identifies non-compliance, the interdisciplinary team will review policies and procedures and submit solutions and/or changes to make as needed and complete further in-service education.

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F 758	Continued From page 41 also received two (2) doses of antianxiety medications in the seven (7) day lookback period. A record review of Resident #120's "Consultant Pharmacist Communication to Nursing" dated 2/28/22, revealed ..." non-compliance with CMS' (Centers for Medicare/Medicaid Services) rule on Psychotropic PRN orders ...Ativan PRN anxiety ordered. We are not in compliance with the CMS rule that states a PRN psychotropic order must be re-evaluated within 14 days of starting and the prescriber must document the continued need and appropriateness of the order along with a specific duration ..." On 03/11/22 at 9:00 AM, during an interview with Director of Nursing (DON), she explained when pharmacist recommendations are received monthly, she reviews them and if the recommendations are for nursing, she will respond as needed. If the recommendations are for the physician to review, she will talk to the physician or nurse practitioner for a response. The DON is responsible for ensuring the pharmacy recommendations are followed through and responses documented. She explained the physician did not want to discontinue the PRN Ativan for Resident #120, but she confirmed that no new orders had been written. The DON also verified the current active order is dated 12/16/21 and does not include a specific duration. She said she would look for physician notes and provide them to the State Agency (SA), but she did not provide any notes regarding documentation for continuing Ativan prior to survey exit.	F 758		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		4/27/22

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F 804	Continued From page 42 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review and test tray, the facility failed to ensure food was palatable were satisfactory for four (4) of 32 sampled residents. Residents #19, #23, #77 and #83. Findings Include: On 03/07/22 03:15 PM in the Resident Council meeting Residents #19, #23 and #83 stated continuously about receiving tasteless food daily. On 3/8/22 at 9:18 AM, in an interview with the Dietary Manager stated he is aware of the bland taste concerns. On 03/06/22 at 11:52 AM, in an interview with Resident # 83, she stated the food does not have any taste. It tastes like it is "right out of the can". On 03/06/22 at 12:08 PM, in an interview with Resident # 77, the resident stated the food does not taste good. On the 3/8/22 at 1:10 PM, the State Agency (SA) received a test tray for lunch. The meal consisted of country fried steak with white gravy, mashed	F 804	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law. 1. The Dietary manager met with Residents # 19, 23, 77, and 83 on 04/05/22 to discuss food preferences. 2. All residents in the facility have the potential to be affected by this practice. 3. The Dietary Manager (DM) provided education to the dietary staff on food preparation procedures to include food items prepared according to the menu, production guidelines, and recipes that meet nutritional value and palatability beginning on 04/04/22 and ending on 04/08/22. The Administrator will sample one (1) test tray weekly for 4 weeks, then monthly for	

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F 804	Continued From page 43 potatoes, baked pork chop, buttered rice, collard greens, and carrots. The collard greens, buttered rice and carrots did not have any taste, were not seasoned, and were not palatable. On 3/9/22 at 11:02 AM, the SA asked the DM about the lunch meal on 3/8/22. The DM stated that he does not like collard greens. He stated the collard greens could use more garlic powder. The DM stated that he will try to put flavor in the food without adding salt. He stated the food could have been seasoned better and the rice could have been cooked a little less. The DM confirmed the food was bland. On 3/11/22 at 11:00 AM, in an interview with the Administrator, she stated there is no policy related to palatable food. She was aware that the residents had complaints related to satisfactory food temperature and palatability of the food that is served. Record review of the "Admission Record" for Resident #19, revealed an admission date of 7/1/2019, with diagnoses including Type 2 Diabetes Mellitus and Primary Hypertension. Record review of Resident #19's Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/3/21 revealed a Brief Mental Status (BIMS) score of 12, which indicated the resident's cognition is moderately impaired. Record review of the "Admission Record" for Resident #23, revealed an admission date of 4/21/21 with diagnoses including Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris and Essential Hypertension.	F 804	three (3) months to ensure the meals being served are palatable and satisfactory beginning on 03/29/22 and ending on 07/01/22. 4. The Administrator will report findings to the facility's Quality Assurance Performance Improvement (QAPI) committee meeting monthly to monitor compliance for a period of three (3) months to end on 07/01/22. The first Quality Assurance Performance Improvement (QAPI) meeting to review findings will be held in April 2022. If the Quality Assurance team identifies non-compliance, the interdisciplinary team will review policies and procedures and submit solutions and/or changes to make as needed and complete further in-service education.	

