

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/25/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255276	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/07/2022
NAME OF PROVIDER OR SUPPLIER THE MADISON HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 111 KELLY BLVD MADISON, MS 39110		
(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 Agency (SA) conducted an annual recertification along with complaint investigations (CI MS #18572 and CI MS #18185) from 4/4/2022 through 4/7/2022. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated CI MS #8572 for Quality of Care for resident not being groomed adequately and Residents Rights for resident not treated with dignity and cited F550 and F677. The SA did not substantiate CI MS #18185 for employee to resident abuse. The SA also cited F645, F646, F656, F676, F689, F693, F812, F880, F888, and F919.	F 000			
F 550 SS=D	The facility had a census of 54 and held a license for 60 beds at the time of survey. Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		5/31/22	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/29/2022

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 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, resident interviews, record review, and facility policy review, the facility failed to ensure that each resident was treated with dignity as evidenced by failure to provide verbal communication to residents during care, knock on resident's door before entering, cover a resident and close door during care, and failure to provide a privacy bag for a catheter for 4 of 24 residents observed. Resident #19, #27, #42, #43. Findings Include Resident #27	F 550	On 4/7/2022, certified nursing assistants were inserviced on promoting/maintaining resident dignity related to resident #27 and #43 including knocking before entering room introducing self, explaining care, and interacting with resident during care. On 4/7/22, Certified nursing assistants were inserviced on keeping resident covered and door closed during care including resident #19. On 4/7/22, resident #42 foley catheter bag was placed in a privacy bag. All residents have the potential to be affected by this deficient practice.		

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F 550	Continued From page 2 Review of the facility policy titled, "Promoting/Maintaining Resident Dignity" with a revision date of 1-19, revealed, " It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. " Under "Compliance Guidelines." #1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights...#5. When interacting with a resident, pay attention to the resident as an individual... #7. Explain care or procedures to the resident before initiating the activity. #8. Staff members do not talk to each other while performing a task for the resident as if the resident is not there. Conversation should be resident focused, and resident centered...#12. Maintain resident privacy." An observation on 04/04/22 at 11:59 AM, revealed Certified Nurse Assistant (CNA) #7 yelled from Resident #27's room to CNA #6 who was in the hall and asked her to come help pull the resident up in the bed. State Agency (SA) observed CNA #6 enter Resident #27's room without knocking and assisted CNA #7 to pull the resident up in the bed. Observed that neither CNA spoke to the resident while performing the task and before leaving the resident's room. An interview on 4/5/22 at 3:30 PM, with CNA #5 revealed that when staff enters a resident's room the staff member should knock on the door, speak to them, and let them know why they are entering their room. She revealed that not speaking to a resident while performing care	F 550	On 4/7/2022 the Director of Nursing began inservicing all certified nursing assistants and nurses on promoting and maintaining residents' dignity. Inservice complete on 4/28/2022. On 4/6/2022, all residents with Foley catheters were provided a fig leaf bag or privacy bag by registered nurse Supervisor and Director of Nursing began inservicing all nurses and certified nursing assistants on providing all residents with a foley catheter a privacy bag or fig leaf bag to maintain dignity. Inservice complete on 4/28/2022. The Staff Development Coordinator or Director of Nursing will conduct three (3) observations for providing dignity, privacy with foley catheter bag beginning 5/5/22 per week for the next three (3) months to ensure staff are promoting and maintaining resident dignity in accordance with our facility's practice guidelines and regulatory requirements. Observation reports will be reviewed by the Quality Assurance Committee monthly x three (3) months to assure substantial compliance has been achieved as determined by the committee beginning 5/12/22.		

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F 550	Continued From page 3 would be rude and a dignity issue. She revealed that it is all about how you approach people when providing care. An interview on 4/5/22 at 4:30 PM, with CNA #8 revealed that the staff should always knock and tell the resident their name and what you are needing to do when entering their room. An interview on 4/6/22 at 1:00 PM, with CNA #6 revealed that it could be a dignity issue if staff did not speak to a resident when they entered their room and performed a task. She revealed that staff should knock, speak, and let them know what you are needing to do. She revealed that if staff does not speak to residents, then the residents may think we are upset with them or just having a bad day. She revealed that if people do not get spoken to then they sometimes will not speak. She revealed she did not remember not speaking to Resident #27 while helping pull her up in the bed. She revealed that she feels like sometimes the staff gets in a hurry and busy trying to complete the task and forget we need to socialize with them more. An interview on 4/7/22 at 10:00 AM, with the Director of Nursing (DON) revealed that staff should knock on the resident's door and introduce themselves if the resident does not know them, explain the care that needs to be performed and just socialize with them. She revealed that she is not sure if it would be a dignity issue or just non-sociable when a staff member does not speak to a resident while performing care An interview on 4/7/22 at 12:15 AM, with Resident #27 revealed that most of the time the staff does not speak to her when they come in to do	F 550			

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F 550	Continued From page 4 something. She revealed that the staff will talk to each other in front of her, sometimes they have their blue-tooth headphones on and take personal phone calls on their cell phones. She revealed that she does not care if they want to ignore her, but it would be nice to be included. Record review of Resident #27's Admission Record revealed an admission date of 10/09/15 with medical diagnoses that include Type 2 Diabetes Mellitus and Major Depressive Disorder. Record review of the residents Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/8/22 revealed a Brief Interview of Mental Status (BIMS) of 15, which indicates the resident is cognitively intact. Resident #43 An observation on 04/04/22 at 10:40 AM, revealed Resident #43 lying in bed, awake, alert and with speech that is hard to understand due to a Cerebrovascular Disease with an onset date of 10/15/13. An observation of CNA #7 enter the resident's room with a fresh glass of water and sit it on the resident's over-bed table. Observed CNA #7 point to the two glasses of water that were already on his over-bed table without speaking. Observed the resident speak to CNA #7, pull one of the glasses toward him and pushed the other glass toward the CNA #7. CNA #7 took the glass of water that the resident pushed toward her and left the room without speaking to the resident. An observation on 4/4/22 at 12:25 PM, revealed Resident #43 lying in bed, awake and alert. Observed CNA #6 enter Resident #43's room	F 550			

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F 550	Continued From page 5 with his lunch tray, set it up on his over-bed table and leave the room without speaking to the resident. An interview on 4/6/22 at 1:00 PM, with CNA #6 revealed that it could be a dignity issue if staff did not speak to a resident when they entered their room and performed a task. She revealed that staff should knock, speak, and let them know what you are needing to do. She revealed that if staff does not speak to residents, then the residents may think we are upset with them or just having a bad day. She revealed that if people do not get spoken to then they sometimes will not speak. She revealed Resident #43 is hard to understand, but she did not remember, not speaking to him while setting his lunch tray up. She revealed that she feels like sometimes the staff get in a hurry and busy trying to complete the task and forget we need to socialize with them more. An interview on 4/7/22 at 11:58 AM, with Resident #43 revealed the staff usually does not talk to him when they come in his room. Record review of Resident #43's Admission Record revealed an initial admission date of 10/15/13 and medical diagnoses that include Hemiplegia and Hemiparesis following unspecified cerebrovascular disease affecting right dominant side. Record review of Resident #43's MDS with an ARD of 2/26/22 revealed a BIMS of 15, which indicates the resident is cognitively intact.	F 550			

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F 550	Continued From page 6 Resident #19 On 04/04/22 at 10:18 AM, an observation of Resident #19 from the hallway, revealed the door was open, and Resident #19 was lying in bed with only a brief on. No top sheet or blanket was covering him. On 04/05/22 at 08:51 AM, an observation of Resident #19 from the hallway, revealed him lying in bed exposed with only a brief on. Licensed Practical Nurse (LPN) #1 was in the room working on the resident's gastrostomy tube. The nurse exited the room leaving the door open with the resident remaining exposed with only a brief on. A Certified Nursing Assistant (CNA) entered the room closing the door behind her. An interview on 04/06/22 at 03:02 PM, with Licensed Practical Nurse (LPN) #1 revealed that Resident #19 should be covered when the door is open. LPN #1 stated that it could embarrassing to him, and it is a dignity issue. Record review of Resident #19's Admission Record revealed the resident was admitted to the facility on 10/26/20 with diagnoses of Huntington's Disease, Dysphagia, Convulsions, and a Personal History of Traumatic Brain Injury. Record review of MDS with an ARD of 01/25/2022 revealed Resident #19 with a BIMS score of 03, which indicated the resident has severe cognitive impairment. Resident #42	F 550			

