STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255109	A. BUILDING _____ B. WING _____	07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF SOUTHAVEN	1730 DORCHESTER DR SOUTHAVEN, MS 38671

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification and Compliant Investigations (CI) MS #19370, CI MS # 19362, CI MS #19225, CI MS # 18823 from 07/17/22 to 7/21/22. On 7/27/22, the SA returned to the facility for investigation of CI MS # 19414 for possible abuse. This was not substantiated and no citations were written. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA substantiated CI MS #18823 for call light system, Activities of Daily Living (ADLs) and environment. F584, F677 and F919 was cited. CI MS # 19370 was unsubstantiated for elopement but cited F609 for not notifying the SA timely. CI MS # 19362 for Quality of Care/treatment/staffing and CI MS # 19225 related to infection control was not substantiated. The SA also cited F623 notice of transfer/discharge, F656 develop/implement a care plan, F686 treatment/services to prevent pressure ulcers, and F761 label/storage of medications during the survey. At the time of survey, the facility had a census of 118 and was licensed for 140 beds.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		9/9/22

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

Electronically Signed | 08/18/2022

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F 584	Continued From page 1 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to provide a clean and safe environment as evidenced by missing tiles, missing baseboard,	F 584	F584 483.10(i) Safe Environment SS=D 1. Room 9 on the East Wing one square	

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F 584	Continued From page 2 missing air conditioner vent cover, damaged furniture and standing water on the floor in a resident's room with electrical cords running through the water for two (2) of 32 rooms observed on the East Wing. Findings Include: Room 9 East Wing Review of the facility policy titled, "Diversicare Healthcare Services Maintenance Policy and Procedure" with a revision date of 9/1/2014 revealed under, "Purpose...This procedure should assist the Maintenance Department in prioritizing the center's everyday needs to ensure a safe and secure environment for residents, visitors, and employees". An observation on 07/18/22 at 10:45 AM, of Room 9 on the East Wing revealed one square foot of tile missing from under the Intravenous (IV) pole and approximately four (4) feet of brown vinyl baseboard are disconnected from the wall and laying behind the bed. This observation revealed a dark brown, reddish substance covers the entire bottom of metal areas to the bedside table. There were six (6) vent cover slats missing from the front of the air conditioner which is visible to the hallway. The window curtain was disconnected from the curtain rod on the right side of the window exposing the outside and a small three-drawer chest was missing the front on the first and third drawers. An observation on 7/19/22 at 10:25 AM, of Room 9 on the East Wing revealed the condition of the room remained the same as the initial observation on 7/18/22 with no apparent repairs.	F 584	foot of tile missing from under the intravenous IV pole was replaced on 7/21/2022 by the Maintenance Director. Approximately, 4 feet of brown vinyl baseboard was glued in place back to the wall behind the bed. The dark brown, reddish substance in the bottom metal areas of the bedside table was cleaned by housekeeper on 7/21/2022. The 6 vent covers/slats missing from the front of the air conditioner visible to the hallway were placed by the Maintenance Director on 7/21/2022 The window curtain was reattached to the curtain rod by the Maintenance Director on 7/21/2022. The small three-drawer chest was repaired by the Maintenance Director on 7/21/2022. The approximately 3 feet of brown vinyl baseboard off behind the toilet was glued in place to the wall on 7/21/2022 by the Maintenance Director. The window curtain was reattached to the curtain rod 7/21/22 by The Maintenance Director. Room 1 East Wing the towels with brown and green substance on them lying up against the left wall in front of the air conditioner and the 2 foot of water was removed from the floor in front of the wet towels 7/21/2022, by the Maintenance Director. The cord was removed from the area and positioned against the wall by the Maintenance Director on 7/21/2022. The cable was removed from the floor, dried and placed against the wall by the Maintenance Director on 7/21/2022. The boiler room leak was noted to be the cause of the water standing in Room 1, which was repaired by The Maintenance Director on 8/18/2022.	

