STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255142	A. BUILDING _____ B. WING _____	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OCEAN SPRINGS HEALTH & REHABILITATION CENTER	1199 OCEAN SPRINGS ROAD OCEAN SPRINGS, MS 39564

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification along with six (6) complaint investigations (CI): MS #18410, MS #18423, MS #18499, MS #18631, MS #18736 and MS #18767 at the facility from 4/25/22 to 4/29/22. During the survey, the SA determined that the facility was not in compliance with the requirements of participation for Medicare and Medicaid and cited F550, F585, F608, F610, F677, F686, F760 and F812 The SA did not substantiate MS #18423 for verbal abuse, MS #18736 for staffing, residents left soiled for extended amount of time, and roach infestation, MS #18499 for meds not given, misappropriation of property, and quality of care or MS #18767 for not providing appropriate end of life services. The SA substantiated MS #18410 for not providing nail care and cited F677. MS #18631 was substantiated for medications not being given according to physician's orders and wound care not provided according to professional standards and cited F686 and F760. The SA also cited F550, F585, F610 and F812 during the survey. The facility held a license for 115 beds with a census of 78.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		6/10/22

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

Electronically Signed | 05/24/2022

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 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all 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, interviews, record review and facility policy review the facility failed to treat a resident in a dignified manner by not covering the resident during incontinence/catheter care for	F 550	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the	

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F 550	Continued From page 2 one (1) of eight (8) care observations. (Resident #77) Review of the facility's "Policies and Procedures" with the "Subject" of "Perineal Care" with a revised date of 9/5/2017 revealed, "Procedure ...Remove necessary clothing ...Wash, rinse and dry the skin, being certain to expose all skin surfaces which are soiled ..." On 04/26/22 at10:07 AM, the State Agency (SA) observed incontinent/catheter care with Certified Nursing Assistant (CNA) #8 for Resident #77. Her husband remained in the room for the procedure. CNA #8 pulled the residents gown up, pulled the cover down, and exposed her perineal area. CNA #8 then went to the sink and filled the water basin, leaving the resident exposed. Resident #77 pulled her gown back down to cover herself. CNA #8 then returned to the resident to perform incontinent/catheter care. CNA #8 pulled the gown up and asked the resident to open her legs. CNA #8 cleansed the catheter tubing by anchoring the tip of the tube near the meatus and wiped the resident from front to back. CNA #8 then turned the resident over and wiped from front to back with the resident uncovered. During an interview on 04/26/22 at 10:30 AM, with Resident #77, she confirmed she did not feel comfortable with her body being exposed. She explained that it is hard to be comfortable with people looking at her private area and that is why she had pulled her gown down while the CNA was filling the wash basin. She thought it would cause a problem if she had spoken up about her discomfort.	F 550	Statement of Deficiencies. This Plan of Correction is prepared solely because by the provisions of State and Federal laws. F550 * On April 27, 2022, Resident #77 was assessed for negative effects resulting from exposure by Director of Nursing, no adverse findings noted. On April 27, 2022, CNA # 8 was in-serviced on dignity, perineal care and resident rights, by Director of Nursing On April 27, 2022, Director of Nursing observed CNA # 8 perform perineal care skills check off to include monitoring for covering of resident and dignity. * All residents that receive incontinent/catheter care interviewed by the Director of Nursing, beginning on May 2, 2022, no adverse findings noted. * Registered Nurse Educator will observe perineal care for five (5) residents weekly x 4 weeks, then monthly x 3 months to ensure resident is covered during incontinent/catheter care, beginning May 10, 2022. All nursing staff in-serviced on resident rights, dignity to include covering of resident, and perineal care by Registered Nurse Educator, beginning May 3, 2022. * Findings were brought to the Quality Assurance Performance Improvement Committee Meeting by Director of Nursing on May 16, 2022 and will continue monthly x three (3) months to determine	

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F 550	Continued From page 3 During an interview on 4/26/22 at 11:00 AM, with CNA #8, he confirmed that he failed to cover Resident #77 perineal area during care and left her exposed while filling the wash basin. He verified that he should have covered the resident, but because he was nervous and not thinking straight, he did not realize it until he had completed the care. During an interview on 04/26/22 at 03:07 PM, with the Director of Nursing (DON), she confirmed that CNA #8 failed to follow the facility's policy by leaving Resident #77 exposed during care. The DON said CNA #8 should have covered the resident and only exposed the part that was being cleaned. Record review of the Resident #77's "Admission Record" revealed the facility admitted her 3/24/22 with diagnoses that included Encounter for Othe Orthopedic Aftercare, Presence of Left Artificial Hip Joint, and Displaced Fracture of Epiphysis of the Left Femur. Record review of the Comprehensive Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 03/31/22 revealed Resident #77 had a Brief Interview of Mental Status (BIMS) of 14 that indicated Resident #77 is cognitively intact. Review of the facility's "In-Service Sign-in Sheet" dated 1/26/2022 with "Topic" listed as State Regulations, Privacy and Dignity revealed CNA #8's signature which indicted he received training related to privacy and dignity.	F 550	the effectiveness and make any necessary changes as indicated.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4)	F 585		6/10/22

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§483.10(j) Grievances.
§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for

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F 585	Continued From page 5	F 585		

completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be

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F 585	Continued From page 6 taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, the facility failed to resolve a resident's grievance regarding personal property for one (1) of three (3) residents reviewed for misappropriation of property. Resident #20. Record review of the facility's "Clinical Guideline - Complaint/Grievance" with a revision date of 8/9/2018, revealed, " ...Purpose: To support each resident's right to voice grievances; resulting in a follow-up and resolution while keeping the resident apprised of its progress toward resolution ...Process ... The grievance follow-up should be completed in a reasonable time frame; this should not exceed 14 days... The individual voicing the grievance shall receive follow up communication with the resolution ..." Record review of Resident #20's "Admission Record" revealed he was admitted by the facility initially on 7/30/21 and had a recent re-admission date of 1/11/22. He had diagnoses including Acute on Chronic Systolic (Congestive) Heart	F 585	F585 * On April 29, 2022, Assistant Director of Nursing reported to the state agency allegation of misappropriation for Resident #20. On April 29, 2022, Resident #20 interviewed by Administrator and Social Services Director regarding missing ring. On April 29, 2022, Social Services Director was in-serviced on facility policy and procedure for grievances/complaints and completing thorough investigation, by Administrator. On April 29, 2022, Resident #20 was provided with a lock box to store his valuables, by Social Services Director. * All residents have the potential to be affected. On May 3, 2022, Administrator reviewed resident grievances for the previous six (6) months for thorough investigation. All grievances had been addressed	