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F 550	Continued From page 7 Review of facility policy titled, "Maintaining Privacy and Dignity For Residents with Foley Catheter Drainage Bags", with a revision date of 2/16 revealed, " It is the policy of this facility to provide privacy and dignity to all residents that have a urinary drainage bag in use. The procedure revealed the drainage bag will be maintained in a storage pouch to hide the contents and prevent embarrassment to the resident". On 04/04/22 at 10:57 AM, 12:05 PM, and 03:05 PM, observations revealed Resident #42's urinary catheter bag was visible to the hallway. The catheter bag was on the right-hand side of the bed facing the entrance room door without a privacy bag. Urine was noted in urinary catheter bag. On 04/05/22 at 8:50 AM, and again at 3:50 PM, observations revealed Resident #42's urinary catheter bag on the right side of the bed facing the entrance room door without a privacy bag and visible to the hallway. During an observation on 04/06/22 at 09:33 AM , Resident #42's urinary catheter bag was on the right side of the bed without a privacy bag and facing the entrance room door. The catheter was visible from the hallway. During an observation and interview, on 04/06/22 at 1:00 PM, with the Director of Nurses (DON), she confirmed the resident had a privacy bag on the back of his wheelchair, but he should have a privacy bag for his bed, and his catheter bag should not be visible to the hallway.	F 550			

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F 550	Continued From page 8 A record review of Resident #42's Admission Record revealed the resident was admitted to the facility on 02/16/2022 with diagnoses of Neuromuscular Dysfunction of the Bladder and Fracture of Left Femur. Record review of the MDS with an ARD of 02/22/2022, revealed Resident #42 had a BIMS score of 15, which indicated the resident was cognitively intact.	F 550			
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires	F 645		5/31/22	

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F 645	Continued From page 9 the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i) The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as	F 645			

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F 645	Continued From page 10 described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record reviews, and staff interviews, the facility failed to complete a Preadmission Screening (PAS) Level One (I) Assessment for a resident for one (1) of two (2) residents reviewed for Preadmission Screening and Resident Review (PASARR). Resident #34 Findings include: Review of the facility titled "PASRR" Policy," with no date on the policy, revealed "POLICY - It is the policy of this facility to do the Pre-Admission Screening process. Preadmission Screening (PAS) must be submitted within 30 days of the physician's certification. All persons requiring nursing facility level of care must have a PAS completed for admission to a Medicaid certified nursing facility." Record review revealed there was not a copy of a PAS Level I Assessment available from admission for Resident #34. An interview on 4/5/22 at 04:20 PM, with Social Services, confirmed the PAS Level I Assessment was not completed, upon admission to the nursing facility for Resident #34. Social Services revealed a PAS Level I Assessment needed to be completed for every resident that would be a long term stay in the nursing facility and confirmed a PAS Level I Assessment not being completed for Resident #34 prevents her from knowing if Resident #34 was appropriate for a nursing facility placement. Social Services also confirmed a completed PAS Level I Assessment could have possibly triggered a Preadmission Screening and	F 645	Resident #34 had a new Preadmission Screening and Resident Review (PASRR) completed by social worker on 4/28/22. All resident have the potential to be affected by this deficient practice. The social worker and Director of Nursing were inserviced by corporate compliance nurse consultant on 4/28/22 on Preadmission Screening and resident Review (PASRR) compliance. The social worker or Director of Nursing will audit new admissions daily, Monday through Friday x 6 weeks, beginning 5/2/22, and then continued by social worker to assure PASSR has been done for all admissions. Observation reports will be reviewed by the Quality Assurance Committee monthly x three (3) months to assure substantial compliance has been achieved as determined by the committee beginning 5/12/22.		

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F 645	Continued From page 11 Resident Review (PASRR) Level II Assessment that could have possibly provided additional information of whether Resident #34 was appropriate for nursing facility placement and/or possible recommendations of mental health services, to be provided to Resident #34, while living in the nursing facility. An interview on 4/6/22 at 09:50 AM, with the Administrator confirmed Resident #34 should have had a PAS Level I Assessment done upon admission, which could have possibly generated a PASRR Level II Assessment, and would have possibly provided the nursing facility with the information of whether Resident #34 was appropriate for nursing facility placement and if Resident #34 needed additional mental health services to be provided while in the nursing facility. Record review of the Admission Record revealed Resident #34 was admitted to the nursing facility on 11/25/20, with diagnoses that included Dementia in Other Diseases Classified Elsewhere with Behavioral Disturbance, Other Recurrent Depressive Disorders, and Schizophrenia Unspecified.	F 645			
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by:	F 646		5/31/22	

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F 646	Continued From page 12 Based on facility policy review, record reviews, and staff interviews, the facility failed to complete a Change in Status Form to generate a request for a Preadmission Screening and Resident Review (PASRR) Level Two (II) Assessment, for a resident with a mental status change, for one of two residents reviewed for PASRR. Resident #34. Findings include: Review of the facility titled, "PASRR" Policy," with no date on the policy, revealed "POLICY - It is the policy of this facility to do the Pre-Admission Screening process. PAS must be submitted within 30 days of the physician's certification. All persons requiring nursing facility level of care must have a PAS completed for admission to a Medicaid certified nursing facility." There was no information included in the policy regarding submissions for a change in a resident's mental health status. Record review revealed there was not a copy of a Change in Status Form available for a geriatric inpatient psychiatric facility admission on 2/19/21, for Resident #34. An interview on 4/5/22 at 04:20 PM, with Social Services, confirmed the Change in Status Form was not completed/submitted for Resident #34 to update the state mental health agency on the mental status change that resulted in a geriatric inpatient psychiatric facility admission on 2/19/21. Social Services also confirmed that the Change in Status Form should have been submitted to the state mental health agency, to allow for possible update of the PASRR Level II process, to inquire about possible additional mental health services	F 646	Resident #34 had a new Preadmission Screening and Resident Review (PASRR) completed by social worker on 4/28/22. All residents with a significant change in mental status have the potential to be affected by this deficient practice. The social worker and Director of Nursing were inserviced by the corporate compliance nurse consultant on 4/28/22 on Preadmission Screening and Resident Review (PASRR) compliance and tracking log for changes in mental status. All residents who receive geriatric inpatient psychiatric services or are given a new psychiatric diagnosis, will be screened and have a "change in status" form completed by the social worker beginning 4/28/22. The social worker or Director of Nursing will audit all hospital transfers to psychiatric inpatient services and those with a new psychiatric diagnosis in house to assure that the change in status form has been completed. This will take place weekly x 6 weeks beginning 5/2/22, then ongoing by the social worker to maintain compliance. Observation reports will be reviewed by the Quality Assurance Committee monthly beginning 5/12/22 x three (3) months to assure substantial compliance has been achieved as determine by the committee.		

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F 646	Continued From page 13 recommendations to be provided to Resident #34 in the nursing facility. An interview, on 4/6/22 at 09:50 AM, with the Administrator, confirmed that Resident #34 should have had a Change in Status Form completed/submitted to the state mental health agency to provide an update that Resident #34 had a mental status change that required a geriatric inpatient psychiatric facility admission on 12/19/22. That would have provided a possible update to the PASRR Level II process, and the facility could have possibly obtained mental health services recommendations for care for Resident #34 in the nursing facility. Record review of the Admission Record revealed Resident #34 admitted to the nursing facility on 11/25/20. Record review of the Diagnosis Information section of the Admission Record revealed diagnoses of Dementia in Other Diseases Classified Elsewhere with Behavioral Disturbance, dated 11/25/20, Other Recurrent Depressive Disorders, dated 11/25/20, and Schizophrenia Unspecified, dated 11/25/20. Record review of the Physician's Orders, dated 02/19/2021, for Resident #34, revealed, "May transfer to (name of the facility removed here) Geri-Psych for evaluation and treatment."	F 646			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		5/31/22	

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F 656	Continued From page 14 care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 656			