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F 584	Continued From page 3 An observation on 7/20/22 at 4:25 PM, of Room 9 on the East Wing revealed the condition of the room remained the same as the observation on 7/18/22 with no apparent repairs. An observation of the bathroom in the resident's room revealed approximately three (3) feet of brown vinyl baseboard off behind the toilet. On 07/20/22 at 5:45 PM, an interview with the Maintenance Director revealed that he makes rounds once a month to look for problems in the building. The Maintenance Director confirmed that he has not had an assistant in a year and has recently just gotten some help and that he does not make rounds daily. He reported that he has his assistant make rounds every week and he is supposed to fix any issues that he sees. An interview on 7/21/22 at 8:50 AM, with Housekeeper#3, revealed when a problem is found in a room, she writes it down and gives it to the Housekeeping Supervisor, and the Housekeeping Supervisor gets the message to the Maintenance Supervisor. She revealed that she does not have access to the electronic system for requesting repairs that the facility uses because she is a contracted worker. An interview on 7/21/22 at 8:55 AM, with Licensed Practical Nurse (LPN) #8 revealed when there is an issue in a room, they enter it into the electronic reporting system for repairs and it notifies maintenance of the issue. She revealed she wasn't sure if anything had been put in the electronic reporting system about the condition of the room. During an interview and observation on 7/21/22 at	F 584	2. All residents have the potential to be effected by this deficient practice. All rooms were inspected by the Maintenance Director and Regional Maintenance Director with repairs made to ensure a safe, clean, comfortable, and homelike environment 8/15/22-8/18/22. 3. To ensure that the problem does not recur, the Maintenance Director will check work orders daily and complete timely; Monday thru Friday and emergently as needed. The Maintenance Director will report work orders and completion to the Administrator for verification and completeness weekly beginning 8/19/2022. The Maintenance Director was in-serviced on room inspection and reviewing work orders and timely completion by The Administrator on 7/21/2022. Facility Staff were in-serviced 7/21/22, on reporting damages timely to Maintenance for a safe, clean, comfortable and homelike environment. 4. To monitor the performance of our corrective action and to ensure sustainability, the Administrator and the Maintenance Director will make rounds 1x/week x 4 weeks beginning 8/15/2022, then monthly to ensure a safe, clean, comfortable, homelike environment. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 8/22/2022 by the Maintenance Director for review and revision as necessary. QA will review the findings and determine if a need to alter our corrective action.	

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9:05 AM, with the Facility Administrator, she confirmed the curtain was off the right side of the window and the room was in disrepair and the bathroom baseboards needed to be replaced. She stated, "the room will be fixed today."

An interview on 7/21/22 at 1:25 PM, with the facility Administrator revealed the facility did not have a specific policy on a homelike environment. She revealed the "Resident Bill of Rights" was used for homelike environment concerns. She revealed that the facility's homelike environment policy is included in our residents' rights because each resident is entitled to a homelike environment.

Room 1 East Wing

An observation of room 1 East on 07/18/22 at 11:05 AM, and again at 3:43 PM, revealed several wet towels with a brown and green substance on towels lying up against the left wall in front of the air conditioner. An approximate 2-foot-wide area of water was standing on the floor in front of the wet towels. A white electrical air conditioner cord and a black cable cord were laying in the water.

An observation on 07/19/22 at 10:00 AM, and again at 3:55 PM, revealed several wet towels with brown and green substance on the towels lying up against the left wall in front of the air conditioner. An approximate 2-foot-wide area of water was standing on the floor in front of the wet towels.

An interview and observation on 7/19/22 at 3:55 PM, with Licensed Practical Nurse (LPN) #7, confirmed that this is an accident waiting to

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happen, the resident could slip and fall, and it is also a fire hazard. She confirmed that the Certified Nurse Assistants (CNAs) are supposed to make rounds on residents at least every two (2) hours and this should have been found.

An interview on 7/19/22 at 4:00 PM, with Licensed Practical Nurse (LPN) #8 confirmed that housekeeping was cleaning the rooms on the east hall today and room 1 East should have been cleaned.

An interview and observation on 7/19/22 at 4:15 PM, with the Housekeeping Supervisor revealed that the east hall was cleaned today by Housekeeper #4. The Housekeeping Supervisor revealed that each room is cleaned daily, including floors mopped and she knew that the housekeeper had cleaned room 1 East. Upon observation with the Housekeeping Supervisor of room 1 East, several dry white towels were lying on the floor and no water was noted. A white air conditioner cord and black cable cord were noted lying on the dry white towels. The House Supervisor revealed that honestly, this has been a problem for quite some time and that she has reported this to the Maintenance Supervisor. She revealed the way they are supposed to report issues is through the electronic documentation system, however, she was a contracted employee and did not have access to the system. She revealed that she either texts or calls the maintenance supervisor when there are issues, and she has spoken with the Maintenance Supervisor several times to report this issue to him verbally.

An interview and observation on 7/19/22 at 4:40 PM, with the Maintenance Supervisor revealed

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that he thought it was the air conditioner leaking then he determined it was something leaking from the boiler room which is adjacent to room 1 East. He did confirm that if an electrical cord was laid down on the wet floor that it could be a problem and that if water was on the floor that it is a trip hazard for the resident in that room.

An interview on 7/19/22 at 5:05 PM, with the facility Administrator revealed that the air conditioner unit was broken a while back and the Maintenance Supervisor fixed it. She revealed it has been working fine until it was reported to her yesterday that it was leaking. The Administrator revealed the facility has an electronic work order system that all employees including contracted workers have access to. The Administrator revealed whenever there's an environmental issue in the facility all staff knows to report it through the electronic work order system.

An observation on 7/20/22 at 2:20 PM, by State Agency (SA) revealed water on the floor approximately 2 feet wide in front of the air conditioner unit. There were also two (2) square foot tiles missing where the wet towels had been laying previously.

A record review of the Work order report from 11/1/2021-7/20/2022 revealed no work orders were submitted for water leakage in room 1 East.

