STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255338	A. BUILDING _____ B. WING _____	05/19/2022

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LAMAR HEALTHCARE & REHABILITATION CENTER	6428 US HIGHWAY 11 LUMBERTON, MS 39455

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F 000	INITIAL COMMENTS The State Survey Agency (SSA) conducted an annual recertification along with a Complaint Investigation (CI), MS #18737 from 05/16/2022 through 05/19/2022. During the survey, the SSA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SSA cited F638, F657, F689, F692, and F732 during the survey. The SSA did not substantiate MS #18737 related to staffing, call lights not answered, and responsible representative notification. The census at the time of the survey was 57, with a bed capacity of 120.	F 000		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to complete and submit quarterly Minimum Data Set (MDS) Assessments timely for seven (7) of 33 residents reviewed for MDS assessments. Resident #2, Resident #3, Resident #10, Resident #11, Resident #12, Resident #14, Resident #15 Findings include: A record review of the facility's policy "MDS Completion and Submission Timeframes", with a revised date of July 2017, revealed a policy	F 638	The plan of correction is being submitted pursuant to 42 C.F.R 488.402 (d)(1) and State Operations Manual 7304. This plan of correction is not intended to be an admission or used for any other purpose other than the purpose stated herein. 1. The minimum data sets assessments for residents #2, 3, 10, 11, 12, 14, and 15 have been submitted on 05/22/2022 by minimum data set nurse to reflect their current status. Will monitor for 90 days.	6/30/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/10/2022

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F 638	Continued From page 1 statement "Our facility will conduct and submit resident assessments in accordance with the current federal and state submission timeframes." The policy had listed under policy interpretation and implementation the following: 1. The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted ... in accordance with current federal and state guidelines. 2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument (RAI) manual..." A record review of Centers for Medicare and Medicaid (CMS) RAI Version 3.0 Manual dated October 2019 revealed, "The Quarterly assessment is an OBRA (Omnibus Budget Reconciliation Act) non- comprehensive assessment for a resident that must be completed at least every 92 days ..." Resident #2 A record review of the "Face Sheet" revealed the facility admitted Resident #2 on 01/14/2016. A record review of the most recent Minimum Data Set (MDS) assessment for Resident #2 revealed it was a quarterly review assessment with an Assessment Reference Date (ARD) of 01/04/2022. There were more than 92 days since the last assessment. Resident #3 A record review of the "Face Sheet" revealed the facility admitted Resident #3 on 08/31/2017.	F 638	2. All residents have the potential to be affected. 3. Minimum data set Nurse will continue using the implemented tracking logs for needed minimum data set assessments. Individual logs will be started on each resident at admission and will be maintained until discharge as a backup for facility minimum data set software "assessment due" report starting on 05/22/2022. An in- service was completed by staff development nurse to the minimum data set nurse on 6/1/2022 on completion of quarterly assessments every 90 days for all residents. 4. Director of Nursing will perform audits weekly for assessment completion compliance starting on 6/20/2022 for 90 days. Any exceptions will be noted and corrected immediately by minimum data set nurse and reported to facility monthly Quality Assurance and Performance Improvement Meeting starting on 6/24/2022 for further review and recommendations for 90 days.	

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F 638	Continued From page 2	F 638		

A record review of the most recent MDS assessment for Resident #3 revealed it was a quarterly review assessment with an ARD of 01/10/2022. There were more than 92 days since the last assessment.

Resident #10

A record review of the "Face Sheet" revealed the facility admitted Resident #10 on 10/12/2015.

A record review of the most recent MDS assessment for Resident #10 revealed it was a quarterly review assessment with an ARD of 01/11/2022. There were more than 92 days since the last assessment.

Resident #11

A record review of the "Face Sheet" revealed the facility admitted Resident #11 on 08/28/2018.

A record review of the most recent MDS assessment for Resident #11 revealed it was a quarterly review assessment with an ARD of 01/11/2022. There were more than 92 days since the last assessment.

Resident #12

A record review of the "Face Sheet" revealed the facility admitted Resident #12 on 04/30/2013.