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F 656	Continued From page 15 Based on observation, staff interviews, record review and facility policy review, the facility failed to develop and implement comprehensive care plans for three (3) of 24 residents reviewed for care plans, Resident #19, Resident #20 and Resident #42. Findings include: Resident #19 A record review of the facility Policy, Titled, "Care Plans-Comprehensive" with a revision date of 10/2016, revealed, "An individualized (person centered) comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident." Under Policy interpretation and implementation. #3. Each resident's comprehensive care plan is designed to: (f) Identify the professional services that are responsible for each element of care. A record review of Resident #19's Comprehensive Care Plan initiated 10/26/2020 and reviewed on 02/04/2022 revealed, "Focus The resident has an ADL (Activities of Daily Living) Self Care Performance Deficit r/t (related to) Huntington disease ...Interventions ... BATHING: Check nail length and trim and clean on bath day and as necessary" Observations on 04/04/22 at 10:44 AM and at 12:11 PM, revealed Resident #19 lying in bed, hair matted with white fuzz in it. Fingernails are long and jagged approximately one-half (1/2) inch past the tip of the fingers on each hand.	F 656	Resident #19 fingernails were cut and hair was brushed to remove fuzz on 4/6/22 by registered nurse supervisor. Placed resident #20 white board, dry erase marker, and eraser in reach on 4/6/22 by social services director. Resident #42 fingernails were cut and nail care was added to care plan on 4/6/22 by Minimum Data Set (MDS) nurse. Resident #42 was provided a privacy bag for foley catheter on 4/6/22 by registered nurse supervisor. All residents have the potential to be affected by this deficient practice. Director of Nursing inserviced the Minimum Data Set (MDS) nurse, certified nursing assistants and nurses beginning on 4/7/22 and completed 4/28/22 on "Develop/Implement Comprehensive Care plans including nail care, shampooing hair, communication, and foley catheters. The Minimum Data Set (MDS) nurse or Director of Nursing will conduct three (3) care plan reviews per week for six (6) weeks beginning 5/2/22 to ensure comprehensive care plans are developed/implemented for residents. Observation Reports will be reviewed by the Quality Assurance Committee monthly x three (3) months beginning 5/12/22 to assure substantial compliance has been achieved as determined by the committee.		

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F 656	Continued From page 16 An observation on 04/05/22 at 09:14 AM, revealed Resident #19 lying in bed, hair matted with white fuzz in it. Nails are long and jagged approximately 1/2 inch past the tip of the fingers on each hand. An observation on 04/06/22 at 11:12 AM, Resident #19 was lying in bed. Hair matted with white fuzz. Fingernails were long and jagged approximately 1/2 inch long past the tips of fingers on both hands. An interview and observation on 04/06/22 at 01:05 PM, with the Director of Nurses (DON) confirmed the resident's nails are long and need to be trimmed. The DON removed a piece of white material from the resident's hair and stated that it looks like fuzz. The DON confirmed this should not be in his hair. During an interview on 04/07/22 at 05:05 PM, the Director of Nurses (DON) confirmed Resident #19's care plan was not followed for hair and nail care. Resident #20 A record review of Resident #20's comprehensive care plan initiated 10/29/2020 and last care plan review completed 02/04/2022 revealed, "Focus The resident has a communication problem r/t (related to) being legally deaf and mute ...Interventions ... Ensure availability and functioning of adaptive communication equipment message board, telephone amplifier, computer, etc. ...Monitor effectiveness of communication strategies and assistive devices Provide translator as necessary to communicate with the	F 656			

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F 656	Continued From page 17 resident ...Use communication techniques which enhance interaction: Allow adequate time to respond. Repeat as necessary, clarification from the resident, to ensure understanding, Face when speaking and make eye contact, Ask yes/no questions if appropriate, Use simple, brief, consistent words/cues,, Use alternative communication tools as needed, such as communication book/board, writing pad, gestures, signs,, and pictures" An observation on 04/04/22 at 10:15 AM, Resident # 20 could be heard loudly down the hall. Upon entering Resident #20's room the resident had a splint in her left hand and continued to make verbal sounds and shake the splint. Resident #20 tried to communicate via sign language in a frustrated manner. Certified Nurse Assistant (CNA) #1 entered the room and said that she doesn't like the splint, and gets upset when she has to wear it. An observation on 04/04/22 at 03:00 PM, revealed Resident #20 sitting in a Geri-chair in her room. She was attempting to communicate via sign language and hand gestures. An interview on 04/06/22 at 02:55 PM, with Licensed Practical Nurse (LPN) #1 confirmed it's very difficult to understand what she wants, but I think the aides can understand her. The nurse confirmed there wasn't anything in the room to aide in communication with the resident. An interview on 04/06/22 at 03:00 PM , with the Social Worker (SW), revealed Resident #20 is deaf and mute. The social worker stated, the resident has a communication board, a whiteboard, and a phone in her room that is used	F 656			

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F 656	Continued From page 18 for communication. An observation and interview on 04/06/22 at 03:10 PM, in Resident #20's room with the Social Worker (SW), and Director of Nurses (DON) confirmed there was no communication board or white board visible in the room. The DON began looking in the resident's chest of drawers for the communication board and found it in the second drawer under a brief. The SW found the whiteboard on the top shelf of the residents closet. The SW and DON confirmed that there was not a marker in the room to write on the communication board. The SW picked up a remote for the Sorenson device which was located on top of the chest of drawers. The SW revealed the resident a light on top of the machine will alert the resident when a call is coming through. The social worker (SW) picked up the power cord to the Sorenson device and stated that it was disconnected. The SW revealed she had connected the device two (2) weeks ago but it is disconnected now. The DON and SW confirmed that the staff would not be able to communicate with her with the whiteboard in the top of the closet and the communication board in the drawer and the device not plugged in. The SW revealed that she had done an inservice at the old facility, but had not done one since being in the new facility. On 04/07/22 at 05:06 PM, in an interview with the Director of Nurses (DON) confirmed that Resident #20's communication careplan was not being followed. Resident #42 An observation on 04/04/22 at 10:20 AM and at	F 656			

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F 656	Continued From page 19 3:10 PM, revealed Resident #42's fingernails long and approximately 1/2 inch past the tips of fingers on both hands. An observation on 04/05/22 at 08:50 AM, revealed fingernails untrimmed. An observation and interview on 04/05/22 at 03:50 PM, revealed Resident #42's fingernails untrimmed. The resident stated that he doesn't know the last time his fingernails were trimmed. An observation on 04/06/22 at 09:15 AM and again at 12:50 PM, revealed resident's fingernails continued to be untrimmed and approximately 1/2 inch past the tips of fingers on both hands. An observation and interview on 04/06/22 at 01:00 PM, with the Director of Nurses (DON) confirmed his nails were long and need to be trimmed. The DON stated, "I will make sure this gets done. " An interview on 04/07/22 at 01:16 PM, with the Minimum Data Set (MDS) nurse, revealed that she was responsible for completing the care plan. She stated that there was a box to check for nail care and that she failed to check it. An interview on 04/07/22 at 05:21 PM, with the DON confirmed that Resident #42 did not have a nail care plan and that he should have had one. A record review of Resident #42 comprehensive care plan initiated 02/17/2022 revealed, Focus The resident has indwelling Catheter ...Interventions/Tasks Position catheter bag and tubing below the level of the bladder and away from entrance room door.	F 656			

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F 656	Continued From page 20 Observations on 04/04/22 at 10:57 AM, 12:05 PM, and 03:05 PM, revealed Resident #42's urinary catheter bag was visible to the hallway. The catheter bag was on the right-hand side of the bed facing the entrance room door without a privacy bag. Urine was noted in the urinary catheter bag. Observations on 04/05/22 at 8:50 AM, and again at 3:50 PM, revealed Resident #42's urinary catheter bag on the right side of the bed facing the entrance room door without a privacy bag and visible to the hallway. During an observation on 04/06/22 at 09:33 AM , Resident #42's urinary catheter bag was on the right side of the bed without a privacy bag and facing the entrance to the room, visible from the hallway. During an observation and interview on 04/06/22 at 1:00 PM with the Director of Nurses (DON), She confirmed the care plan was not followed. Resident had a privacy bag on the back of his wheelchair, but he should have a privacy bag for his bed, and his catheter bag should not be visible to the hallway.	F 656			
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate	F 676		5/31/22	

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F 676	Continued From page 21 that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to utilize assistive devices available to maintain resident's communication abilities for three of four survey days. Resident #20. Findings include:	F 676	Social worker placed resident #20 white board, dry erase marker, and eraser within reach on 4/6/22. Social worker placed a ticket to to repair communication box on 4/7/22. All residents have the potential to be affected by this deficient practice.		