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F 585	Continued From page 7 Failure, Essential Hypertension, and Acute Kidney failure. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/24/22 revealed Resident #20 had a Brief Interview of Mental Status BIMS) score of 15, which indicated he was cognitively intact. On 04/25/22 at 03:00 PM, in an interview with Resident #20, he stated that he was missing a ring. He described the Social Services Designee (SSD) and stated the missing ring was reported to her at the end of last year (2021). The resident stated the SSD did look for the ring but did not locate it. Record review of the facility's "Grievance Log" revealed an entry for Resident #20 which indicated the "Date Grievance Received" as 11/14/21, the "Type of Grievance" is indicated as "Other", and the "Date of the Incident" and the "Date Parties Informed of Findings" is listed as 11/14/21. The "Disposition Of Grievance" is indicated as "Resolved". The description of the nature of the grievance is listed as "resident reported missing clothes and a ring". Record review of the facility's "Grievance Investigation" dated 11/14/21, revealed the name of the resident was not indicated on the report. The description of the incident as provided by the resident stated, "Resident stated he is missing clothes and a ring. He stated he may have lost the ring." Recommendations/corrective actions taken were indicated as "SS (Social Services) called family p (after) reporting ring missing. Clothes were found in laundry p south activity. Some other rings were found in resident's	F 585	appropriately. Courtesy rounds were made with residents with Brief Interview Mental Status (BIMS) score of 12 or above to determine any potential for abuse, neglect, or misappropriation concerns by Administrator beginning May 3, 2022 and ending May 24, 2022. On May 16, 2022, Business Office Manager mailed letter to all resident Responsible Parties to inform them of policy regarding personal belongings/valuables. * Registered Nurse Educator in-serviced facility staff on grievances, to include a thorough investigation, beginning on May 3, 2022. Grievances will be brought to Department Head morning meeting each morning and discussed to include, status of either needing further investigation or to be resolved, beginning May 3, 2022. Future allegations of Abuse, Neglect, and Misappropriation will be reported to State Agency according to State and Federal Regulations. *Administrator will monitor grievance log weekly times three (3) weeks, then monthly times three (3) months for completed investigation. Rounds will be made by Administrator to interview cognitive residents with a Brief Interview Mental Status (BIMS) greater than 12 to determine if any misappropriation has occurred weekly times three (3) weeks, then monthly times three (3) months. Findings were brought to the Quality	

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suitcase. Son did not express concern of replacing missing ring." The investigation indicated that the grievance was resolved to the satisfaction of all concerned. The "Date resident/individual received response of finding" was listed as 11/14/21. The "Time" was blank.

On 04/28/22 at 02:46 PM, in an interview with Social Services (SS) stated Resident #20 had told her he was missing a gold ring. She stated she phoned the resident's son, and the son was aware of the missing ring. She stated the missing ring was reported to her and she reported it to the Administrator.

On 4/28/22 at 03:18 PM, in an interview with Resident #20's son, he stated his dad had told him about his gold ring with diamonds that was missing. The son described the ring as being gold and had diamonds from one corner to the other corner. He confirmed he had spoken with the SSD about the missing ring, and he was told the SSD would keep a look out for it. He stated he initiated the phone call to the SSD; she did not initiate the call and she never responded to let him know the outcome or if the issue was resolved or not. He stated he lives several states away and felt like there was nothing he could do about his dad's missing items.

On 4/28/22 at 03:34 PM, in an interview with the SSD, she stated she had marked the grievance as "resolved" on the grievance log because she did not think the resident's son was concerned about it.

On 4/28/22 at 5:50 PM, in an interview with the Interim Administrator, she stated that she had spoken with Resident #20's son and his story and

Assurance Performance Improvement Committee by Administrator on May 16, 2022 and will be continued monthly for three (3) months to determine effectiveness and make necessary changes as indicated.

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F 585	Continued From page 9 the SSD's story "does not add up".	F 585		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and facility policy review, the facility failed to thoroughly investigate a resident's allegation of misappropriation of personal property for one (1) of three (3) residents reviewed for misappropriation of property. (Resident #20) Record review of the facility's policy, "Protection of Resident's Personal Property," (undated) revealed, "Policy ...6. The Administrator or his/her designee will log the missing items, complete an investigation on all missing items and document results of findings ...The Administrator will ensure that the resident/ responsible parties informed of	F 610	F610 * On April 29, 2022, Assistant Director of Nursing reported to the state agency allegation of misappropriation for Resident #20. On April 29, 2022, Resident #20 interviewed by Administrator and Social Services Director regarding missing ring. On April 29, 2022, Social Services Director was in-serviced on facility policy and procedure for grievances/complaints and completing thorough investigation, by Administrator.	6/10/22