A record review of the most recent MDS assessment for Resident #12 revealed it was a quarterly review assessment with an ARD of 01/11/2022. There were more than 92 days since the last assessment.

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	255338	A. BUILDING _____ B. WING _____	05/19/2022

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F 638	Continued From page 3	F 638		

Resident #14

A record review of the "Face Sheet" revealed the facility admitted Resident #14 on 03/11/2021.

A record review of the most recent MDS assessment for Resident #14 revealed it was an annual assessment with an ARD of 01/11/22. There were more than 92 days since the last assessment.

Resident #15

A record review of the "Face Sheet" revealed the facility admitted Resident #15 on 07/06/2021.

A record review of the most recent MDS assessment for Resident #15 revealed a quarterly review assessment with an ARD of 01/12/2022. There were more than 92 days since the last assessment.

On 05/18/22 at 10:23 AM, during an interview with the Director of Nursing (DON)/MDS nurse, she stated it was her responsibility to complete the MDS assessments. She stated she had been doing other duties in the facility related to her DON responsibilities and she had not been able to keep up with MDS Assessments. She stated she used the RAI manual for reference for completing MDS assessments. She confirmed the MDS Assessments on the residents were past due, and she was aware of the importance for MDS assessments to be completed in a timely manner.

At 1:30 PM on 05/19/22, during an interview with the Administrator, she stated she was not aware the DON/MDS nurse was truly behind on MDS

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F 638	Continued From page 4 assessments. She expected the MDS nurse to be up to date with completing MDS assessments.	F 638		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Final version Based on observations, interviews, and record reviews the facility failed to revise the care plan	F 657	1. The comprehensive care plan for resident #15 has been completed on 05/20/2022 by minimum data set nurse to reflect their current status and	6/30/22

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F 657	Continued From page 5 when the desired outcome of a decrease in falls was not met for one (1) of eighteen residents, Resident #15. Findings include: Review of the facility's, "Care Plans, Comprehensive Person -Centered policy" , with a revision date of December 2016 revealed the Policy Statement "A comprehensive, person -centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. " The policy further stated "Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team must review and update the care plan:...when the desired outcome is not met..." Review of the Comprehensive care plan dated 07/21/21 revealed a problem of "The resident has multiple falls and impaired cognition." which was implemented on 07/21/2022. The goal of the problem was to "Have decreasing number of falls" with a target date of 08/01/2022. The interventions included: Give verbal reminders not to ambulate or transfer without assistance. Ensure that resident wears properly - fitting non-skid soled shoes for ambulation. Assess resident's need for assistive /supportive device. Do not keep bedrails up unless necessary. Observe resident for adverse side effects toxicity of medications in current drug regimen. Maintain resident environment free of clutter and safety hazards. Place items frequently used by resident within easy reach to avoid resident reaching for items. Provide environment with adequate lighting	F 657	interventions. Minimum Data Set nurse will revise each residents comprehensive care plan within 7 days of the quarterly or yearly assessment starting on 6/1/2022. Director of Nursing will monitor for 90 days. 2. All residents have to potential to be affected. 3. Minimum Data Set nurse will develop or revise comprehensive care plans no later than 7 days after the Resident Assessment Instrument comprehensive assessment is completed. Revision of resident #15 comprehensive assessment began on 05/20/2022 by Minimum Data Set nurse. An audit was started on 6-20-2022 to revise all residents current care plans for risk for falls or actual falls by minimum data set nurse. Audit will be completed by 7/08/2022 and discussed at Quality Assurance and Performance Improvement meeting on 7/08/2022. In-service was completed by staff development nurse on 6/8/2022. 4. Director of Nursing will perform audits each week of comprehensive assessments starting on 6/1/2022 for revision date compliance according to Resident Assessment Instrument for all residents for 90 days. Any exceptions will be noted and corrected immediately by Minimum Data Set nurse and reported to facility monthly Quality Assurance and Performance Improvement meeting starting on 6/24/2022 for further review and recommendations.	

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F 657	Continued From page 6	F 657		

free of glare and analyze previous falls by resident to determine weather pattern or trends can be addressed.