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F 676	Continued From page 22 Review of the facilities policy, "Communications Within and External to the Facility" updated 2/21/21 reveals the facility will protect and facilitate the resident's right to communicate with individuals and entities within and external to the facility. An observation on 04/04/22 at 10:15 AM, Resident #20 could be heard loudly down the hall. Upon entering Resident #20's room the resident had a splint in her left hand and continued to make verbal sounds and shake the splint. Resident #20 tried to communicate via sign language in a frustrated manner. Certified Nurse Assistant (CNA) #1 entered the room and said that she doesn't like the splint, and gets upset when she has to wear it. An observation on 04/04/22 at 03:00 PM, revealed Resident #20 sitting in a Geri-chair in her room. She was attempting to communicate via sign language and hand gestures. An interview on 04/06/22 at 02:55 PM, with Licensed Practical Nurse (LPN) #1 confirmed it's very difficult to understand what she wants, but I think the aides can understand her. The nurse confirmed there wasn't anything in the room to aide in communication with the resident. An interview on 04/06/22 at 03:00 PM, with the Social Worker (SW), revealed Resident #20 is deaf and mute. The social worker stated, the resident has a communication board, a whiteboard, and a phone in her room that is used for communication. An observation and interview on 04/06/22 at 03:10 PM, in Resident #20's room with the SW	F 676	Director of Nursing inserviced all certified nursing assistants and nurses beginning on 4/6/22 and completed on 4/28/22 on "communication within and external to the facility". The Social worker or Director of Nursing will conduct three (3) reviews per week x three (3) months beginning 5/2/22 of residents with a communication deficit to ensure communication aides are available and working properly. Observation reports will be reviewed by the Quality Assurance committee monthly beginning 5/12/22 x three (3) months to assure substantial compliance has been achieved as determined by the committee.		

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F 676	Continued From page 23 and Director of Nurses (DON) confirmed there was no communication board or white board visible in the room. The DON began looking in the resident's chest of drawers for the communication board and found it in the second drawer under a brief. The SW found the whiteboard on the top shelf of the residents closet. The SW and DON confirmed that there was not a marker in the room to write on the communication board. The SW picked up a remote for the communication device for the deaf, which was located on top of the chest of drawers. The SW revealed to the resident there is a light on top of the machine that will alert the resident when a call is coming through. The social worker SW picked up the power cord to the communication device and stated that it was disconnected. The SW revealed she had connected the device two (2) weeks ago but it is disconnected now. The DON and SW confirmed that the staff would not be able to communicate with her with the whiteboard in the top of the closet and the communication board in the drawer and the device not plugged in. The SW revealed that she had done an inservice at the old facility, but had not done one since being in the new facility. An interview on 04/06/22 at 03:35 PM, with Certified Nurse Assistant (CNA) #2, revealed the Resident is very hard to understand, she gestures and nods. CNA #2 stated that Resident #20 used to write on a board, but she can't anymore. CNA #2 stated that she didn't even know if she had a board anymore. An interview on 04/06/22 03:36 PM, with Certified Nurse Assistant (CNA) #3 stated that Resident #20 is very hard to understand, but she can point	F 676			

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F 676	Continued From page 24 some. When the SA questioned her about devices for communication, she stated she was not sure where it was. An interview on 04/06/22 at 03:37 PM, with Certified Nurse Assistant (CNA) #4 revealed that the resident is hard to understand. CNA #4 stated that she did not work with this resident much. A record review of in-service training, by Social Worker (SW) dated 11/10/2020, Title and detailed content of inservice: Information on how to use the communications device (with attached phone number), information on communicating with deaf and mute persons, Resident in 15B is deaf and mute. She has a communication book and board to make her needs known. Staff can use communication board to communicate with resident. White board is available to write on in order to communicate. A record review of Resident #20's Admission Record revealed she was admitted to the facility on 10/28/2020, with diagnoses including Deaf nonspeaking not elsewhere classified, Cognitive communication deficit, Anxiety disorder, Restlessness and Agitation. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/27/2022 revealed a Brief Interview for Mental Status (BIMS) score of 01 indicating Resident # 20 had severe cognitive impairment.	F 676			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		5/31/22	

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F 677	Continued From page 25 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, facility policy review and record review, the facility failed to provide personal hygiene as evidenced by long and jagged nails and flecks of white material in resident's hair for 2 of 24 residents observed. Residents #42 and Resident #19. Findings include: A record review of the facility policy "Fingernails/Toenails, Care of", undated, revealed, "Policy The purposes of this policy is to clean the nail bed, to keep nails trimmed, and to prevent infections ...Procedure ...6. Nail care includes daily cleaning and regular trimming ... 8. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin... " A record review of the facility policy titled "Shampooing Hair Policy", undated, revealed, Policy ... The purpose of this policy is to clean and maintain the resident's with healthy hair and scalp. Procedure 1. Use a comb to remove any tangles before washing the hair." Two observations on 04/04/22 at 10:44 AM and at 12:11 PM, of Resident #19 lying in his bed. His hair was matted with white fuzz in it. Nails are long and jagged approximately one -half (1/2) inch past the tip of the fingers on each hand. During an observation on 04/05/22 at 09:14 AM, Resident #19 was lying in bed, hair matted with	F 677	Resident #19 and resident #42 fingernails were cut on 4/6/22. Resident #19 hair was cleaned and combed on 4/6/22. Nailcare be performed daily as needed and hair will be combed daily. All residents have the potential to be affected by this deficient practice. The Director of Nursing inserviced all certified nursing assistants and nurses beginning on 4/6/22 and completed on 4/28/22 on Activities of Daily Living". The Director of Nursing or registered nurse supervisor, will conduct three (3) observations of resident activities of daily living per week x six (6) weeks beginning 5/2/22 to ensure activities of daily living care is provided to residents. Observation reports will be reviewed by the Quality Assurance Committee monthly x three (3) months beginning 5/12/22 to assure substantial compliance has been achieved as determined by the committee.		

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F 677	Continued From page 26 white fuzz in it. Nails continue to be long and jagged approximately 1/2 inch past the tip of the fingers on each hand. An observation on 04/06/22 at 11:12 AM, revealed Resident #19 lying in bed. His hair was matted with white fuzz. Fingernails were long and jagged approximately 1/2 inch long past the tips of fingers on both hands. An interview and observation on 04/06/22 at 12:50 PM, with Certified Nurse Assistant (CNA) #1 confirmed the resident's nails are long and jagged and need to be trimmed and smoothed out. CNA #1 confirmed the jagged edges of the nails could cut us or the resident could cut himself. CNA #1 also confirmed that the resident has white fuzz in his hair. She stated she is not sure where it comes from but it is always like that. She stated, "the resident's hair could be picked out." An interview and observation on 04/06/22 at 01:05 PM, the Director of Nurses (DON) removed a piece of white material from the resident's hair and stated that it looks like fuzz. The DON confirmed this should not be in his hair. She also confirmed the resident's nails are long and need to be trimmed. She stated that he could scratch and hurt himself with the jagged nails and she would make sure they get trimmed. A record review of the Admission Record for Resident #19 revealed he was admitted to the facility on 10/26/20 with diagnoses of Huntington's Disease, Anxiety, Convulsions, and a Personal History of Traumatic Brain Injury. Record review of Minimum Data Set (MDS) with	F 677			

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F 677	Continued From page 27 an Assessment Reference Date (ARD) of 01/25/2022 revealed Resident #19 with a Brief Interview for Mental Status (BIMS) score of 03, which indicated resident has a severe cognitive impairment, requires extensive assistance of one person with personal hygiene. and total assistance of one person with bathing. Resident #42 An observation on 04/04/22 at 10:20 AM and at 3:10 PM, revealed Resident #42's fingernails long and approximately 1/2 inches past the tips of fingers on both hands. An observation on 04/05/22 at 08:50 AM, revealed Resident #42's fingernails untrimmed. An observation and interview on 04/05/22 at 03:50 PM, revealed Resident #42's fingernails untrimmed. The Resident stated that he doesn't know the last time his fingernails were trimmed. Observations on 04/06/22 at 09:15 AM and again at 12:50 PM, revealed the resident's fingernails continued to be untrimmed and approximately 1/2 inch past the tips of fingers on both hands. An observation and interview on 04/06/22 at 12:50 PM, with Certified Nurse Assistant (CNA) #1 confirmed the nails are long and needed to be trimmed and smoothed out. Resident #42 stated that he would like his fingernails cut. An observation and interview, on 04/06/22 at 01:00 PM, with the Director of Nurses (DON) confirmed his nails were long and need to be trimmed. The DON stated, "I will make sure this gets done. "	F 677			

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F 677	Continued From page 28 A record review of Resident #42's Admission Record revealed the resident was admitted to the facility on 02/16/2022, with diagnoses of Neuromuscular Dysfunction of the Bladder, Chronic Gout, and Fracture of Left Femur. A record review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/22/2022, revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact and requires extensive assistance of one person with personal hygiene.	F 677			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, staff interviews, record review, and facility policy review, the facility failed to ensure a resident who was at risk for wandering was appropriately monitored and supervised to prevent wandering into other residents' rooms for one (1) of four (4) survey days. Resident #46. Findings include: A review of facility policy titled, "Resident at Risk	F 689	Resident #46 was placed on one on one on 4/4/22 and sent to the behavioral health for evaluation on 4/5/22. Resident returned to facility on 4/18/22 and placed one on one supervision until a transfer could be made. Resident was transferred to a memory care unit on 4/29/22 for a more secure environment. All residents have the potential to be affected by this deficient practice.	5/31/22	