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F 610	Continued From page 10 the results of the investigation..." On 04/25/22 at 03:00 PM, Resident #20 stated that he was missing a gold ring with three diamonds in it. He put his ring in the bedside nightstand in the drawer and the end of last year (2021) and it was gone when he went to look for it. He described the Social Services Designee (SSD) and said he had told her his ring was missing. He stated the ring was missing it was the end of last year. On 04/28/22 at 02:46 PM, in an interview with the SSD, she stated Resident #20 had told her he was missing a gold ring. She phoned the son, and the son was aware the ring was missing. She stated the missing ring was reported to her and she reported it to the Administrator. On 04/28/22 at 02:58 PM, in an interview with Resident #20 with the SSD present, Resident #20 stated he had a ring missing and the SSD had she looked for it and could not find the ring. On 4/28/22 at 3:05 PM, in an interview with Director of Nursing (DON), she stated she did not know about Resident #20 having any missing items. On 4/28/22 at 03:18 PM, in an interview with Resident #20's son, he stated his dad had told him about the gold ring with diamonds that was missing. He confirmed he had spoken with the SSD about the missing ring, and he was told the SSD would keep a look out for its. He clarified that he initiated the phone call to the SSD; she did not initiate the call and she never responded to let him know the outcome or if the issue was resolved or not. He stated he lives several states	F 610	On April 29, 2022, Resident #20 was provided with a lock box to store his valuables, by Social Services Director. * All residents have the potential to be affected. On May 3, 2022, Administrator reviewed resident grievances for the previous six (6) months for thorough investigation. All grievances had been addressed appropriately. Courtesy rounds were made with residents with Brief Interview Mental Status (BIMS) score of 12 or above to determine any potential for abuse, neglect, or misappropriation concerns by Administrator beginning May 3, 2022 and ending May 24, 2022. On May 16, 2022, Business Office Manager mailed letter to all resident Responsible Parties to inform them of policy regarding personal belongings/valuables. * Registered Nurse Educator in-serviced facility staff on grievances, to include a thorough investigation, beginning on May 3, 2022. Grievances will be brought to Department Head morning meeting each morning and discussed to include, status of either needing further investigation or to be resolved, beginning May 3, 2022. Future allegations of Abuse, Neglect, and Misappropriation will be reported to State Agency according to State and Federal Regulations. *Administrator will monitor grievance log weekly times three (3) weeks, then	

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F 610	Continued From page 11 away and felt like there was nothing he could do about his dad's missing items. On 04/29/22 at 10:36 AM, in an interview with DON stated she became DON the last few days of January 2022 until the present. She said she does not know the policy on personal property but if an item is reported as missing, then she would have bought it up in the daily "stand up" meeting. She would have checked the resident's room and verify if the item was on the inventory sheet completed on admission. She would then take that information to the Administrator because the Administrator has the final say. On 04/29/22 11:04 AM, in an interview with Resident #20, he stated the ring was his "pride and joy" because his son bought it for him. He said it was valued at $1735.00.. Record review of Resident #20's "Admission Record" revealed he was admitted by the facility initially on 7/30/21 and had a recent admission date of 1/11/22. He had diagnoses including Acute on Chronic Systolic (Congestive) Heart Failure, Essential Hypertension, and Acute Kidney failure. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/24/22 revealed Resident #20 had a Brief Interview of Mental Status BIMS) score of 15, which indicated he was cognitively intact.	F 610	monthly times three (3) months for completed investigation. Rounds will be made by Administrator to interview cognitive residents with a Brief Interview Mental Status (BIMS) greater than 12 to determine if any misappropriation has occurred weekly times three (3) weeks, then monthly times three (3) months. Findings were brought to the Quality Assurance Performance Improvement Committee by Administrator on May 16, 2022 and will be continued monthly for three (3) months to determine effectiveness and make necessary changes as indicated.	
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		6/10/22

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F 677	Continued From page 12 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review the facility failed to ensure residents who were dependent on staff for showering, shaving, and nail care received those services for five (5) of six (6) residents reviewed for Activities of Daily Living (ADLs) assistance. Resident #48, Resident #49, Resident #56, Resident #58, and Resident #60. Review of the faciality's "Policies and Procedures" with the "Subject" of "Bathing/Showering", revised on 9/1/2017, revealed "Policy: Assistance with showering and bathing will be provided at least twice a week and PRN to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. This schedule will take precedence over the twice a week and PRN cleansing ..." Review of the facility's "Policies and Procedures" with the "Subject" of "Podiatry", revised on 8/24/2017 revealed, "Policy: Podiatry consults are available to residents in need of services other than routine care. Procedure ...The consulting podiatrist will complete the physician consultation form and/or podiatry assessment and return it to the charge nurse for filing in the medical record..." Resident #48 On 4/25/22 at 2:37 PM, Resident #48 said he did not get a shower every week and the last shower he received was on 4/18/22. Prior to that, he went two (2) weeks without a shower. He has	F 677	F677 * On April 29, 2022, Resident #48 was showered, by Certified Nursing Assistant. Unit Manager will audit bath list daily to ensure completion of resident baths, beginning May 25, 2022 On April 30, 2022, Resident #49 was showered. shaved and hair washed by Certified Nursing Assistant. Unit Manager will audit bath list daily to ensure completion of resident baths, beginning May 25, 2022 On May 6, 2022, Podiatry visit for Resident # 56, toenails were cut and trimmed. Staff nurse will check, clean and trim fingernails and toenails weekly on Sundays, beginning May 8, 2022. On April 30, 2022, Resident #58 was shaved to removed facial hair and hair brushed by Certified Nursing Assistant. Unit Manager will audit bath list daily to ensure completion of resident baths, beginning May 25, 2022 On April 29, 2022 Resident # 60 refused his bath. On May 3, 2022, Resident #60 was showered, shaved and hair washed by Certified Nursing Assistant. Unit Manager will audit bath list daily to ensure completion of resident baths, beginning May 25, 2022 * All residents have the potential to be affected. All residents were assessed for nail care,	