In an interview and observation on 07/21/22 at 9:20 AM, the facility Administrator confirmed the water on the floor of room 1 East was from an issue in the boiler room where a water leak had begun and traveled to the resident's room and was observed on the floor in front of the air conditioning unit. She revealed that she has

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F 584	Continued From page 7 instructed her staff to monitor the area every 15-30 minutes and to avoid placing towels on the floor. Observation of a wet caution sign was placed at this time.	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		9/9/22

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(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the

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F 623	Continued From page 9 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide the responsible party with a notice of transfer to the hospital for one (1) of three (3) residents transferred to the hospital. Resident # 27 Findings include: Record review of a typed document dated 7/21/22, on facility letterhead and signed by the Administrator revealed, "Diversicare of Southaven do not have a former policy for notification of Transfer to the hospital." An interview on 7/19/22 at 12:23 PM, with	F 623	F623 483.15(c) (3)-(6) (8) Notice Requirement before Transfer/Discharge SS=D 1. Resident #27 and Responsible Party were delivered the notice of transfer to an acute facility via US Mail on 8/5/2022. 2. Residents of the facility with an unplanned center initiated transfer or discharged have the potential to be affected by deficient practice. 3. Going forward, to ensure the problem does not recur, the social worker will provide each resident with an unplanned	

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F 623	Continued From page 10 Resident #27 revealed he was recently in the hospital. An interview on 7/21/22 at 11:20 AM, with Social Services revealed that she has not been sending any written notification to the family when residents go to the hospital. She stated that she found out about the form yesterday. An interview on 7/21/22 at 11:40 AM, with the Administrator (ADM) revealed she was aware of the regulation concerning transfer to an acute care facility but was not aware that the staff did not know because this regulation occurred before she came to this facility. Record review of the facility Progress Notes dated 6/23/22 revealed Resident #27 was sent out to the hospital on 6/23/22. Record review of the Transfer/Discharge Report revealed Resident #27 was admitted to the facility on 7/13/21 with diagnoses including Cerebral Infarction, Other Signs and Symptoms involving Cognitive Functions following Cerebral Infarction, Major Depressive Disorder, and Cutaneous Abscess, unspecified. Review of the Minimum Data Set (MDS) with an Advanced Reference Date (ARD) of 5/2/22 revealed a Brief Interview for Mental Status (BIMS) score of eight (8) which indicated Resident #27 had moderately impaired cognition.	F 623	center initiated transfer a notice of transfer along with the documented reason as soon as possible after the discharge. The Administrator in-serviced Social Workers 7/20/2022 on the transfer/discharge policy. The transfer/discharge letter will be mailed to the responsible party. 4. To monitor the performance of our corrective action and sustainability, the administrator will review all transfers/discharges to ensure a letter regarding transfer/discharge was presented to resident and mailed to responsible party beginning 8/15/2022, 5x/week x 2 weeks, 3x/week x 2 weeks, and then 1x/week x 4 weeks. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly, for a minimum of 3 months, by the Administrator for review and revision as necessary. QA will review the findings of compliance and determine if additional corrective action is needed.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		9/9/22

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

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F 656	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to develop a comprehensive care plan for refusal of Activities of Daily Living (ADL) care for one (1) of 27 resident care plans reviewed. Resident # 27. Findings include: Record review of the facility policy, "Care Plans", undated, revealed "Policy: Care plans will be developed for all patients and residents based upon the Resident Assessment Instrument (RAI) manual guidelines. Care plans are developed by the interdisciplinary team and revised as needed according to resident and patient status or change." An observation on 07/18/22 at 03:31 PM, revealed Resident #27's fingernails were trimmed but had yellowish brown material under all nails and facial hair. An observation on 7/20/22 at 9:15 AM, with Registered Nurse (RN) #1 confirmed Resident #27 needed a shave and his fingernails needed cleaning. During an interview, on 7/20/22 at 11:15 AM, with Registered Nurse (RN) #1 stated that Resident #27 refuses care. She stated that he refuses care and curses staff. RN #1 confirmed she did not see a care plan for refusal of Activities of Daily Living (ADL) care. An interview, on 7/20/22 at 11:30 AM, with the Minimum Data Set (MDS) nurse confirmed that the resident did not have a care plan for refusal of	F 656	F656 483.21(b) (1) Develop/Implement Comprehensive Care Plan SS=D 1. On 7/21/22, resident #27 comprehensive care plan was updated by Minimum Data Set (MDS) Nurse to reflect resident's refusal of Activities of Daily Living (ADL) care. 2. On 7/22/22, residents who require assistance with activities of daily living have the potential to be affected by the deficient practice and will be reviewed during routine meetings by Director of Nursing and the Minimum Data Set.. 3. On 7/26/22, the Minimum Data Set (MDS) nurses, Director of Nursing Services, and Assistant Director of Nursing Services to perform 100% audit of resident's requiring assistance with activities of daily living for compliance with assistance and ones identified as refusing will be care planned to reflect their refusal. On 7/22/22, the Minimum Data Set (MDS) nurses, Director of Nursing Services, and Assistant Director of Nursing Services were in-serviced on the development and update of comprehensive care plan for residents who refuse activities of daily living by Director of Clinical Operations. Starting date of 7/22/22, the Minimum Data Assessment Nurses, Director of Nursing Services, Assistant Director of Nursing Services will review documentation daily to develop a care plan customized for residents' who refuse activities of daily living.	