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F 689	Continued From page 29 for Wandering Behavior," dated February 2017, revealed, "This facility ensures that residents who exhibit wandering behavior receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Policy explanation and compliance guidelines: 'Wandering' is random or repetitive locomotion that may be goal-directed (e.g., the person appears to be searching for something such as an exit) or not-goal directed or aimless..." Observation and interview on 4/4/22 at 3:05 PM, the State Agency (SA) tried to locate Resident #46. An interview with Certified Nurse Assistant (CNA) #6 revealed she had seen the resident a few minutes earlier in the hallway near his room. CNA #6 asked other staff about Resident #46's location and these staff members looked for the resident. An observation on 4/4/22 at 3:12 PM, revealed CNA #6 located Resident #46 in the bathroom of Resident #35's room, two doors down from his room. The resident living in that room was noted to be in bed and appeared to be asleep. An interview with CNA #6 on 4/4/22 at 3:15 PM, revealed Resident #46 rolled his wheelchair up and down the halls and in and out of residents' rooms to visit, but "he is not a wanderer or exit seeking." An interview on 4/5/22 at 4:15 PM, with Resident #9, revealed the man living in the room next to hers came into her room last night, even though her door was closed. She stated she told him to get out and he did, but he came back. She stated	F 689	Director of Nursing completed in-service of all staff on 4/28/22 on the facility policy for wandering behaviors. Those at high risk for wandering will be placed on every 1 hour monitoring. The Director of Nursing or registered nurse supervisor, will complete four (4) weekly chart audits for six (6) consecutive weeks beginning 5/2/22 to ensure that appropriate interventions have been put in place for residents who have been determined to be at high risk for wandering to ensure resident safety and that care plans have been updated to reflect these interventions. Observation reports will be reviewed by the Quality Assurance Committee monthly beginning 5/12/22 x two (2) months to assure substantial compliance has been achieved as determined by the committee.		

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F 689	Continued From page 30 several minutes ago, the same resident was trying to go into her room again and she did not let him in. She stated she does not want him in her room and wants someone to help her keep him out. An interview with CNA #8 on 4/5/22 at 4:20 PM, revealed she did not witness the interaction between Resident #46 and Resident #9. She stated that concerning Resident #46, "a lot of residents have problems with him going in and out of their rooms." Stated she had not reported this since everyone was aware of Resident #46's wandering. An interview with Licensed Practical Nurse (LPN) #1 on 4/5/22 at 4:25 PM, revealed Resident #46 wandered around the facility but was not exit seeking. She stated he recently started approaching other residents' rooms and had wandered into other residents' rooms. She stated even though he went into other residents' rooms, "he doesn't mean anything by it." An interview with LPN #6 on 4/5/22 at 4:30 PM, revealed in the previous facility building Resident #46 wandered and took items from people, but he had been more calm in the new building. She stated the resident is not exit seeking, but he does roll around the hallways and has gone into other residents' rooms. She stated she had not reported this since it was known to all the staff. An interview with CNA #4 on 4/5/22 at 4:55 PM, revealed Resident #46 had wandered into other residents' rooms and had to be redirected. She stated she had not reported to the charge nurses because everybody knew he wandered and they were "seeing him wander, too."	F 689			

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F 689	Continued From page 31 An interview with Registered Nurse (RN) #2 on 4/5/22 at 5:08 PM, revealed Resident #46 had recently started wandering the halls and for the past few days, he had been wandering into residents' rooms. She stated when the resident was in another resident's room, the staff asked them about Resident #46 being in their rooms and they said they were "okay with it." She stated his condition had deteriorated over the past several weeks and currently requiring more assistance and redirection. She stated Resident #9 had told her Resident #46 came into her room. An interview with CNA #5 on 4/5/22 at 5:11 PM, revealed, Resident #46 "goes up and down the halls and in and out of rooms." She stated he would go into a room, look around, and come back out. She stated he would occasionally try to take someone's food, but nothing else. An interview with the Director of Nurses on 4/5/22 at 5:00 PM, revealed Resident #46 had wandered up and down the halls and doorways recently, but she did not realize he went into other residents' rooms. She stated she should have known this was occurring to have helped decrease this behavior. An interview with Resident #42 on 4/5/22 at 5:18 PM, revealed Resident #46 had come into his room a few days ago. He stated he just rolled in and then rolled back out. He stated that was the only time that had happened. An interview with Resident #43 on 4/5/22 at 5:20 PM, revealed that several times a man resident in a wheelchair had come into his room and has looked around then turned around and went back	F 689			

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F 689	Continued From page 32 out. An interview with Resident #27 on 4/5/22 at 5:25 PM, revealed a resident in a wheelchair had come into her room and told her that her room was his room, but she told him it was her room and he left. She stated she thought it had happened other times, but she was not sure when. An interview with RN #2 on 4/7/22 at 9:35 AM, revealed Resident #46 had been wandering up and down the hall and went into other residents' rooms to visit. She stated she only knew of one incident when he went into the bathroom of another resident on the day that SA entered the building. She stated she did not report his wandering since it was not noted to her that this was wanderings. An interview with CNA #5 on 4/7/22 at 9:45 AM, revealed Resident #46 goes in rooms and comes out. She stated no one had reported to her about him staying in a room and she had not reported to anyone since he just "goes in and looks around then comes out." An interview with LPN #1 on 4/7/22 at 10:15 AM, revealed the resident would roll up and down the hallway and would go to other resident's doorway and would look in and she would hear the other resident fussing at him to leave. She stated the resident left and the staff redirected him. She stated she had never seen him actually in another resident's room, but he would be in the doorway. She stated it had never been reported to her that he was in another's resident's room and she had not reported since he was not all the way in another person's room. The SA asked her about	F 689			

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F 689	Continued From page 33 her earlier statement about resident going into other resident's rooms and she said it was in the doorway and not into the room. An interview with the Minimum Data Set (MDS) Coordinator on 4/7/22 at 10:45 AM, revealed Resident #46 had a quarterly care plan meeting on 3/31/22 and his wandering was discussed in the meeting. She stated the resident's behavior of wandering goes "way back" and apparently it had improved over time and had recently become an issue again. She stated this was discussed and they discussed interventions for his wandering. She stated they discussed keeping an eye out on him to keep him out of other residents' rooms, redirecting him, and offering activities for him. An interview with the Social Worker on 4/7/22 at 11:00 AM, revealed Resident #46's care plan meeting was on 3/31/22. She stated that recently after his last hospitalization, his wandering seemed to increase. She stated he had always enjoyed rolling in the hallways, but recently he was going into other residents' rooms. She stated this was discussed in the last care plan meeting and interventions for staff to watch him and to redirect him were also discussed. An interview with the Activity Director on 4/7/22 at 11:45 AM, revealed she attended Resident #46's most recent care plan meeting. During the meeting, it was discussed about his increased wandering in the hallways and into some of the resident's rooms. She stated interventions discussed were to watch him closely, redirect him, talk to him, and give him activities. An interview with the DON on 4/7/22 at 1:00 PM,			F 689			

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F 689	Continued From page 34 revealed she was unaware of Resident #46's recent increase in wandering. She stated she had not read the recent notes or care plan meeting notes on the resident's wandering and she was unaware of his history of wandering. She stated she was aware he was rolling up and down the hallway, but was not aware of him going into other residents' rooms. The DON confirmed the facility failed to ensure the resident was monitored closely to prevent his wandering into other residents' rooms. She confirmed his wandering could have led to other resident's items being taken and could have risked harm to the resident or to another resident. An interview with the Administrator on 4/7/22 at 4:55 PM, revealed the residents have the right to be able to enjoy the common areas of the facility, but residents should not go into other residents' rooms uninvited. She confirmed the facility has the responsibility to ensure a resident does not wander into another resident's room. She confirmed the need to keep residents safe and free of someone coming into their rooms and this resident should have been monitored closely. Record review of Social Services Plan of Care Note dated 3/31/2022 revealed, "Care Plan Meeting: RR (Resident Representative) did not attend. Resident is receiving long term care. No plan of discharge. Resident has exhibited wandering. Staff redirects. Will continue to monitor." Record review of Resident #46's Admission Record revealed the resident was admitted to the facility on 1/26/2016. Diagnoses include Metabolic Encephalopathy, Cognitive Communication Deficit, Dementia, and Conduct	F 689			