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F 677	Continued From page 13 informed the staff that he is scheduled to receive a shower on first shift now, and not on second shift. Resident #48's hair was oily. On 4/26/22 at 02:12 PM, in an interview with Resident #48, he stated he should have received a shower yesterday on 4/25/22 but he did not get a shower. He is supposed to get showers on Monday, Wednesday, and Friday. Record review of Resident #48's "Admission Record" revealed a readmission date of 2/17/22 and an original admission date of 10/11/18. He had diagnoses including Resident has diagnosis of Morbid Obesity and Congestive Heart Failure. Record review of the Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 2/24/22 revealed Resident #48 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated resident was cognitively intact. Record review of Resident #48's "Edit Task" report dated 4/29/22 with the "Standard Task" as "Shower/Bath" revealed the "Task Schedule" as "Monday Wednesday Friday ...Q(Every)Shift: *Days". Record review of Resident #48's "Documentation Survey Report (V2) for "Mar-22" revealed he did not receive a scheduled shower during March. "On 3/8/22, it is recorded as "97" which means, "Not Applicable". He received a bed bath, not a shower, on 3/8/22, 3/19/22, 3/22/22, and 3/25/22. Resident #48 should have received a shower on 3/2/22, 3/5/22, 3/10/22, 3/12/22, 3/15/22, 3/17/22, 3/26/22, 3/29/ss, and 3/31/22.	F 677	by Registered Nurse on May 2, 2022 with nails trimmed for residents identified. All residents were observed for ADL care, to include facial hair and greasy hair, on May 2, 2022 by Director of Nursing with shower/bath, shave, and hair washed for residents identified. * All nursing staff in-serviced on bathing, showering, and nail care, by Registered Nurse Educator, beginning on May 2, 2022. Beginning on May 2, 2022, Registered Nurse Educator in-serviced nurses and certified nursing assistants on how to add a resident to podiatry list and where the list is located. Assistant Director of Nursing updated Point Click Care order set for all diabetic residents to receive nail care weekly, beginning on May 5, 2022. Assistant Director of Nursing updated Point of Care order set, for all non-diabetic residents to receive nail care weekly, beginning on May 5, 2022. Assistant Director of Nursing completed Bath schedule and placed at nurses station. Each shift the staff nurses will complete a bath list from the bath schedule for the Certified Nursing Assistants informing them of baths (to include bathing, shaving, washing hair and nail care) scheduled for the shift. The certified nursing assistants will perform baths and sign on the bath list when completed. The staff nurse will ensure bath has been completed and sign the bath list. On April 28, 2022, Assistant Director of	

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F 677	Continued From page 14 Record review of Resident #48's "Documentation Survey Report (V2) for "Apr-22" revealed he did not receive a shower from April 1-14, 2022. He was scheduled to receive a shower on 4/2/22, 4/5/22, 4/7/22, 4/9/22, 4/12/22, and 4/14/22. He did not get a shower on 4/19/22, 4/23/22, and 4/26/22. On 4/28/22 at 3:40 PM, in an interview with the Director of Nursing (DON) she stated Resident #48 is scheduled for showers on Tuesday, Thursday, and Saturday. On 04/29/22 at 09:11 AM, in an interview with Resident #48, he stated he has never refused a bath. During a two-week period, he was offered a bed bath once in the last two weeks. He had reported his concerns with showering to the Social Services Designee (SSD) and was told he get a bath in 10 minutes. Shortly thereafter, the facility staff called him to the dining hall for a special meeting. He just wanted a shower on his scheduled days. On 4/29/22 at 09:42 AM, in an interview with the SSD, she stated Resident #48 did speak with her about not getting showers. She stated she completed a grievance, and he did receive a shower that day, so she resolved the grievance. His shower days were changed from the evening shift to the day shift per his request. He had not mentioned it to her again after that. On 4/29/22 10:29 AM, in an interview with the DON, she stated the nurse on the cart is responsible for making sure residents get their scheduled baths. She stated the nurse on the cart should follow up with CNA and the resident. If a resident refuses a shower, the nurse should	F 677	Nursing placed a Podiatry List in the 24 hour binder at each nurses station. Staff will add any resident needing a referral to the Podiatrist to the list. Prior to Podiatrist visit, Unit Manager will consult with Medical Director/Nurse Practitioner regarding referrals to Podiatrist and write orders as indicated. *Licensed Practical Nurse will perform rounds three (3) times per week for four (4) weeks, then monthly times three (3) months, to observe nail care, hair care, and facial hair, beginning on May 10, 2022. The Unit Managers will audit bath lists daily to ensure completion, beginning May 25, 2022. Findings were brought to the Quality Assurance Performance Improvement Committee Meeting by Director of Nursing on May 16, 2022 and will continue monthly times three (3) months to determine the effectiveness and make any necessary changes as indicated.	

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document the refusal in the progress notes.

Record review of the March and April progress notes for Resident #48 revealed there was no documentation related resident refusals of baths or showers.

Resident #49

On 4/25/22 at 4:12 PM, the State Agency (SA) observed Resident #49 lying in bed with long facial hair and hair was greasy in appearance. He reported he does not know about his baths or showers.

On 4/26/22 at 2:45 PM, the SA observed Resident #49 lying in bed. His hair appears greasy and dirty, and he had long facial hair.

On 4/27/22 at 09:45 AM, during an interview with Certified Nurse Aide (CNA) #5, she explained she always tries to give her residents including Resident #49 a wash down/ bed bath every morning on here first round. She explained Resident #49 is scheduled for showers on the evening shift. She did not wash his hair this morning and she agreed that his hair was greasy.

On 4/27/22 at 3:30 PM, during an interview with CNA #3, she reported that on some evenings, each CNA will have up to five (5) showers and not all showers are given. If all showers scheduled are not given, she tries to give the resident a bed bath.

At 3:40 PM on 4/27/22, during an interview with CNA #6, she reported she does not know when Resident #49 receives his showers, but the facility

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has a bath schedule. She reported she will give Resident #49 a shower tonight due because his hair is greasy.

A record review of Resident #49's "Admission Record" revealed the facility initially admitted him on 2/28/2019 and he was readmitted resident on 1/15/2020 with the diagnoses of Other Specified Interstitial Pulmonary Disease and Chronic Obstructive Pulmonary Disease.

A record review of Resident #49's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/24/22 revealed a Brief Interview for Mental Status (BIMS) score of 8, which indicated he has moderate cognitive impairment. Resident #49 is dependent on staff for two-person assistance for transfers and total assistance for bathing.

A record review of Resident #49's "Documentation Survey Report (V2)" for "Mar-22" revealed he did not receive a shower on 3/12/22, 3/17/22, 3/22/22, 3/29/22, and 3/31/22.