Resident #15

During an interview on 05/16/22 at 12:25 PM with Resident # 15's sister, she stated the facility had not provided good supervision to prevent her brother from falling. The sister said Resident #15 had fallen several times in the courtyard because he went out there by himself during the day and at night without supervision.

During an Observation 05/16/22 at 1:31 PM Resident #15 was observed walking out of the building to the courtyard and to the gazebo unsupervised, there were no staff present. The resident's gait was unsteady. The resident was outside for about 15 minutes.

On 05/16/22 at 04:24 PM Resident #15 was observed walking outside of the side door of the facility to the gazebo. The resident's gait was unsteady and there were no staff present.

During an interview on 05/18/22 at 03:46 PM with the interim Director of Nursing (DON)/Care Plan/Minimum Data Set (MDS) nurse, she confirmed the resident had fallen multiple times. The DON said the resident was impulsive and wandered all over the building. The DON confirmed the care plan was not revised with new interventions after interventions in place failed to prevent the resident from falling. The DON stated increasing monitoring of the resident had not been considered and stated the facility could not provide one-on-one supervision.

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F 657	Continued From page 7 The facility face sheet for Resident #15 revealed the facility admitted the resident on 7/06/21, with diagnoses including Major Depressive Disorder, Diabetes Mellitus and Hypothyroidism. Resident #15's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/12/22 revealed Resident#15 had a brief interview of Mental Status (BIMS) of 06 which indicated Resident #15 was cognitively impaired.	F 657		
F 689 SS=E	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, staff and family interview, record review, and facility policy review, the facility failed to provide adequate supervision to prevent falls for one (1) of four (4) residents investigated for falls resulting in six falls in the previous seven months for Resident #15. Findings Include: Review of the facility's, "Fall-Clinical Protocol" revised March 2018 revealed "The staff and practitioner will review each resident's risk factors for falling and document in the medical record. The physician will identify medical conditions affecting fall risk. The staff will evaluate, and	F 689	1. An every 15 minute safety visualization log has been implemented on 6/8/2022 for resident #15 by Unit Manager registered nurse. Falls will be monitored each week by Director of Nursing for trending to see if every 15 minute safety visualization monitoring intervention is successful until 7/8/2022. A Quality Assurance Meeting will be scheduled on 6/24/2022. 2. All residents have the potential to be affected. 3. Unit A nursing staff will visualize where resident #15 is located in the facility every	6/30/22

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F 689	Continued From page 8 document falls that occur while the individual is in the facility; for example, when where they happen, any observations of the event etc. The falls should be identified as witnessed or unwitnessed events. Based on the preceding assessment, the staff, and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risk clinically significant consequences of falling. The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and document the individual's response to interventions intended to reduce falling or the consequences. If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed for example if the problem that required the intervention has resolved by addressing the underlining cause. If the individual continues to fall, the staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and reconsider the current interventions. Review of the facility's, "Safety and Supervision of Resident" policy revised July 2017. Revealed our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accident are facility-wide priorities. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Review of Resident #15's facility incident reports for falls for the previous seven months revealed	F 689	15 minutes and complete safety visualization log located at Unit A nursing station starting on 6/8/2022 for as long as resident #15 resides in facility. In-service was done by Staff Development Nurse on 6/8/2022 regarding every 15 minute safety visualization checks for resident #15. 4. Director of Nursing will perform audits of safety logs weekly for completion starting on 6/8/2022. Falls logs will be monitored weekly by Director of Nursing for trending starting on 6/8/2022. Any exceptions will be addressed immediately and reported to facility monthly Quality Assurance and Performance Improvement Meeting starting on 6/24/2022 for 90 days for further review and recommendations.	

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F 689	Continued From page 9	F 689		

Resident #15 had experienced six (6) falls in that time period. The falls occurred on 10/27/21, 10/28/21, 11/12/21, 04/04/22, 04/18/22 and 05/8/22. All 6 falls were unwitnessed by staff. The resident was able to indicate he had fallen when found by staff. No significant injuries were sustained in any of the fall events.