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F 689	Continued From page 35 Disorder.	F 689			
F 693 SS=D	Record review of Minimum Data Set dated 12/26/2021, revealed a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review the facility failed to label and date a tube feeding for one (1) of four (4) residents observed. Resident #5	F 693	Resident #5 had tube feeding changed and a new bottle began with proper label on 4/4/22. Policy for Gastric Tube Feeding via continuous pump was updated by the Director of Clinical Operations on 4/20/22.	5/31/22	

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F 693	Continued From page 36 Findings Include A review of the facility policy titled, "Labeling of Enteral Feeding Supplies/Containers" with a revision date of 4/20/19 revealed, "It is the policy of this facility that all enteral feeding bottles/bags will be labeled with the rate of feeding, date bottle/bag began and initials of the nurse initiating as well as the feeding formula listed". An observation on 04/04/22 at 11:38 AM, revealed Resident #5 had a Percutaneous Endoscopic Gastrostomy (PEG) feeding tube connected to a continuous feeding pump. This observation revealed a bottle of Osmolite formula connected to the resident's feeding pump running at 70 milliliter per hour (ml/hr.) with no date/time, resident name, room number(#) or flow rate of feeding labeled on the Osmolite bottle. An observation on 04/04/22 at 03:35 PM, revealed no date/time, resident name/room number or feeding flow rate on the Osmolite formula bottle connected to Resident #5's PEG tube that was running at 70 ml/hr. via pump. An interview on 4/5/22 at 5:00 PM with Licensed Practical Nurse (LPN) #1 revealed that when she hangs a new tube feeding that she is supposed to label it with the resident's name, room #, date and time it was started and the milliliters/hour (ml/hr). If she finds a tube feeding that is not labeled, then she is supposed to hang a new one. She revealed that all this information is written on the tube feeding to let the next nurse know when it was done. She revealed that she was not Resident #5's nurse, but she found another resident's feeding tube not labeled yesterday.	F 693	All enteral tube feeds were checked for proper labeling by the registered nurse supervisor on 4/7/22. All tube fed residents have the potential to be affected by this deficient practice. The Director of Nursing completed in-servicing of all licensed nursing staff on labeling of tube feeding on 4/28/22. The Director of Nursing or Registered Nurse Supervisor will audit four (4) tube feedings per week x six (6) weeks for proper labeling beginning 5/2/22. Observations will be reviewed by the Quality Assurance Committee monthly x two (2) months to assure substantial compliance has been achieved as determined by the committee beginning 5/12/22.		

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F 693	Continued From page 37 An interview on 4/5/22 at 5:08 PM with Registered Nurse (RN) #2 confirmed that when a new feeding tube bottle is hung and attached to a resident's feeding pump then the date and time it is hung, flow rate, resident's name and room number should be written on the formula bottle. An interview on 4/7/22 at 9:22 AM, with LPN #2 revealed she worked 7 AM to 3 PM shift Monday 4/4/22 and she should have caught the fact that Resident #5's feeding tube bottle was not dated or labeled and corrected it. An interview on 4/7/22 at 10:45 AM, with the Director of Nurses (DON) confirmed that when a new feeding tube bottle is hung, it should be labeled with the resident's name, room number, date, and time. The DON revealed that the reason for labeling the feeding tube bottle is to ensure it is the correct resident, formula type and dose. The DON revealed that the date and time being labeled on the feeding bottle ensures that we know when it was hung, because if it was too old then the milk could spoil and make the resident sick. The DON revealed it is the facility policy to hang a brand-new bag if they discover one that is connected but not labeled. Record review of Resident #5's Admission Record revealed an admission date of 9/29/20 with medical diagnoses of Parkinson's Disease and Dysphagia. Record review of Resident #5's "Order Summary Report" revealed an order dated 3/9/22, "Enteral Feed Order every shift for feeding to be turned off at 11 PM and turned on at 12 am every day related to Dysphagia, Oropharyngeal Phase,	F 693			

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F 693	Continued From page 38 Feeding tube-NPO (Nothing by mouth), Head of bed (HOB) up 30-45 degrees. Osmolite @ 70 ML (milliliters) per pump ..."	F 693			
F 812 SS=F	Record review of Resident #5's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/29/21, Section K revealed the resident is receiving tube feedings. Section C revealed a Brief Interview for Mental Status (BIMS) score of 02, which indicates the resident is severely cognitively impaired. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and staff interviews, the facility failed to prevent possible food contamination as evidenced by	F 812		5/31/22	
			On April 4, 2022, the Dietary Manager immediately discarded the three (3) and one-half (1/2) loaves of bread that were		

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F 812	Continued From page 39 observations during the initial kitchen tour of improper thawing of raw chicken and three (3) and one-half (1/2) loaves of expired sliced sandwich bread, for 51 of 53 residents receiving dietary trays. Findings include: Record review of facility policy titled, "Thawing Food" revised 09/14 revealed, "Policy: The facility shall ensure that foods served to residents are thawed in a manner to prevent contamination. PROCEDURE: Frozen food is thawed in one of these ways:.....2. Running water.....b. Completely submerge food under running potable (drinking) water at 70 degrees or below." Review of facility policy titled, "FOOD STORAGE LABELING... with a revision date of 10/17 revealed "POLICY: The facility will ensure the safety and quality of food by following good storage and labeling procedures.....5.i. Identify the food item's use by date or expiration date. ii. Store items with the earliest use-by or expiration date in front of items with later dates. iii. Use items stored in front first. iv. Foods stored in storage units will be surveyed routinely to identify and discard food that have passed it manufacturer use-by-date or expiration date. Suggested time frames: 1. Dry Storage - Weekly..." An observation, during the initial kitchen tour, on 04/04/22 at 10:34 AM, revealed raw chicken thawing in one side of the deep two (2)-compartment sink, completely submerged with no running water. The raw chicken sat at the bottom of the opposite side of the sink that was away from the faucet. The initial kitchen tour	F 812	expired. On April 4, 2022, the Dietary Manager turned on the water over the pan of frozen raw chicken that was in sink as to "completely submerge under potable water at 70 degrees or below with sufficient water pressure to remove loose food bits into the drain". All dietary workers involved were promptly in-serviced on proper thawing procedures and food storage policies on April 4, 2022. The facility has determined that all residents who consume food by mouth have the potential to be affected. On April 11-12, 2022, all dietary staff were in-serviced on the facilities policies and practices pertain to "Thawing Food" and "Food Storage Labeling" to ensure the safety and quality of food. On April 5, 2022, the Dietary Manager assigned the duty of checking for expired food weekly, every Tuesday, to the evening aide on duty. The Dietary Manager will in-service all dietary staff monthly x3 beginning in May 2022, on hire, annually and as needed on food safety policies and precautions in accordance with professional standards for food service safety. Beginning April 8, 2022, the Dietary Manager will monitor dietary staff weekly x3 months or until consistent substantial compliance is met to ensure food safety. Beginning May 12, 2022, the Dietary Manager will bring any adverse findings to the Monthly Quality Assurance Committee meeting x3 months to assure substantial		

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F 812	Continued From page 40 observation also revealed three (3) full loaves of sliced sandwich bread and one-half (1/2) loaf of sliced sandwich bread with an expiration date of March 16, 2022. An interview on 04/04/22 at 10:35 AM, with the Dietary Department (DD) #2 (Manager), confirmed the raw chicken was being thawed in the 2-compartment sink full of water. The chicken sat at the bottom of and on the opposite side of the sink, away from the faucet, there was no water running over the chicken to thaw it, and that was not the proper process to be used to thaw raw chicken. DD #2 revealed that the incorrect thawing process could possibly cause Salmonella bacteria to grow, which could lead to sickness for the residents. DD #2 revealed she did not know the 3 ½ loaves of sliced sandwich bread was expired. There was no specific dietary employee assigned to ensure bread was disposed of after the expiration dates, and that it was the responsibility of all dietary staff to monitor the bread for expiration dates. DD #2 revealed the process for usage of the bread was to stack the oldest bread on the top of all the bread in storage to be used first, before the expiration date, and confirmed the expiration date of March 16, 2022, was on the 3 ½ loaves of sliced sandwich bread. DD #2 revealed the bread could have possibly molded from being kept and used past the expiration date, and could possibly cause the residents to be contaminated with whatever bacteria that could have possibly grown on the sliced sandwich bread. DD #2 revealed that sandwiches were made every evening and are sent to the nursing units to be used as part of the Diabetic residents' evening snack. DD #2 (Manager) revealed she had not conducted in-services with the dietary staff pertaining to	F 812	compliance. Any issues found will be discussed for further recommendations and oversight.		