A record review of Resident #49's "Documentation Survey Report (V2)" for "Apr-22" revealed he did not receive a shower on 4/5/22, 4/7/22, 4/9/22, 4/12/22, 4/14/22, 4/16/22, 4/23/22, and 4/26/22.

A record review of the facility's "North Wing Bath Schedule" revealed Resident #49's room scheduled for baths on Tuesday, Thursday, and Saturday on 3-11 shift.

Resident #56

On 4/25/22 at 1:57 PM, the State Agency (SA)

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and the Director of Nursing (DON) observed Resident #56 in his room. His right and left great toenails had a black discoloration and were long and jagged. The other toenails on the left and right foot were not discolored but were noted to be long and jagged. The 4th toe overlaps the 5th toe on his left foot.

During an interview on 4/28/22 at 2:26 PM, with the DON, she confirmed Resident #56's great toenails were long, discolored, and jagged. The DON said the resident could get her toenails caught in the covers, in her clothes or anything that could cause infection or serious pain. The DON measured the residents' toenails. The right great toe measured at 11/2 inches. The measurements of all the other toes were 1/2-inch past the toe except the middle toes. The left great toe measurements were 11/2 inches. The left 4th digit toe overlaps the left 5th digit toe. All the other toenails had jagged edges.

During an interview on 4/28/22 at 3:00 PM, with the Social Services Designee (SSD) confirmed the podiatrist has not seen Resident #56 since 5/7/21. The SSD said the Podiatrist visited other residents on June 2021, December 2021, and March 2022. She notified all the Department Heads of when the Podiatrist would be providing care to the residents. He usually sees fifteen to twenty residents per visit. If the Department Heads do not provide a list of residents needing podiatry services, she adds resident's names who have not been seen. The Social Worker said she had not been notified that Resident #56 needed to be seen by the Podiatrist.

Record review of the Resident #56's "Admission Record" revealed the facility admitted him on

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8/15/18 with diagnoses including Hemiplegia and Hemiparesis, Type 2 Diabetes Mellitus, and Dysphagia.

Record review of the Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 03/21/22 revealed Resident #56 had a Brief Interview of Mental Status (BIMS) of 03 that indicated he is severely cognitively impaired. A review of Section G revealed he is totally dependent upon staff for personal hygiene.

A record review of the "(PED) Patient Encounter Document - Total Foot Care Clinic" dated 5/7/21 revealed Resident #56 was seen by the Podiatrist. A further review of the medical record revealed no other Podiatrist since 5/7/21.

Record review of an email from the Social Worker sent on 3/21/22 (Monday) to the facility Users revealed there were 22 residents on a list to be seen by the Podiatrist on Thursday (3/24/22). Resident #56 was not on the list.

A record review of the facility's policy "Bathing/Showering" revealed a revision date 09/01/2017. The policy stated, "Assistance with showering and bathing will be provided at least twice a week and PRN to cleanse and refresh the resident. The resident shall be asked on admission to establish a frequency schedule for bathing. This schedule will take precedence over the twice a week and PR cleansing. The resident's frequency and preferences for bathing will be reviewed at least quarterly during care conference."

Resident #58

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On 4/25/22 at 12:20 PM, the SA observed Resident #58 and noted he had long facial hair and long hair not brushed noted.

On 4/26/22 03:37 PM, the SA observed Resident #58 to have long facial hair and his hair was unkempt.

On 4/27/22 at 2:55 PM, during an interview with Licensed Practical Nurse (LPN) #1, she explained Resident #58 has not refused showers on her shift.

On 4/27/22 at 4:05 PM, during an interview with CNA #2, she explained Resident #58 receives showers on the evening shift and the shower schedule is located at the nurse's station. Resident #58 was noted to have long facial hair. CNA #2 reported the staff shave him when he gets his scheduled shower.

On 4/28/22 at 11:20 AM, during an interview with CNA #4, she confirmed Resident #58 receives showers on evening shifts and he is always very cooperative.

On 4/28/22 at 3:00 PM, during an interview with CNA #3, she explained when a resident refuses a shower or bath, she will report the refusal to the nurse and will try again late. If the resident continues to refuse, the bath is charted as "refused".

At 3:10 PM on 04/28/22, during an interview with LPN #2, she explained when a resident refuses a shower, the CNA reports to her and she will try to encourage resident to shower and will try again later.

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On 04/28/22 at 3:20 PM, during an interview with RN #1, she reported there is a lot of residents who refuse showers on evening shift and the staff will encourage the resident to take a shower and will give the bed bath. If a resident continues to refuse showers or bath, the staff will call the family. She reported Resident #58 seldom refuses his showers.

A record review of Resident # 58's "Admission Record" revealed the facility originally admitted him on 11/3/2020 and he has a most recent admission date of 3/5/2021 with diagnoses including Dementia, Type 2 diabetes, and Heart Failure.

A record review of Resident #58's Annual MDS with and ARD of 3/7/22 revealed he had a BIMS score of 8 which indicated he was moderately cognitively impaired. He required limited assistance with and personal hygiene and extensive one-person assistance for bathing support.

A record review of Resident #58's "Documentation Survey Report (V2)" for "Ma-22) revealed he did not receive a shower on 3/5/22, 3/10/22, 3/12/22, 3/15/22, 3/17/22, 3/19/22, 3/22/22, 3/24/22, 3/26/22, 3/29/22, and 3/31/22.

A record review of Resident #58's "Documentation Survey Report (V2)" for "Apr-22" revealed he did not receive a shower on 4/2/22, 4/5/22, 4/9/22, 4/12/22, 4/14/22, 4/16/22, 4/19/22, 4/21/22, 4/23/22, 4/26/22, and 4/28/22.

Resident #60

On 4/25/22 at 11:25 AM, the SA observed

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F 677	Continued From page 21	F 677		

Resident #60 to have greasy hair. There was a strong foul odor noted in the resident's room and in the hallway.

On 4/26/22 at 3:45 PM, the SA observed Resident #60 to have greasy hair and long facial hair. Resident #60's room had a strong foul odor noted in room and out in hallway.