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F 656	Continued From page 13 ADL care. She stated that she is responsible for care plans and develops them from documentation in the record or from discussion of residents during their stand-up meetings. An observation and interview on 7/20/22 at 11:45 AM, with the Assistant Administrator confirmed Resident #27 needed to be shaved. She stated that if he refuses care it should be documented and care planned. Record review of Progress Notes dated 4/21/22, 6/15/22, and 6/16/22 for Resident #27 revealed documentation of refusal of care. Record review of Resident #27's care plan revealed there was no care plan developed for refusal of ADL care. Record review of the Transfer/Discharge Report dated 7/21/22, revealed Resident #27 was admitted to the facility on 7/13/21 with diagnoses including Cerebral Infarction, Other Signs and Symptoms involving Cognitive Functions following Cerebral Infarction, Major Depressive Disorder, and Need for Assistance with Personal Care. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/2/22 revealed a Brief Interview for Mental Status (BIMS) score of eight (8) which indicated Resident #27 had moderately impaired cognition.	F 656	4. On 8/22/22, the Director of Nursing Services/Assistant Director of Nursing Services will audit 5 residents care plans/week x 5 weeks, then 5 residents/ month x 3 months to ensure residents who refuse activities of daily living assistance are care planned. Beginning 8/22/22, any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly by the Director of Nursing Services/Assistant Director of Nursing Services for review and revision as necessary.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		9/9/22

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F 677	Continued From page 14 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide a dependent resident with nail care for one (1) of five (5) residents reviewed. Resident #125 Findings include: During an interview with the Registered Nurse (RN)/Clinical Director on 7/21/22 at 9:30 AM, she stated the facility adopted Edition 10, Clinical Nursing Skills and Techniques Manual as our policy and procedure care guide for shaving and nail care, specifically pages 541 through 550. An observation on 07/18/22 at 03:40 PM, revealed Resident #125 had a brownish material under her fingernails. An observation on 07/19/22 at 10:15 AM, revealed Resident #125's fingernails continued to be dirty with a brownish material under her nails. An observation on 07/20/22 at 09:00 AM, revealed Resident #125's fingernails continued to be dirty with a brownish material under her nails An observation and interview, on 7/20/22 at 9:50 AM, with Certified Nursing Assistant (CNA) #1 revealed she had already given Resident #125 her bath this morning and that the resident's fingernails were dirty with brownish material under the nails. She stated that she should have already gotten to it (cleaning the resident's nails). An interview on 7/20/22 at 9:58 AM, with RN #1 confirmed Resident #125's nails needed to be	F 677	F677 483.24(a) (2) ADL Care Provided for Dependent Residents SS=D 1. Resident # 125 fingernails were cleaned by Certified Nursing Assistant on 7/20/22. 2. Residents of the facility requiring assistance with activities of daily living have the potential to be affected by deficient practice. 3. The Minimum Data Set (MDS) nurses, Director of Nursing Services, and Assistant Director of Nursing Services performed 100% audit of resident□s requiring assistance with activities of daily living to ensure nail care/grooming was performed on 7/27/2022.The Director of Clinical Education in-serviced nursing staff on maintaining good grooming, nail care and nails free from dirt and foreign material under fingernails on 7/21/2022. Resident□s nails will be cleaned by certified nursing assistant and/or nurses on bath day, during activities of daily living and as needed. Other residents in similar situations will be protected by the nurses assuring that nail care will be completed as needed. 4. To monitor the performance of our corrective action and to assure sustainability, the Director of Nursing Services/Assistant Director of Nursing Services will audit 5 residents/week x 5 weeks beginning 8/15/2022, then 5 residents/month x 3 months to ensure	

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F 677	Continued From page 15 taken care of because dirty nails could lead to skin breakdown or infection. Record review of Section G of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/27/22 revealed Resident # 125 requires extensive assist of one (1) for personal hygiene. Section C revealed the resident did not have a Brief Interview for Mental Status score because she was rarely/never understood. Record Review of the Transfer/Discharge Report dated 7/21/22 for Resident #125 revealed she was admitted to the facility on 7/30/15 with diagnoses including Unspecified Dementia without Behavioral Disturbance, Cerebral Infarction, Pseudobulbar Effect, Major Depressive Disorder, and Mixed Receptive-Expressive Language Disorder.	F 677	residents□ nails are clean and appropriately groomed. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 8/22/2022, by the Director of Nursing Services/Assistant Director of Nursing Services for review and revision as necessary.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §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	F 686		9/9/22