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F 804	Continued From page 44 Record review of Resident #23's Quarterly MDS with and ARD of 12/7/21 revealed a BIMS score of 15, which indicated the resident was cognitively intact. Record review of Resident #77's "Admission Record" revealed a most recent admission date of 10/1/2019, with diagnoses including Pressure Ulcer of left buttock Stage 4, Pressure Ulcer of right buttock Stage 4 and Neuromuscular Dysfunction of Bladder, unspecified. Record review of Resident #77's Quarterly MDS with an ARD of 1/17/2022 revealed a BIMS score of 15, which indicated the resident was cognitively intact. Record review of Resident #83's "Admission Record" revealed with an admission date of 1/29/20, with diagnoses including Chronic Systolic (Congestive Heart Failure) and Diabetes Mellitus due to underlying conditions without complications. Record review of Resident #83's Annual MDS with an ARD of 1/14/2022 revealed a BIMS score of 15, which indicated the resident is cognitively intact.	F 804		
F 812 SS=E	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.	F 812		4/27/22

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F 812	Continued From page 45 (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 observations, staff interviews, record reviews, and facility policy review the facility failed to clean the thermometer between each food item during tray line temperature testing and failed to record tray line temperatures for breakfast and lunch two (2) out of six (6) days of survey. Findings Include: Record review of the facility's policy, "Food Temperature", dated 11/13/2009, revealed, "Food is served at the correct temperature. Foods of both plant and animal origin must be cooked, maintained and stored at appropriate temperatures. Procedure... 1. b. Check temperatures of food on the steam tables before it is served...3. Use a sanitized thermometer to evaluate food temperatures of all food items to be served..." On 3/8/22 at 10:45 AM, State Agency (SA) reviewed the tray line temperature check logs and found that there was no evidence that tray line temperatures were recorded for breakfast and	F 812	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law. 1. The Dietary Manager (DM) provided education to the dietary staff on recording tray line temperatures for all three (3) meals that was completed on 03/21/22. 2. All residents in the facility have the potential to be affected by this practice. 3. The Dietary Manager (DM) provided education to the dietary staff on food temperature policy and procedure including calibrating and cleaning the thermometer between each food item during tray line temperature testing beginning on 04/04/22 and ending on	

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	255093	A. BUILDING _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF BILOXI	2279 ATKINSON ROAD BILOXI, MS 39531

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F 812	Continued From page 46 lunch on 3/3/22 and 3/4/22. On 3/8/22 at 11:03 AM, in an interview with the Dietary Manager (DM) stated he should follow up with to make sure tray line temperatures are being done. He stated that that falls on him. He stated if days are missing, he should follow and talk to staff. He stated it is important that food is checked to make sure food is cooked thoroughly and hot when residents get their tray. He stated that food not cooked thoroughly could cause the residents to get sick. During an observation on 3/8/22 at 11:00 AM, tray line temperature checks were done by Dietary #2. He did not calibrate the thermometer. He first checked the country fried steak, mashed potatoes, and carrots. SA asked the DM if they cleaned the thermometer after each food item. The DM stated "yes" and handed Dietary #2 the wipes to clean the thermometer. Dietary #2 cleaned the thermometer and continued to check each item. On 3/8/22 at 4:44 PM, in an interview with Assistant Dietary Manager #3 stated that if it is not charted it is not done. She stated that the temperatures were checked and put on a clip board. She stated its very important that tray line temperatures are done daily. I apologize for that and will pay more attention next time. She stated a resident could get sick from meat not being cooked completely. She stated anything could happen. She stated the resident could get stomach virus, diarrhea, vomiting and salmonella poisoning. She stated the cook is responsible and that she should go behind them to make sure it is done. She stated she should not just take the cooks word that it is done.	F 812	04/08/22. The Dietary Manager (DM) completed a one-on-one education to dietary aide # 2 on food temperature policy and procedure including calibrating and cleaning the thermometer between each food item during tray line temperature testing completed on 04/04/22. The Administrator will audit the tray line temperature logs for completion two (2) times a week for 4 weeks, then monthly for three (3) months to ensure the that tray line temperatures are being recorded per guidelines beginning on 04/01/22 and ending on 07/01/22. 4. The Administrator will report findings to the facility's Quality Assurance Performance Improvement (QAPI) committee meeting monthly to monitor compliance for a period of three (3) months to end on 07/01/22. The first Quality Assurance Performance Improvement (QAPI) meeting to review findings will be held in April 2022. If the Quality Assurance team identifies non-compliance, the interdisciplinary team will review policies and procedures and submit solutions and/or changes to make as needed and complete further in-service education.	

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F 812	Continued From page 47	F 812		

On 3/9/22 at 10:45 AM, in an interview with the DM stated the steps for testing tray line temperatures are: wash hands, apply gloves, calibrate thermometer in ice water, temp food, clean thermometer, and test next item. The DM stated that the thermometer not being clean after testing each food is cross contamination.

On 3/9/22 at 10:50 AM, in an interview with Dietary #2/ Assistant Dietary Supervisor stated that he did not clean the thermometer after testing each food item. He stated that his actions were cross contamination. He stated he should have calibrated the thermometer before testing food temperature.

On 3/9/22 at 11:02 AM, in an interview with the DM, the SA asked the DM if he had any more tray line temperature logs for 3/2/22, 3/3/22, 3/4/22 and 3/6/22. He stated that staff was used to recording tray line temperatures on a clip board. The DM stated he has a book he places sheets in after tray line temps are done. The DM presented logs for 3/2/22 and 3/6/22. SA observed the DM look in binders for the above dates. He did not have tray line temperatures for breakfast and lunch recorded on 3/3/22 and 3/4/22. The DM confirmed they were not done on 3/3/22 and 3/4/22 for breakfast and lunch.