On 4/27/22 at 2:50 PM, Resident #60 reported that he is not sure when he had his last shower/bath.

On 4/27/22 at 4:05 PM, during an interview with CNA #2, she explained she has never given him a shower on her shift. The shower schedule is located at the nurse's station.

On 4/28/22 at 11:00 AM, during an interview with CNA #4, she explained Resident #60 receives his showers and baths on evening shift. She had given him a shower before and required assistance.

On 4/28/22 at 3:00 PM during an interview with CNA #3, she explained when a resident refuses a shower or bath, she will report the refusal to the nurse and then will try again later. If the continues to refuse, it is charted as "refused".

A record review of Resident #60's "Admission Record" revealed he was initially admitted by the facility on 9/10/21 and readmitted on 4/1/2022 with the diagnoses of Congestive Heart Failure and Type 2 Diabetes Mellitus.

Record review of Resident #60's Quarterly MDS with ARD of 3/16/2022 revealed a BIMS score of 13, which indicated he is cognitively intact and

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F 677	Continued From page 22 requires on-person physical assistance with bathing. Record review of Resident #60's "Documented Survey Report (V2)" for "Mar-22" revealed Resident #60 did not receive a bath on 3/11/22, 3/16/22, 3/21/22, 3/23/22, 3/28/22, and 3/30/22. Record review of Resident #60's "Documented Survey Report (V2)" for "Apr-22" revealed he did not receive a bath on 4/1/22, 4/4/22, 4/6/22, 4/11/22, 4/18/22, 4/20/22, 4/22/22, 4/25/22, and 4/27/22. Record review of "South Wing Bath Schedule" provided by the DON revealed Resident #60's room receives baths/showers on Monday, Wednesday, and Friday on the 3-11 shift. On 4/29/22 10:29 AM, in an interview with the DON, she stated the nurse on the cart is responsible for making sure residents get their scheduled baths. She stated the nurse on the cart should follow up with CNA and the resident. If a resident refuses a shower, the nurse should document the refusal in the progress notes. She explained the facility has a bath/shower schedule posted at each nurse station south and north wing. She reported the CNAs are to chart in the computer and on paper for completed baths and showers. DON provided two (2) completed shower list for 7-3 shift and reported she could not find any other "daily bath list." Resident #60 was not listed on the daily bath list. No other documentation was provided during the survey.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		6/10/22

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F 686	Continued From page 23 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: F686 Based on observation, interview, record review and facility policy review the facility failed to clean a residents wound according to professional standards for two (2) of four (4) wound care observations Resident #49 and Resident #63. Findings include: A record review of the facility's "Policies and Procedures" with the "Subject" of "Clinical Guideline Skin & Wound" with an effective date of 4/1/2017 revealed, "Overview: To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing, and decrease worsening of/prevention of pressure injury. Process: ... monitor residents' response to treatment and modify treatment as indicated ..." A record review of the facility's "Policies and	F 686	F686 * Resident #49 and #63 were assessed for signs and symptoms of infection by Director of Nursing on April 29, 2022, no adverse findings. Registered Nurse #2 performed a return demonstration skill check off on wound care, to include cleaning wound from center, moving outward, with Director of Nursing on April 29, 2022. Registered Nurse educator will observe Registered Nurse #2 perform wound care procedure for Resident #49 and Resident #63 weekly times three (3) weeks , then monthly times three (3) months, beginning May 10, 2022. * All residents with an active wound have the potential to be affected. All residents with a wound were assessed for signs and symptoms of infection by the Director of Nursing on April 29, 2022	

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F 686	Continued From page 24 Procedures" with the "Subject" of "Dressing Change" with revision date of 12/6/2017 revealed "Policy: A clean dressing will applied by a nurse to a wound as ordered to promote healing .... Procedure: Cleanse wound as ordered, dispose of gauze ..." Resident #49 On 4/27/22 at 11:30 AM during, an observation and interview with Registered Nurse (RN) #2, she explained Resident #49 was admitted with a left heel wound. The State Agency (SA) observed RN #2 clean a wound to the left heel with blind wipes in an upward motion from bottom and up and wiping every direction three (3) times with 3 four by four (4 x4) gauzes and discarding after each use. RN #2 did not clean the wound from center outward. On 4/27/22 at 11:50 AM, during an interview with CNA #5 who assisted with positioning of Resident #49 during wound care, she explained she observed RN #2 clean the wound to the left heel from the bottom and wipe upward and wiped in all directions. On 4/28/22 at 10:45 AM, during an interview with RN #2, she explained she doesn't remember how she wiped Resident #49's left heel wound yesterday but did confirm she wiped from the bottom upward to clean the left heel wound. She explained the proper technique to clean a wound is to clean inner to outer and throw away after each wipe. She confirmed she did not clean the wound the proper way. She explained cleaning a wound incorrectly could cause a wound infection and the wound not to heal. A record review of Resident #49's "Admission	F 686	through May 18, 2022, no adverse findings. Registered Nurse Educator will observe two (2) wound care procedures weekly times four (4) weeks, then monthly times three (3) months, beginning May 3, 2022. * All nurses were in-serviced on proper wound care procedure by Registered Nurse Educator, beginning on May 3, 2022. All nurses completed skill check off on proper wound care procedure by Registered Nurse Educator, beginning on May 3, 2022. * Registered Nurse Educator will observe two (2) wound care procedures weekly times four (4) weeks, then monthly times three (3) months, beginning May 3, 2022. Findings were brought to the Quality Assurance Performance Improvement Committee meeting by Director of Nursing on May 16, 2022 and will continue monthly times three (3) months to determine the effectiveness and make any necessary changes as indicated.	

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Record" revealed the resident was admitted to the facility 2/28/2019 with diagnoses that included Chronic Obstructive Pulmonary Disease and Alzheimer's Disease.

Record review of Resident #49's "Order Summary Report" dated 4/29/22 revealed " ...Left heel: Rinse with normal saline pat dry, apply skin prep to peri-wound allow to dry, apply Derma gel, change every 48 hours and as needed."