During an interview on 05/16/22 at 12:25 PM with Resident #15's sister, she stated she was concerned that the facility allowed her brother to fall several times. The resident's sister stated she thought the resident was falling a lot because of a lack of supervision in the facility. The sister said the resident's gait was unsteady and he seemed to fall a lot in the facility's courtyard. She stated she was notified of the resident's most recent fall that occurred on 05/08/2022 by Licensed Practical Nurse LPN #1 a day after he fell (on 05/09/2022). She stated later in the day on 05/09/2022 she received a call from the facility Social Worker who told her there had been an interdisciplinary team meeting to discuss Resident #15's behavior of wandering and it was determined the resident needed to be transferred to a facility with an Alzheimer's unit. Resident #15's sister state she asked the social worker why the facility could not just lock the door to the courtyard to prevent the resident from going out unattended. The social worker said the facility could not lock the courtyard door. The resident's sister stated she was told the facility could not monitor the resident one on one. She stated the Social Worker told her the interdisciplinary team felt the resident needed to be in a locked unit.

A review of Resident #15's care plan revealed a problem with an onset of 07/21/2021 of "Multiple falls related to impaired mobility and impaired

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F 689	Continued From page 10	F 689		

cognition". There was a goal of "Have decreasing number of falls" with a target date of 08/01/2022.

An observation on 05/16/22 at 1:31 PM revealed Resident #15 walking outside of the side door to the courtyard. The resident was going to the gazebo unsupervised; no staff was around. The resident's gait was unsteady. Resident #15 ambulated back inside the facility with no staff supervision. The resident was outside for about 15 minutes.

An observation on 05/16/22 at 1:45 PM of the courtyard revealed the gazebo had a concrete floor.

An observation on 05/16/22 at 04:24 PM of Resident #15 revealed he ambulated outside to the courtyard, then ambulated to the gazebo. The resident then turned around and came back into the facility without assistance. The resident's gate was unsteady. There were no staff observed to cue or assist the resident.

During an interview on 05/17/22 at 03:34 PM with LPN #1, she confirmed Resident #15 had fallen several times. LPN #1 said the resident wandered the facility walking and propelling his wheelchair. LPN #1 stated Resident #15 was impulsive and hard to redirect. LPN#1 stated the resident goes in and out of the courtyard all day and during the afternoon without assistance. LPN #1 said she's the only nurse on that end of the building and cannot always keep an eye on him. LPN #1 stated on 04/18/22 at 5:00 PM she was notified by a Certified Nurse Assistant the resident on the ground at the gazebo. LPN #1 further stated the CNA was looking out the

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F 689	Continued From page 11	F 689		

window and saw the resident on the ground. LPN #1 said no one knew how long the resident was out there on the ground. LPN #1 said on 05/8/22 the resident was again found on the ground in the courtyard under the gazebo. The resident's rolling walker was found in the grass across from the sidewalk. LPN #1 confirmed she didn't know how long the resident was there and because it was uncertain if the resident hit his head neurological checks were started immediately to assess the resident for any possible head injury.

In an interview on 05/18/22 at 03:46 PM with the interim Director of Nursing (DON), she confirmed the resident had fallen multiple times. The DON said the resident was impulsive and wandered all over the building. The DON stated she didn't have enough staff to provide one on one supervision for Resident #15.

During an interview on 05/19/22 at 1:00 PM with the Administrator, she acknowledged Resident #15 had multiple falls. The Administrator said the facility doesn't lock the door to the courtyard because the resident enjoys going outside. The Administrator stated staff are in the offices of the facility and there are windows all around the building. She stated staff could look out the window and see the courtyard. The Administrator confirmed the office staff is not there after 5:00 PM and on the weekends and stated she is unsure of how falls could be prevented.