Record review of an in-service on 2/1/22 revealed Dietary Supervisor #2 and Dietary Assistant Manager #3 signatures on the sign in sheet. The in-service was on calibrating thermometers.

Record review of the DM #1 training revealed infection control passed 10/29/21 cleaning and sanitizing passed 11/10/21, time and temperature

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F 812	Continued From page 48 control recording passed 11/10/21, and cross contamination passed 9/15/21.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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;	F 880		4/27/22

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F 880	Continued From page 49 (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, 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 observations, interviews, and facility policy review, the facility failed ensure staff washed or sanitized hands during wound care for one (1) resident of three (3) residents reviewed with wounds. Resident #77 Findings Include:	F 880	This plan of correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements	

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F 880	Continued From page 50 Record review of the facility ' s policy, "Dressings, Dry/Clean" dated 8/25/2014, revealed " ...Steps in the Procedure ...15. Cleanse the wound with ordered cleanser ...16. Use dry gauze to pat the wound dry 17. Change gloves 18. Apply the ordered dressing ..." On 03/06/22 at 12:08 PM, in an interview with Resident # 77, he stated he had a pressure wound on his buttocks. During the wound care observation of the sacral wound, on 3/9/22 at 2:30 PM, for Resident #77, Licensed Practical Nurse #2 (LPN), did not change her soiled gloves, wash or sanitize her hands, or don clean gloves after cleaning the wound and before applying calcium alginate to the sacral wound. On 3/9/22 at 3:45 PM, in an interview with LPN #2, she confirmed that she should have changed her gloves and sanitized her hands before applying the calcium alginate to the wound. She stated she forgot to change gloves and her actions can cause the resident to get an infection. On 3/9/22 at 4:23 PM, in an interview with Director of Nursing (DON), she confirmed LPN #2 should have changed her gloves after cleaning the wound site and before applying calcium alginate and failing to perform these steps is an issue related to infection control. Record review of Resident #77 "Admission Record" for Resident #77, revealed the facility originally him on 4/19/2017 and readmitted him on 10/1/2019, with diagnoses including Paraplegia, Pressure Ulcer of left buttock Stage	F 880	established by the State and Federal law. 1. Resident # 77 was assessed by the Director of Nursing (DON) to rule out any signs or symptoms of infection related to wound care on 03/11/22. There were no signs or symptoms noted. 2. All residents in the facility have the potential to be affected by this practice. 3. The DON completed a one-on-one in-service with Licensed Practical Nurse (LPN) # 2 regarding wound care and hand washing on 03/09/22. All staff will receive CDC approved in-service training regarding Infection Control titled Clean Hands beginning on 03/30/22 and ending on 04/02/22. The Facility will maintain documentation of CDC approved in-service training titled Clean Hands in a binder located in the Administrator’s office. The Administrator will provide an attestation statement once all staff have been in-serviced on 4/2/22. The Director of Nursing (DON) or Assistant Director of Nursing (ADON) will check off on all Licensed Nurses regarding wound care and hand washing by 04/02/22 and at least annually thereafter. The Facility will maintain documentation of competencies in each employee’s record. A Root Cause Analysis was completed with the assistance of the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI)	

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F 880	Continued From page 51 4, and Pressure Ulcer of right buttock Stage 4. Record review of Resident #77 Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/17/2022 revealed a Brief Mental Status (BIMS) score of 15, which indicated he is cognitively intact. Record review of the "Order Summary Report" with "Active Orders As Of: 03/09/2022, revealed a physician ' s order with an order date of 3/9/22 to "Cleanse stage 3 to sacrum with wound cleanser, pat dry, apply calcium alginate cover with dry dressing one time a day". Record review of LPN #2 ' s "Skills Competency Dressing Change - Clean Technique" form dated 11/18/21, revealed LPN #2 ' s skills were satisfactory, including the steps to " ...Cleans(e) the wound according to physician orders ...removes gloves and performs hand hygiene applies new gloves ..." which indicated LPN received training on wound care.	F 880	Committee, and the Governing Body. The Root Cause Analysis identified a lack of consistent staff to provide required education and skill competency check offs contributed to the alleged violation. The Facility will provide ongoing education and skills competency check offs. The DON and/or Assistant Director of Nursing (ADON) will observe two (2) nurses provide wound care weekly beginning on 04/01/22 and ending on 07/01/22 and will document any findings and take immediate corrective action as necessary. 4. The DON will report findings to the facility's Quality Assurance Performance Improvement (QAPI) committee meeting monthly to monitor compliance for a period of three (3) months to end on 07/01/22. The first Quality Assurance Performance Improvement (QAPI) meeting to review findings will be held in April 2022. If the Quality Assurance team identifies non-compliance, the interdisciplinary team will review policies and procedures and submit solutions and/or changes to make as needed and complete further in-service education.	