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F 686	Continued From page 16 by: Based on observation, staff interview, record review, facility policy review and Mississippi State Board of Nursing review (Section 30 Miss. Admin. Code Pt. 2830, Chapter I) the facility failed to provide a Registered Nurse (RN) for assessment of pressure ulcers for one (1) of eight (8) residents reviewed for RN wound assessments. Resident # 24. Findings Include: Review of the facility policy titled, "Skin Care Guideline" with a revision date of July 2018 revealed "Purpose To provide a system for evaluation of skin to identify risk and identify individual interventions to address risk and a process for care of changes/disruption in skin integrity ..." An interview on 07/19/22 at 10:47 AM, with the Resident #24 revealed he developed a pressure ulcer on his right heel since he has been at the facility. An interview on 07/20/22 at 07:47 AM, with the Resident #24 revealed he did not have this sore on his foot when he got here, but he fell and developed cellulitis in that leg. He revealed this spot is like a soft spot that just has not completely healed. He revealed he is independent of self-propelling in his wheelchair, wears tennis shoes, has a leg rest on the right side of his wheelchair now and tries not to use his right foot to propel his chair. He confirms that the staff treat the sore on his right heel but is not sure if they measure and he is not certain of how often. An observation on 7/20/22 at 9:45 AM, revealed	F 686	F686 483.25(b) (1)(I)(ii) Treatment/Sacs to Prevent/Heal Pressure Ulcer SS=D 1. Resident #24 skin and wounds was assessed by a Registered Nurse (RN) on 7/21/22. The assessment revealed no signs and symptoms of an infection or worsening of the wound. There were no negative findings. 2. Residents with pressure ulcers have the potential to be affected by deficient practice. 3. Going forward, the center will assure residents are protected from this practice by assuring a RN assesses the wound on a weekly basis. 100% pressure ulcer audit was performed on all residents by the Assistant Director of Nursing Services and Unit Managers to identify and assess residents with pressure ulcers with plan of treatment implemented 7/27/2022 Nursing staff were in-serviced by Director of Nursing Service/Director of Clinical Education on assessing pressure ulcers and weekly assessment with documentation to be performed by a Registered Nurse on 8/18/2022 4. The Center□s plans to monitor the performance the assure sustainability include the Director of Nursing Services/Assistant Director of Nursing reviewing 5 residents with pressure ulcers/week x 4 weeks beginning 8/15/2022, then 5 residents/month x 3 months to ensure assessments/documentation of pressure ulcers is performed by a Registered	

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F 686	Continued From page 17 Licensed Practical Nurse (LPN) # 3 provided pressure ulcer treatment and dressing change as ordered. This observation revealed no measurement of the pressure ulcer. An interview on 7/20/22 at 10:00 AM, with Licensed Practical Nurse (LPN) # 3 revealed she works 11 PM-7 AM shift, but since their treatment nurse quit on Friday, she has come to days to help with treatments. She revealed she is not certified, but she has done treatments in another facility before. She revealed the LPN's have been doing the measurements of the wounds by using their IPAD that takes a picture and does the measurements. She revealed that a Registered Nurse (RN), Nurse Practitioner (NP) or physician does not assess the wounds on a regular basis. She revealed they have a full time NP in the facility Monday through Friday, but he just looks at the wounds when we ask. She confirmed that an LPN is the only one measuring the wounds. An interview on 7/20/22 at 10:45 AM, with the NP revealed he works at the facility Monday through Friday and a physician comes to the facility every Monday. He confirmed he does not have a lot to do with wounds or pressure ulcers. He confirmed he is just there for guidance and will assess a pressure ulcer if asked. An interview on 7/20/22 at 10:55 AM, with the Assistant Director of Nurses (ADON) confirmed she does not do wound assessments, measurements, or treatments. She revealed that the Director of Nurses (DON) does the wound evaluations and checks orders. She confirmed that LPN # 3 is going to day shift to do treatment, since our treatment nurses last day was Friday. She confirmed that the treatment nurse uses an	F 686	Nurse. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly by the Director of Nursing Services/Assistant Director of Nursing beginning 8/22/2022 for review and revision as necessary. The audits will be taken to QAPI for a minimum of 3 months.	

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electronic tablet to take pictures of the pressure ulcers and that does the measurements for them. She revealed that the facility uses the NP as needed and a wound clinic in town to send residents out for wound care. She revealed that the NP will assess new admits that come in with pressure ulcers.

An interview on 7/20/22 at 11:10 AM, with the Director of Nurses (DON) revealed that the facilities treatment nurses last day was Friday 7/15/22 and that LPN # 3 from the night shift is helping with treatments because she has done them before. She confirmed that no one in the facility is certified to do pressure ulcer treatments and measurements. She confirmed that she does not measure the pressure ulcers. She confirmed that the treatment nurse, which is an LPN, is the one doing the measurements. She confirmed that the LPN uses a tablet to take a picture and obtain the measurements.

An interview on 07/20/22 at 03:05 PM, with the RN/Clinical Director confirmed that there was not a nurse that was certified for pressure ulcers in the facility. She confirmed that an RN is supposed to verify measurements of pressure ulcers after the LPN and measure for depth. She revealed the DON and ADON were aware this needed to be done.