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F 812	Continued From page 41 proper thawing of foods or storage/disposal of expired foods since she started. An interview on 4/7/22 at 09:00 AM, with the DD #1, revealed she was thawing the raw chicken out and was not using the correct thawing process. DD#1 revealed she would normally put raw meat in a deep pan and then place the deep pan of raw meat under cool running water to thaw. DD #1 revealed not thawing the raw chicken correctly could possibly cause the residents to get Salmonella or food poisoning of some kind. An interview on 4/7/22 at 11:30 AM, with the Administrator confirmed the residents could possibly get Salmonella poisoning due to the dietary staff not using the correct thawing process to thaw out the raw chicken. The Administrator also confirmed there was a possibility of growth of bacteria on the sliced sandwich bread that expired on March 16, 2022, which could possibly cause some form of illness to the residents.	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:	F 880		5/31/22	

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F 880	Continued From page 42 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, 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.	F 880			

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F 880	Continued From page 43 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to provide a proper barrier during medication administration and failed to ensure a catheter bag was properly positioned for three (3) of five (5) residents observed during medication pass and catheter observations. Unsampled Resident #1, Resident #33 and Resident #42 Findings include: Record review of the facility policy titled, "Nasal Spray Administration", dated 2/18/20, revealed "Nasal spray medications are administered ...in accordance with professional standards of practice ...Policy Explanation and Compliance Guidelines: 2. Procedure: ... c. Place the equipment on the cleaned bedside stand or overbed table. Arrange the supplies so that they can be easily reached. Place paper towel, napkin or other barrier on table ..." The facility was unable to locate or produce a policy related to catheter bag storage and proper coverage for privacy issues.	F 880	Resident #42's urinary catheter bag was immediately removed from the floor, replaced with a fig leaf bag and hung at bedside on 4/6/22. On 4/7/22, registered nurse #1 was immediately inserviced on nasal spray administration and eye drop administration including the use of a barrier to prevent the spread of infection by the Director of Nursing. All residents who have foley catheters and/or use nasal spray or eye drops have the potential to be affected by this deficient practice. The Director of Nursing provided training to all staff on infection control and prevention from online infection prevention training courses offered by the Centers for Disease Control per Directed Plan of Correction (DPOC) including "Indwelling Urinary Catheters" and "Sparkling Surfaces". Training completed 4/28/22. A Root Cause Analysis (RCA) was completed by the Director of Nursing		

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F 880	Continued From page 44 An observation on 04/06/22 at 8:55 AM, during medication pass revealed Registered Nurse (RN) #1 entered Unsampld Resident #1's room to administer eye drops. RN #1 removed the bottle of eye drops from the box and placed the box on the resident's chest of drawers without the use of a barrier. Following administration of the eye drops, RN #1 returned to the medication cart, wiped the eye drop bottle with a disinfectant wipe and put the bottle in the contaminated box and placed it in the medication cart. An observation on 04/06/22 at 9:00 AM, revealed RN #1 took nasal spray into Resident #33's room. RN #1 removed the nasal spray from the box and placed the box on the resident's bedside table without the use of a barrier. RN #1 returned to the medication cart with the bottle and the contaminated box in her hand. She wiped the nasal spray bottle with a disinfectant wipe and placed it in the contaminated box. RN #1 returned the contaminated box to the medication cart. An interview on 04/06/22 at 9:10 AM, with RN #1 revealed that she should not have set the eye drops on the chest of drawers and should not have placed the nasal spray on resident's bedside table without a barrier. She stated that this could cause cross contamination. An interview on 04/07/22 at 10:05 AM, with the Director of Nursing (DON) revealed that a barrier should be used when administering nasal sprays or eye drops when the box containing the medications is taken into the resident's room. The DON also stated that this is an infection control problem if a barrier is not used because the boxes are placed back into the medication cart	F 880	and the Infection Preventionist (IP) Nurse on 4/28/22. On 4/6/22, the Director of Nursing began in-servicing and staff competencies of all licensed nursing staff on nasal spray and eye drop administration including the use of a barrier per facility policy and on foley catheter care policy including bag placement. Inservices and competencies completed on 4/28/22. The Infection Preventionist (IP) or Nurse or Director of Nursing will audit four (4) foley catheters per week x six (6) weeks beginning 5/2/22 to ensure privacy and proper placement per policy. The Registered Nurse supervisor or Director of Nursing will audit three (3) nurses per week x 6 weeks for use of barrier per policy beginning 5/2/22. Observations will be reviewed by the Quality Assurance Committee monthly beginning 5/12/22 x two (2) months to assure substantial compliance has been achieved as determined by the committee.		

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F 880	Continued From page 45 after use. Record review of Unsampler Resident #1's Admission Record revealed the resident was admitted to the facility on 03/21/2022 with diagnoses that included Chronic Kidney Disease, Stage 3, Non-Type 2 Diabetes. Record review of Resident #33's Admission Record revealed the resident was admitted to the facility on 02/08/2022 with diagnoses that included Pneumonia, Rheumatoid Arthritis and Shortness of Breath. Resident #42 On 04/04/22 at 10:57 AM, an observation revealed Resident #42's urinary catheter bag on the floor and without a cover. On 04/05/22 at 3:50 PM, an observation revealed Resident #42's urinary catheter bag on the floor and without a cover. An interview on 04/06/22 at 1:00 PM, with the Director of Nurses (DON), she confirmed the catheter bag should be in a privacy bag and off the floor. The DON stated that with the catheter bag being on the floor it could cut a hole in it and also cause infections. A record review, of Resident #42's Admission Record revealed the resident was admitted to the facility on 02/16/2022 with diagnoses of Neuromuscular Dysfunction of the Bladder, Chronic Gout, and Fracture of Left Femur.	F 880			
F 888 SS=F	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x)	F 888		5/31/22	

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F 888	Continued From page 46 §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i) (1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.	F 888			

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F 888	Continued From page 47 §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all	F 888			

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F 888	Continued From page 48 documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to	F 888			

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F 888	Continued From page 49 the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review the facility failed to prevent the possible spread of COVID-19 as evidenced by failure to fully implement their policy to ensure that all staff are fully vaccinated or received an exemption for two (2) of 97 employee records reviewed. Findings Include: Record review of the facility policy titled, "Employee COVID-19 Vaccinations" undated, revealed "It is the policy of this facility to ensure that all eligible employees are vaccinated against COVID-19 as per applicable Federal, State and local guidelines ... Compliance Guidelines: "1. The facility will ensure that all eligible employees are fully vaccinated against COVID-19, unless religious or medical exemptions are granted. 2. Employees, who provide any care, treatment, or other services for the facility and/or its residents regardless of clinical responsibility or resident contact are required to be fully vaccinated against COVID-19 ..." Record review of the facility form "COVID-19 Staff Vaccination Status for Providers" revealed that Certified Nurse Assistants (CNA) #12 and #13 were not fully vaccinated and did not have a granted exemption.	F 888	Certified nursing assistant #12 & #13 were pulled from schedule on 4/5/22. Certified nursing assistant #12 & #13 completed their COVID vaccination series on 4/6/22 & 4/7/22. All newly hired staff will be fully vaccinated or have an exemption prior to hire. All residents have the potential to be affected by this deficient practice. On 4/6/22, the Director of Nursing inserviced the Infection Preventionist (IP) nurse on COVID-19 employee vaccination policy. The Infection Preventionist (IP) nurse or Director of Nursing will audit all new employees weekly x six (6) weeks to ensure the COVID 19 employee vaccine policy is followed beginning 5/2/22. Observations will be reviewed by the Quality Assurance Committee monthly beginning 5/12/22 x two (2) months to assure substantial compliance has been achieved as determined by the committee.		