A review of the facility's face sheet for Resident #15 revealed the resident was admitted by the facility on 7/06/21, with diagnoses including Diabetes Mellitus and Hypothyroidism. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/12/22

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LAMAR HEALTHCARE & REHABILITATION CENTER	6428 US HIGHWAY 11 LUMBERTON, MS 39455

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F 689	Continued From page 12 revealed Resident#15 had a brief interview of Mental Status (BIMS) of 06 which indicated Resident #15 was cognitively impaired.	F 689		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to implement monitoring of meal consumption amounts for residents with weight loss for two (2) of three (3) residents reviewed for nutrition. Resident #34 and Resident #52 Findings include: Record review of the facility's policy "Food and	F 692	1. Registered Dietician will assess resident #34 and #52 for further recommendation. Assessment by dietician done on 6/14/2022. Findings will be discussed at 6/24/2022 Quality Assurance and Performance Improvement Meeting. Director of Nursing will monitor for 90 days.	6/30/22

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F 692	Continued From page 13 Nutrition Services" with a revision date of October 2017 revealed, " ...Policy Interpretation and Implementation ... 8. Nursing personnel, with the assistance of the food and nutrition services staff, will evaluate (and document as indicated) food and fluid intake of residents with, or at risk for, significant nutritional problems ..." Resident #34 A record review of Resident #34's "Face Sheet" revealed the facility admitted him on 04/02/19 with diagnoses including Encounter for Surgical Aftercare for Surgery on the Teeth or Oral Cavity, Osteoarthritis, Chronic Obstructive Pulmonary Disease, and Congestive Heart Failure. A record review of Resident #34's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/23/22 revealed a Brief Interview for Mental Status (BIMS) score of 08, which indicated moderate cognitive impairment. The MDS also indicated Resident #34 had weight loss. On 05/16/22 at 11:59 AM, during an interview with Resident #34, he stated he believed he had lost weight because he had been sick, but now he is feeling better. A record review of Resident #34's "Weight Change History" revealed his weight was recorded on 11/06/2021 at 127.8 pounds (lbs.) and on 04/29/2022 at 122.8 lbs. He had a weight change of -3.91% (weight loss) from 11/06/2021 to 04/29/2022 (180 days). A record review of "Meals/Snacks" for Resident #34's meal consumption revealed on 05/01/2022 there was no documentation of percentage of	F 692	2. All residents have the potential to be affected. 3. In-service by Staff Development nurse done on 6/8/2022 with all nursing staff regarding charting of by mouth intake and meal intake each shift. Licensed Practical nurses will monitor certified nursing assistant documentation of by mouth intake and meals for each resident each shift. 4. Director of Nursing will perform audits of documentation completion weekly for 90 days starting on 6/13/2022. Any exceptions will be noted and corrected immediately by nursing staff and reported to facility monthly Quality Assurance and Performance Improvement Meeting starting on 6/24/2022 for further review and recommendations for 90 days.	

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F 692	Continued From page 14	F 692		

meal consumption for the breakfast, lunch, or dinner meals. On 05/02/22 there was no documentation of percentage of meal consumption for the dinner meal. On 05/03/22 there was no documentation of percentage of meal consumption for the dinner meal. From 05/04/2022 through 05/06/2022, there was no documentation of percentage of meal consumption for the breakfast, lunch, or dinner meals. On 05/07/22 there was no documentation of percentage of meal consumption for the dinner meal. On 05/08/22, there was no documentation of percentage of meal consumption for the lunch or the dinner meals. From 05/09/2022 through 05/17/2022, there was no documentation of percentage of meal consumption for the breakfast, lunch, or dinner meals.

Resident #52

A record review of Resident #52's "Face Sheet" revealed the facility initially admitted her on 03/09/18 and readmitted her on 02/14/22 with diagnoses including Pneumonia, Unspecified Atrial Fibrillation, Heart Failure, and Dysphagia.

A record review of Resident #52's Significant Change MDS with an ARD of 03/26/2022 revealed a BIMS score 04, which indicated severe cognitive impairment.

A Record review of Resident #52's "Weight Change History" revealed her weight was recorded on 11/02/2021 at 150.8 lbs; 04/29/2022 at 134.4 lbs. She had a weight change of -10.88% (weight loss) from 11/02/2021 to 04/29/2022 (180 days).