An interview on 07/20/22 at 03:10 PM, with the RN/Clinical Director, DON and ADON confirmed they nor any other RN or clinician have been measuring the pressure ulcers after the LPN's have measured. The DON revealed she has been viewing the picture that the LPN puts in the record with the measurements and signing behind her. The DON and ADON confirmed that

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an RN or Clinician has not been going behind the LPN and confirming the measurements or measuring for depth, but they should have. The DON confirmed that an RN needs to measure the depth and confirm the LPN's measurements for accuracy.

An observation on 7/21/22 at 10:45 AM, with the Director of Nursing (DON) revealed she measured the resident's pressure ulcer with a measurement of 0.3 centimeters (cm) x 0.2 cm with no depth.

An interview on 7/21/22 at 11:00 AM, with the DON confirmed she realizes the importance of an RN assessing a pressure ulcer with or after an LPN. She revealed she does not know when an RN last measured or assessed a pressure ulcer in this facility. She confirmed her measurement today was .35 cm x .2 cm and the last measurement by an LPN was on 7/11/22 of 0.25 cm x 0.3 cm with no depth. She confirmed that it is important for an RN to observe the wound, because she can see things that maybe the LPN missed.

An interview on 7/21/22 at 3:30 PM, with RN-Infection Control Nurse confirmed that the residents "Skin & Wound Evaluations V5.0" were completed by an LPN.

A record review of the facility Pressure Ulcer Record confirmed that weekly skin audits were being performed by the LPN.

Record review of the resident's Admission Record revealed an admission date of 11/29/18 with medical diagnoses that included Cellulitis of the right lower limb and Dementia.

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Record review of Resident #24's "Skin & Wound Evaluation V5.0" revealed the following:

6/28/22-skin & wound evaluation completed by an LPN indicated the resident had a pressure ulcer staged as a deep tissue injury (DTI) that was in-house acquired.

7/4/22-skin & wound evaluation completed by an LPN indicated the resident had a pressure ulcer staged as a DTI that was in-house acquired.

7/11/22-skin & wound evaluation completed by an LPN indicated the resident had a pressure ulcer staged as a DTI that was in-house acquired.

Record review of Physician's Orders revealed the following order:
Order dated 7/13/22; Pro Heal Critical Care two times a day for Wound healing until 08/14/2022 23:59.

Review of the residents Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/3/22 revealed in Section M the resident is "at risk" for developing pressure ulcers/injuries with no pressure ulcers at present. Section C revealed a Brief Interview for Mental Status (BIMS) with a score of 14, which indicates the resident is cognitively intact.

Record review of the Mississippi State Board of Nursing Section 30 Miss. Admin. Code Pt. 2830, Chapter I and pursuant to the Mississippi Nursing Practice Law revealed the following:
Is it within the scope of practice of the licensed practical nurse to perform assessments?
Nursing assessment is outside the scope of

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F 686	Continued From page 21 practice of the licensed practical nurse. As stated in 30 Miss. Admin. Code Pt. 2830, Chapter I and pursuant to the Mississippi Nursing Practice Law, "The registered nurse shall be held accountable for the quality of nursing care given to patients. This includes assessing the patient's needs, formulating a nursing diagnosis, planning for, implementing, and evaluating the patient's care..." It is further stated that the licensed practical nurse "may assist the registered nurse in the planning, implementation and evaluation of nursing care by," in part, "observing, recording and reporting to the appropriate person the signs and symptoms that may be indicative of change in the patient's condition." Therefore, it is the registered nurse's responsibility to perform the initial systems and collective assessment of the patient. The licensed practical nurse may assist the registered nurse with collecting data for that initial assessment and must document and sign the portion of the assessment he/she did. The registered nurse must document and sign the portion of the assessment which he/she completed. The registered nurse may delegate the observation and recording of a patient's ongoing or subsequent status to the appropriately educated and competent licensed practical nurse. However, the registered nurse is held accountable for the quality of nursing care given by self or others being supervised.	F 686		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		9/9/22

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F 761	Continued From page 22 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility policy review the facility failed to store narcotics in a permanently fixed locked box for two (2) of three (3) medication rooms reviewed. Findings Include: Record review of the Facility Policy, "Storage and Expiration Dating of Medications, Biologicals" with revision date of 01/01/22 revealed under, "Procedure" number 3. General Storage Procedures: 3.1.1 Store all drugs and biologicals in locked compartments, including the storage of Schedule II - V medications in separately locked, permanently affixed compartments, permitting only authorized personnel to have access."	F 761	F761 483.45(g)(h)(1)(2) Label/store Drugs and Biologicals SS=E 1. There were no individual residents effected with this deficiency. A separate lock box was permanently affixed in the locked refrigerators in the 2 medication rooms on 7/20/2022, by the Maintenance Director for storage of controlled drugs. 2. Residents of the facility receiving refrigerated controlled substances have the potential to be affected by the deficient practice. 3. Going forward, to protect the residents, the center will store all controlled substances in permanently	