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F 888	Continued From page 50 Record review of CNA #12's vaccination record revealed she received her one dose of a multi-dose COVID-19 vaccination on 2-3-21 and has continued to work at the facility full time with her last day to work being 4-2-22. Record review of CNA #13's vaccination record revealed she received one dose of a multi-dose COVID-19 vaccination on 11-17-21 and has continued to work full time at the facility with her last day to work being 4-5-22. An interview on 4-5-22 at 9:30 AM, with the Infection Preventionist (IP) revealed she just started as the IP about a month ago and she is not aware of any deadline they have had in regards to the staff completing their COVID-19 vaccination or requesting an exemption. She revealed she is aware of the guidance that all staff is suppose to be fully vaccinated or have a granted exemption at this point. She confirmed there are three CNA's that are not fully vaccinated, but one of them is not due for her second vaccination yet. She confirmed that CNAs #12 and #13 should have had their second COVID-19 vaccine already and they have continued working here. She confirmed she understands the risk of those CNAs continuing to work in the facility without being fully vaccinated. An interview on 4-5-22 at 3:45 PM, with the Director of Nurses (DON) revealed the facility has had no positive COVID-19 residents or staff in the last 4 weeks and they test unvaccinated staff twice per week and those unvaccinated staff have to wear an N95 mask. An interview on 4-6-22 at 9:38 AM with the Administrator revealed that she is aware of the	F 888			

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F 888	Continued From page 51 regulations and confirmed that she knew they were suppose to have all staff fully vaccinated or exemptions granted at this point. She revealed that the facilities last IP left on 1-12-22 and the current IP started about a month ago. The Administrator revealed she was not aware that they had two CNAs that had not had their 2nd COVID-19 vaccine and was continuing to work. The Administrator revealed that the IP that left on 1-12-22 was probably aware that those two CNAs needed their second COVID-19 vaccination. The Administrator revealed that they had told all staff that they had to have their 1st vaccination by the first deadline or an exemption. The Administrator confirmed she was unaware of who was keeping up with the staff vaccinations and the new guideline, but she wasn't. She confirmed the facility did develop a policy to ensure all staff were fully vaccinated or had an exemption, but had not fully implemented it. She confirmed that CNA #12 and #13 must have slipped through the cracks. An interview on 4-6-22 at 9:49 AM, with CNA #12 revealed that a facility staff member called her yesterday afternoon and told her she had to have her second COVID-19 vaccination before she could return to work. She revealed this was the first she had heard of it. She revealed she has been trying to get an appointment with the local pharmacy and she wishes she had known sooner so she did not have to miss work. She confirmed that she had been being tested twice per week and was wearing an N95 mask at work. She denied having COVID-19 or any signs or symptoms of COVID-19. She confirmed that her last day to work was 4-2-22. An interview on 4-6-22 at 4:20 PM, with the DON confirmed that having two CNAs working and not	F 888			

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F 888	Continued From page 52 being fully vaccinated could increase the risk of spreading COVID-19 infection within the facility. An interview on 4-7-22 at 5:00 PM, with Human Resources (HR) staff revealed she completes the work schedule for the facility. She revealed that she was told on 4-5-22 that CNA #12 and #13 could not come back to work until they received their second COVID-19 vaccination. HR staff revealed CNA #13 was already at the end of her shift on 4-5-22 before she was made aware.	F 888			
F 919 SS=F	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record reviews, and facility policy review the facility failed to provide a sufficient volume level on the resident call light system as evidenced by the inability to hear the call light system alarm on the nursing unit halls for four (4) of 4 days of survey. Findings include: Review of the facility policy titled, "Call Light, Answering," undated, revealed, "Purpose - The purpose of this procedure is to respond to the resident's requests and needs..."	F 919	On April 7, 2022, the Administrator increased the call light system monitor's volume, located at the 200 Hall nurse's station desk from medium to high allowing staff to hear call lights to the end of residents' halls. All residents residing in rooms where call lights could not be heard had the potential to be affected. On April 7-14, 2022, the Administrator in-serviced all staff on maintaining the call light system monitor's volume on high at	5/31/22	

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F 919	Continued From page 53 An observation on 4/4/22 at 10:30 AM, revealed the call light globes, located above the resident room doors would light up when the call light system was activated, but no call light system alarm was heard on the nursing unit halls to alert the staff that the call light was activated. The call light system monitor was located at the 200 Hall nurse's desk and all the resident calls for assistance for the 100 Hall, 200 Hall, and 300 Hall, were to be answered through that one (1) call light system monitor. The State Agency (SA) was able to hear the call light system alarm while at the nurse's desk, which was at a low volume, but could not hear the call light system alarm at one of the closest resident rooms, #201, which was approximately 20-25 feet away from the 200 Hall nurse's station desk. The State Agency walked down to the end of the 100 Hall, which was approximately 40-50 feet away from the 200 Hall nurse's desk, walked down to the end of the 200 Hall, which was approximately 40 to 50 feet away from the 200 Hall nurse's station, and walked down to the nurse's station on the 300 Hall, which was approximately 30-40 feet away from the 200 Hall nurse's station, and was not able to hear the call light system alarm. An interview on 4/5/22 at 04:35 PM, with Registered Nurse (RN)#2 revealed that some nursing staff members had revealed to her as the RN Supervisor that they could not hear the call light system alarm if they were not directly at the nurse's station. RN #2 also revealed that there was not a staff member assigned to the desk to be able to monitor the call light system at all times. RN #2 revealed not being able to hear the call light system alarm was a problem the facility staff had been dealing with for a while but could not reveal how long the problem had existed. RN	F 919	all times. On April 8, 2022, the Administrator placed a sign by the call light system monitor stating that the volume of call lights must be maintained at high at all times and that the Administrator was to be notified immediately of any issues with the call light system monitor. Beginning on April 8, 2022, the Administrator will monitor the call light system monitor's volume daily, Monday through Friday, for (30) thirty days. The administrator will immediately address any issues with call lights. Beginning April 14, 2022, all issues with call lights will be brought to the Weekly Quality Assurance Committee x4 weeks by the Administrator for further recommendations and oversight.		

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F 919	Continued From page 54 #2 revealed a verbal report had been made to the higher-level staff regarding the problem. An interview on 4/5/22 at 04:38 PM, with Certified Nurse Aide (CNA)#5, who was located behind the 300 Hall nurse's desk revealed that the CNA staff had expressed to her, as the Lead CNA, they are not able to hear the call light system alarm on the 100 Hall, 200 Hall, or the 300 Hall. CNA #5 revealed she could not hear the call light system alarm while she sat at the nurse's desk on the 300 Hall, and could only hear the call light system alarm when she stood at the 200 Hall nurse's station desk. CNA #5 revealed she had instructed the CNA staff to look up at the globes over the residents' rooms to see if a call light was on when they were out on the halls. An interview on 4/6/22 at 09:40 AM, with the Director of Nursing (DON), revealed the call light system alarm volume was too low to be heard down the nursing unit halls from the 200 Hall nurse's desk. The DON revealed the call light system alarm volume being down that low could possibly cause a call light not to be answered timely. An interview on 4/7/22 at 09:25 AM, with CNA #9 who was located on the 300 Hall, revealed she was not able to hear the call light system alarm when out on the nursing unit. CNA #9 revealed she could hear the alarm if she stood at the 200 Hall nurse's station desk. An interview on 4/7/22 at 09:29 AM, with CNA #10 who was located on the 300 Hall, revealed she was not able to hear the call light system alarm when she was away from the 200 Hall nurse's station desk.	F 919			

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F 919	Continued From page 55 An interview on 4/7/22 at 09:34 AM, with RN #1 who was located on the 100 Hall, revealed she cannot hear the call light system alarm when away from the 200 Hall nurse's station desk. An interview on 4/7/22 at 12:30 PM, with Licensed Practical Nurse (LPN) #4, who was located on the 300 Hall, revealed she cannot hear the call light system alarm on the 300 Hall, because the call light system's volume was too low to hear from the 200 Hall nurse's station desk. An interview on 4/7/22 at 12: 35 PM, with CNA #11, who was located on the 300 Hall, revealed she could not hear the call light system alarm when she was on the 300 Hall. An observation and interview on 4/7/22 at 03:25 PM, with the Administrator revealed the Administrator increased the call light system monitor's volume, located at the 200 Hall nurse's station desk from medium to high. The SA went down the 200 Hall to listen for the call light system alarm's sound. The call light system alarm sound could be heard down to the end of the 200 hall, 40-50 feet away from the 200 Hall nurse's station desk, due to the increased volume. The Administrator also walked down the 200 Hall, past room #212, approximately 30 feet from the 200 Hall nurse's station desk, confirmed she was able to hear the call light system alarm. She revealed she had assigned the RN Charge Nurses to stay at the nurse's desk to monitor the call light system alarm and inform staff when a resident needed assistance but revealed there was not a written schedule for the assignment. The Administrator revealed that the call light	F 919			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255276	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/07/2022
NAME OF PROVIDER OR SUPPLIER THE MADISON HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 111 KELLY BLVD MADISON, MS 39110		
(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 919	Continued From page 56 system volume was low because she thought the high volume was too much noise. The Administrator revealed the call light system volume not being heard by the nursing staff could have possibly caused residents call lights not to be answered in a timely manner.	F 919			