A record review of Resident #49's "Annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) 2/24/22 revealed a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impaired. Review of Section M revealed Resident #49 had one (1) Stage 3, one (1) Stage 4, and one (1) unstageable pressure wound.

Resident #63

On 4/27/22 at 10:45 AM, during an observation with the wound care nurse (RN #2), revealed during wound care for Resident #63 she used one (1) 4x4 gauze soaked in normal saline, wiped, and blotted the sacral wound. She did not clean the sacral wound from inner to outer and discard the gauze after the wipe.

On 4/28/22 at 10:45 AM, during an interview with RN #2, she explained Resident #63 was admitted with a sacral wound. RN #2 confirmed she only used one 4 x 4 gauze to clean Resident #63's sacral wound yesterday. She explained the proper technique to clean a wound is to clean inner to outer and throw away after each wipe. She confirmed she did not clean the wound the proper way. She explained cleaning a wound

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F 686	Continued From page 26 incorrectly could cause a wound infection and wound not to heal. A record review of Resident #63's "Admission Record" revealed the resident was admitted to the facility on 11/30/22 with diagnoses that included Osteomyelitis of vertebra, Sacral and sacrococcygeal region. A record review of Resident #63's "Order Summary Report" revealed an order 4/18/22 for Acetic Acid Solution 0.25% apply to sacrum topically one time a day for sacrum, cleanse pressure ulcer to sacrum with normal saline, pat dry, apply acetic acid ¼ strength wet to dry, cover with absorptive dressing daily and as needed. A record review of Resident #63's Quarterly MDS with an ARD of 3/9/2022 revealed. Review of Section M revealed he had one (1) Stage 4 wound that was present upon admission. On 04/28/22 at 4:30 PM, during an interview with Director of Nursing (DON), she confirmed the wound care for Resident # 49 and Resident # 63 observed by SA completed by RN #2, was improper wound care techniques. She explained improper wound care could mean the wound was not properly cleaned. She stated all wounds are different and depending on the wound bed would it cause further damage to the wound	F 686		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 760		6/10/22

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F 760	Continued From page 27 by: Based on observation, interview, record review and facility policy review the facility failed to prevent a significant medication error when a resident did not receive sliding scale insulin per physician's orders for one (1) of two (2) residents reviewed. Resident #234. Findings include: A record review of the facility's "Policies and Procedures" with a "Subject" of "Blood Glucose Monitoring and Disinfecting" with a revision date of 3/1/2021, revealed "Procedure: Verify Physician order ..." A record review of the facility's policy "Administering Medications" with a revised date of April 2019 revealed, "Policy Medications are administered in a safe and timely manner, and as prescribed ..." A record review of Resident #234's "Admission Record" revealed the facility admitted Resident #234 on 4/19/2022 with diagnoses including Pneumonia and Type 2 Diabetes Mellitus with Hyperglycemia. A record review of Resident #234's "Order Summary Report" revealed an order dated 4/20/22 for "Blood glucose before meals and at bedtime (ACHS) and an order dated 4/20/22 for Novolog solution 100 units/milliliter (ml) inject as per sliding scale: if 0-59 = 0 units follow hypoglycemic protocol; 60 - 150 = 0 units; 151 - 250 = 3 units; 251 - 350 = 5 units; 351 + = 8 units Call provider, encourage oral fluids unless contraindicated, subcutaneously as needed for Diabetes."	F 760	F760 * On April 26, 2022, Resident #234, Novolog Insulin Sliding Scale order was clarified to before meals and at bedtime. On April 28, 2022, Assistant Director of Nursing completed a Medication Discrepancy Report. On April 26, 2022 Resident #234 was assessed for potential negative effects by Assistant Director of Nursing, with no adverse findings noted. Assistant Director of Nursing in-serviced Licensed Practical Nurse #4 on Point Click Care data entry of medication orders, following Physician orders and medication error, on April 28, 2022. Resident #234 discharged home on April 27, 2022 with no further action required. * All residents receiving Insulin per sliding scale have the potential to be affected. On May 3, 2022, Assistant Director of Nursing reviewed all orders for residents receiving insulin per sliding scale, no issues identified. * All residents receiving Insulin per sliding scale have the potential to be affected. On May 3, 2022, Assistant Director of Nursing reviewed all orders for residents receiving insulin per sliding scale, no issues identified. Assistant Director of Nursing in-serviced all nurses on Point Click Care data entry of medication orders, following physician's orders, and medication errors, beginning May 3, 2022.	

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F 760	Continued From page 28 A record review of Resident #234's Electronic Medication Administration Record (EMAR) revealed an order for "Blood Glucose ACHS before meals and at bedtime". There was no sliding scale coverage indicated for this order on the EMAR. There is an order on the EMAR for "Novolog solution 100 units/ml (Insulin Aspart) inject as per sliding scale: if 0-59 = 0 units follow hypoglycemic protocol; 60-150 = 0 units; 151-250 = 3 units; 251-350 = 5 units; 351 + = 8 units Call provider, encourage oral fluids unless contraindicated, subcutaneously prn (as needed) for Diabetes." This order was prn only and did have sliding scale insulin coverage based on the prn accucheck result. Review of the EMAR for April 2022 revealed the following accucheck results for Resident #234: 4/21/22 at 11:30 AM accucheck result was 224; 4/21/22 at 9:00 PM accucheck result was 335; 4/22/22 at 11:30 AM accucheck reults was 170; 4/22/22 at 4:30 PM accucheck result was 293; 4/22/22 at 9:00 PM accucheck result was 259; 4/24/22 at 9:00 PM accucheck result was 314; 4/25/22 at 9:00 PM accucheck result was 218; 4/26/22 at 11:30 PM accucheck result was 210; 4/26/22 at 4:30 PM accucheck result was 394; 4/26/22 at 9:00 PM accucheck result was 235. There are no sliding scale insulin units recorded as being given to reduce Resident #234's blood glucose level on the EMAR for these entries. On 4/26/2022 3:50 PM, State Agency (SA) observed Licensed Practical Nurse (LPN) #4 obtain Resident #234's blood glucose prior to administrating medications. Resident's blood glucose results was 394, LPN #4 administered 8 units of Novolog and called the physician.	F 760	*Assistant Director of Nursing will audit all sliding scale insulin orders and electronic health records weekly times four (4) weeks, then monthly times three (3) months, beginning May 3, 2022. Any errors identified will be corrected immediately. Findings were brought to the Quality Assurance Performance Improvement Committee Meeting by Assistant Director of Nursing on May 16, 2022 and will continue monthly times three (3) months to determine the effectiveness and make any necessary changes as indicated.	