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F 761	Continued From page 23 An observation on 07/20/22 at 5:00 PM, of the medication storage room on the east hall with Licensed Practical Nurse (LPN) #1 revealed a locked refrigerator with a small locked box inside located on the top shelf. This lock box was empty and not permanently affixed. An observation on 07/20/22 at 5:10 PM, of the medication storage room on the west hall with Registered Nurse (RN) #1, revealed a small refrigerator with 2 small unopened vials of injectable lorazepam in a clear bag on the second shelf inside. An observation on 07/20/22 at 5:20 PM, of the medication storage room in the Rehabilitation Wing, revealed a lock box inside the refrigerator not permanently affixed. Nine small vials of injectable lorazepam, a bottle of liquid morphine and a bottle of liquid lorazepam for oral use were observed inside locked box. An interview on 07/20/22 at 5:05 PM, with LPN #1 revealed that she was not aware that the lock box was supposed to be permanently attached. An interview on 07/20/22 at 5:15 PM, with RN #1 revealed that she did not know that narcotics were supposed to be in a lock box and permanently secured. She also revealed that the medication room is always locked and only the Medication Nurses have the keys to access the room. An interview on 07/20/22 at 5:25 PM, with LPN #2, revealed that she did not know that lock boxes containing narcotics had to be permanently attached.	F 761	affixed compartments. The nursing staff were in-serviced by the Director of Clinical Education on 7/20/22 addressing that the lock box must be affixed in a locked refrigerator storage in the medication room for permitting only authorized personnel to have access. A 100% audit of each lock box to ensure it was permanently affixed in the locked refrigerator was performed by Director of Nursing Services and Assistant Director of Nursing Services on 7/20/22. 4. To monitor the performance of our corrective action ad to assure sustainability, the Director of Nursing Services and Assistant Director of Nursing Services will audit the refrigerator 1 x/week x 4 weeks beginning 7/25/2022, then monthly x 3 months to ensure the drugs and biologicals are properly stored in the locked refrigerator storage. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly beginning 8/22/2022 for a minimum of 3 months by the Director of Nursing Services/Assistant Director of Nursing Services for review and revision as necessary.	

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F 761	Continued From page 24 An interview on 07/20/22 at 5:30 PM, with the Assistant Director of Nursing (ADON) revealed that she was not aware of the federal regulation that required lock boxes containing Schedule II-V narcotics to be permanently affixed. An interview on 07/21/22 at 9:40 AM, with the Director of Nursing (DON), revealed that she was aware that locked boxes are required in some states but was not certain about in Mississippi. She revealed that she did know that the lock boxes should be welded into the refrigerator to prevent anyone from walking out with the whole box. An interview on 07/21/22 at 9:45 AM, with the Administrator revealed that she was not aware of the federal regulation that required locked boxes containing narcotics to be secured. She also revealed that she understands the risk of not having a secured locked box which could allow someone to take the whole box out and leave with it.	F 761		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility	F 919	F919	9/9/22

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F 919	Continued From page 25 policy review the facility failed to maintain a properly functioning call system for one (1) of two (2) wings observed. East Wing Findings Include: Review of facility policy titled, "Nurse Call System" dated September 1, 2014, revealed, "Purpose: To maintain center nurse call systems in an ideal mechanical condition to ensure optimum performance when residents request assistance from staff ...Monthly the Nurse Call system should be checked for the following: 4. Any component that does not function should be repaired as soon as practically feasible. 5. Systems with audio functions should be tested monthly. Any non-operating components should be repaired as soon as practically feasible." An observation on 7/19/22 at 10:42 AM, revealed the call light above resident Room #1 and on the control box at the nurse's desk of the East Wing were both on, but no audible sound was noted. An observation on 7/19/22 at 10:44 AM, revealed the call light above resident Room #23 and the light on the control box at the nurse's desk of the East Wing were both on, but no audible sound was noted. An interview on 7/19/22 at 11:45 AM, with Certified Nursing Assistant (CNA) #1 revealed the audible alarm goes off at the nurse's station but she cannot hear it at the end of the hall. She stated she looks above the doors when she exits a room to see if another resident is needing assistance and since she relies on the lights more than the audible alarm, she is uncertain how long the alarm has not been sounding. She	F 919	483.90(g)(2)v Resident Call System SS=E 1. Call light system on the East Wing was assessed for malfunctioning by Maintenance Director on 7/19/22. The Director of Nurses, Assistant Director of Nurses and Unit Manager assessed all residents on East wing on 7/19/22 to assure there was no unmet need. No negative findings were noted. Residents whose call light system was malfunctioning were provided alternate means to notify staff of need; hand held bells on 7/19/2022. For those Residents who were unable to use the call bells, nursing staff monitored those residents every 15 minutes for needs. The rounds lasted until the Maintenance Director repaired call light system on 7/20/22. 2. All Residents of the facility have the potential to be affected by the deficient practice. 100% of all residents were assessed on 7/19/22 to assure call lights were functioning. 3. The call light systems on all stations was inspected by the Maintenance Director on 7/20/2022 and found to be functioning properly. The Administrator in-serviced the Maintenance Director on call light system inspection weekly and immediate repair with alternate form of staff notification of needs to be provided when needed on 7/21/22. A new annunciator was ordered for East Wing and it was installed on 8/18/22 by the Regional Director of Maintenance. 4. To monitor our corrective action and assure sustainability, the Administrator and the Maintenance Director will	