A record review of "Meals/Snacks" for Resident

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F 692	Continued From page 15	F 692		

#52's meal consumption revealed on 05/01/2022 there was no documentation of meal consumption for the breakfast, lunch, or dinner meals. On 05/02/22 there was no documentation of meal consumption for the dinner meal. On 05/03/22 there was no documentation of meal consumption for the dinner meal. From 05/04/2022 through 05/06/2022, there was no documentation of meal consumption for the breakfast, lunch, or dinner meals. On 05/07/22 there was no documentation of meal consumption for the dinner meal. On 05/08/22 there was no documentation for the lunch or dinner meals. On 05/09/2022 there was no documentation of the breakfast, lunch, or dinner meals. On 05/10/22 there was no documentation of meal consumption for the dinner meal. From 05/11/2022 through 05/17/2022, there was no documentation of meal consumption for the breakfast, lunch, or dinner meals.

On 05/18/22 at 11:05 AM, during an interview with Certified Nursing Assistant (CNA) #4, she stated when residents eat meals in the dining room CNAs that are assigned to the dining room are responsible for inputting the meal consumption amount into the computer for those residents.

On 05/18/22 at 11:25 AM, during an interview with Certified Nurse Aide (CNA) #1, she explained meal intakes are entered in the computer, but there were a lot of meal intakes "in the red", which meant there were no meal consumption amounts documented for the days highlighted in red on the computer.

On 05/18/22 at 2:10 PM, during an interview with the Director of Nursing (DON), she stated the documentation of meal intake amounts should be

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F 692	Continued From page 16 recorded on the "MEALS/SNACKS" record. She was unable to explain why there was missing documentation regarding meal intakes. She confirmed it was the CNAs responsibility to record the residents' meal consumption amount into the medical record and that currently there is no one who is checking behind the CNAs to ensure the documentation is completed. At 2:30 PM on 05/18/22, during an interview with CNA #1, she confirmed it is the CNA's responsibility to document and chart the resident's meal intakes. She stated the facility had a lot of agency CNAs and getting them to chart had been a problem. She reported the facility used to write all meal consumption on a meal log, but now they are recorded in the Kiosk. On 05/18/22 at 3:15 PM, during an interview with Licensed Practical Nurse (LPN) #3, she reported she does not review the CNA documentation regarding meal consumption for residents. At 4:20 PM on 05/18/22, during a phone interview with the Registered Dietician (RD), she stated she reviews the residents' meal consumption amounts during her assessments and could only review what was documented in the record. She confirmed she had not reported to anyone that there were residents at the facility whose meal consumption documentation was not completed.	F 692		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:	F 732		6/30/22

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F 732	Continued From page 17 (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and facility policy review, the facility failed to post the direct care daily staffing numbers in a location accessible to residents and visitors for four (4) of four (4) days of survey. This affected all	F 732	1. Daily Nurse Staffing form will be posted daily starting on 6/1/2022 at facility nursing stations by Unit Manager. 2. All residents have the potential to be	

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F 732	Continued From page 18 residents in the facility. Findings Include: Record review of the facility's policy "Posting Direct Care Daily Staffing Numbers" with a revised date of July 2016 revealed, "Policy Statement Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. Policy Interpretation and Implementation 1. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format ..." On 05/19/2022 at 03:00 PM, the State Agency (SA) toured the facility to locate the posting of the direct care daily staffing numbers. The SA was unable to locate the posting. On 05/19/22 03:47 PM, in an interview with the Director of Nursing (DON), she stated she had never posted the direct care daily staffing numbers. She was unaware that the direct care daily staffing hours should be completed and posted, and she has not been posting the hours. On 05/19/22 at 03:50 PM, in an interview with the Administrator, she stated the direct care daily staffing numbers should be posted daily on "A Hall" for staff, visitors and residents to see. The DON is responsible for posting the numbers.	F 732	affected. 3. Unit Manager will be responsible for posting the daily staffing report. Unit Manager been in-serviced on the regulation by Staff Development nurse on 6/1/2022. 4. Administrator will perform audits weekly for completion of daily staffing sheet being posted starting on 6/1/2022 for 90 days. Any exceptions will be noted and corrected by Unit Manager and reported to facility monthly Quality Assurance and Performance Improvement Meeting starting on 6/24/2022 for 90 days.	