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Resident #234 reported she knew her blood sugar was high because she felt shaky.

On 4/26/22 at 2:00 PM, during an interview with Resident #234, she reported she is a diabetic and the facility has been checking her blood sugars four times a day and sometimes give her insulin and sometimes they do not.

On 4/27/22 at 9:00 AM, during an interview with the Nurse Consultant, she explained she had reviewed the resident's physican orders for the accucheck ACHS. She discovered that on 4/20/22, LPN #4 had entered an order for accuchecks ACHS into the computer, but she did not input the corresponding Novolog sliding scale per the physician's telephone order. The Nurse Consultant verified this was a medication error.

On 4/27/22 at 5:15 PM, during an interview with Registered Nurse (RN) #3, he explained he is the evening supervisor and on 4/20/22, LPN #4 came to him reporting Resident #234's blood sugar was elevated. He advised her to call the physician and get orders for accuchecks ACHS with sliding scale insulin. The order was not entered into the computer correctly because the sliding scale perameters were not entered with the accuchecks.

On 4/28/22 at 4:00 PM, during an interview with the Advanced Registered Nurse Practitioner (ARNP), she explained she expects accucheck orders to have sliding scale insulin coverage and to be given as ordered.

On 04/28/22 at 5:00 PM, during an interview with the Director of Nursing (DON), she explained she expects all nurses to follow physician orders

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F 760	Continued From page 30 when administering medications. On 04/28/22 at 5:55 PM, during an interview with LPN #4, she explained she had not received training on how to place the physician orders in the computer. She reported she did call the physician when the resident complained her blood sugar needed to be checked because she thought her blood sugar was high. She received an order over the phone from the physician to obtain accuchecks ACHS with sliding scale insulin and she entered the order in the computer the "best she could" and had no assistance.	F 760		
F 812 SS=D	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, interviews, record review	F 812	F812	6/10/22

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F 812	Continued From page 31 and facility policy review the facility failed remove expired food items from the pantry, failed to date open food items and failed to reseal a hamburger bun package for one (1) of three (3) kitchen observations. Record review of the Facility's "Policies and Procedures" with the "Subject" as "Dry Food Storage", dated 11/30/2014, revealed, "Policy: To prevent damage, infestation and spoilage of food and maintain quality food products ...Procedure: ... Open packages will be stored in closed containers or secured with metal ties, etc. and dated ..." On 04/25/22 at 010:30 AM, an initial observation of the kitchen with the Regional Dietary Director (RDD) revealed a bag of hamburger buns torn open and exposed to air on the bread cart. There were 2 containers of thickened apple juice with expiration dates of 4/12/22 and 4/15/22. The following food/items did not have date they were initially opened for use: a 1-gallon container of sweet and sour sauce, half full., a 1-gallon container of worcestershire sauce, a 10-ounce bottle of sweet and sour sauce, and a 10-ounce container of salsa. On 4/25/22 at 11:10 AM, in an interview with the RDD, he stated the purpose of writing the date on item when it is opened is to let staff know how long it has been open and it lets you know when to discard the item. He stated the hamburger buns should have been sealed. It is possible they could cause a problem for the resident. He stated expired items should be discarded on or before the date of expiration, and it was the Chef's responsibility to check the items. He stated there was a possibility that residents could receive an	F 812	* On April 25, 2022, Chef removed expired food from pantry, unsealed hamburger bun package, and undated open food items from the kitchen. On April 25, 2022, Registered Dietician and Chef checked all food items for labeling, dates, and storage with no other adverse findings noted. * All residents have the potential to be affected. * All dietary staff in-serviced on proper labeling, dating, sealing of food items and removal of expired food items, by Chef on April 25, 2022. All dietary staff in-serviced on dietary log for monitoring food in refrigerator and storage areas, by Chef on May 2, 2022. * Daily monitoring of refrigerator and dry storage area, by Kitchen supervisor to ensure all food items are properly dated, sealed, and removed from shelves prior to expiration, beginning April 26, 2022. Chef or Kitchen supervisor to audit dietary log five (5) times per week times four(4) weeks, then monthly beginning April 26, 2022. Registered Dietician will perform Kitchen inspection to include review of dietary logs and daily monitoring of refrigerator and dry storage areas, monthly beginning on May 25, 2022. Findings were brought to Quality Assurance Performance Improvement Committee Meeting by Chef on May 16, 2022 and will continue monthly times	

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OCEAN SPRINGS HEALTH & REHABILITATION CENTER	1199 OCEAN SPRINGS ROAD OCEAN SPRINGS, MS 39564

(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 812	Continued From page 32 expired food item if the items weren't discarded when expired. On 4/26/22 at 3:14 PM, in an interview with the Chef he stated, "I apologize for the expired food being on the shelf." He stated it was his responsibility to pull expired items and discard them. He stated everyone in dietary should check for expired items and discard them. He stated the purpose of pulling expired foods is to make sure the residents do not get sick. It was for the resident's safety. He stated the expiration date is on the food for a reason. All food items should have an open date on them when they are opened. He stated the hamburger buns should have been opened properly by the top and resealed. Record review of Chef Dietary Orientation Checklist dated 5/4/20, revealed the Chef had received training on food storage procedures. The Chef's initials were noted on the checklist.	F 812	three (3) months to determine effectiveness and make any necessary changes as indicated.	