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F 919	Continued From page 26 revealed the call system is needed to help the residents get the assistance they need. An interview on 7/19/22 at 11:55 AM, with CNA #2 revealed when the call system button is pressed in the resident's room, the light above their door turns on and the alarm sound goes off at the nurse's station to alert staff a call light has been activated. The interview revealed she relies on the lights being lit above the resident's room and is unaware of the sound not working. An interview and observation on 7/19/22 at 12:05 PM, with the Administrator revealed the staff should answer the call light within 3-5 minutes. She stated the call system consists of lights and sound to alert the staff that a resident needs assistance. The State Agency (SA) asked the Administrator to activate a call light and demonstrate what occurs when light is activated. The Administrator went into Room 9 on the East Wing and activated the call system. The light above door and on control panel both turned on, but no audible alarm was heard. The Administrator stated they previously had a problem with the call light system, but she thought that was resolved since she had not been informed of other issues. The Administrator confirmed the audible alert is needed to notify the staff of a resident needing assistance and this system not functioning properly could lead to a delay in receiving needed care for the residents. An interview on 7/19/22 at 5:30 PM, with Licensed Practical Nurse (LPN) #5 revealed the audible alarm on the call system has not been working properly for several weeks or months. She revealed the light above the resident's door and on the control panel light up, but no audible	F 919	complete routine rounds 1x/week for 4 weeks beginning 8/15/2022, to include checking Resident's Call System. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of 3 months beginning 8/22/2022, by the Maintenance Director for review and revision as necessary. The audits will be taken to QAPI for a minimum of 3 months.	

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alarm is made. She stated she relies on the lights and the audible alarm especially when she is in a room with a resident. If she continues to hear an alarm it alerts her that all of the staff must be providing care and she should step away as soon as possible to find out what resident needs assistance. She stated that without the audible alarm to alert staff of assistance needed, she feels that it is possible that "some residents might have waited longer than they should have to for care." She stated bells were given to the residents today for them to use when assistance is needed.

An interview on 7/20/22 at 8:35 AM, with LPN #7 revealed the audible alarm on the call system has not been working right for 2 - 3 months and "it is like a short in the wire since it will work at times." She stated they have now given the residents bells to use and have in-serviced the CNA staff to do 15-minute checks and the nurse staff to document every hour on the residents that cannot use the bell.

An interview on 7/20/22 at 8:40 AM, with CNA #3 revealed the call system sound alarm has not been working on the call light system for a while, but she is unsure how long. She stated the audible alarm is helpful, but she mainly goes by the lights above each resident's door to know which residents need assistance. She stated that yesterday the staff handed out bells for the residents to use.

An interview on 7/20/22 at 11:45 AM, with LPN #6 revealed the residents were given bells yesterday to use while the sound on the call system was not working. She stated the lights on the call system are working, but the audible alarm has not been

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working properly for several weeks. She stated in the past, bells would be given to a resident if his/her call light was not working properly.

An interview and observation on 7/20/22 at 2:10 PM. with the Maintenance Director revealed on 2/2/22, the motherboard of the East Wing call system was making a constant "abnormal sound" and he called the technician from the call system's repair unit and the technician walked him through the steps to remove the clicking noise. The Maintenance Director showed texts and pictures on his phone with that date of his communication with the technician. He followed these instructions and the clicking noise stopped. He stated on that date, he was checking for the abnormal sound and not servicing the system for the audible alarm not functioning when call system was activated and he was not notified any other time of the system not making an audible sound when call system activated. He revealed he does not keep paper records of his maintenance, but it is recorded in the maintenance log of the computer system. He stated he checked the system when a concern was reported and rounded monthly but did not find concern with the call system.

An interview on 7/20/22 at 4:35 PM, with the Maintenance Director to clarify his work on the call system on the East Wing revealed on the computerized maintenance report, there was an open date of 1/21/22 and closed date of 2/7/22 (with closed by staff listed as Maintenance Director), for the request for "call light system is not working - making a ticking noise at desk" on "East wing - nurses station." He confirmed that was the date of 2/2/22 repair mentioned previously. SA asked about another submission

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F 919	Continued From page 29 for maintenance with open date of 2/16/22 and closed date of 2/23/22 (with closed by staff listed as Maintenance Director) for "call lights are not sounding" with location of "east" wing. He confirmed he did not work on the system at that time and has no idea why it has his name listed as closed by him. He stated the only time he worked on the system was when the clicking noise was heard or when individual lights were not working properly but did not know until we arrived that there was a concern with the audible alarm not working. An interview on 7/20/22 at 4:40 PM, with the Administrator, revealed each resident should have the assurance that the call system functions properly and that they will receive the assistance needed. She confirmed the facility failed to ensure all portions of the call system were functioning properly and the residents need a properly functioning system to ensure they receive timely assistance.	F 919		