STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255175	A. BUILDING _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF BROOKHAVEN	519 BROOKMAN DRIVE BROOKHAVEN, MS 39601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey from 11/28/22 through 12/1/22. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for participation. The SA cited deficiencies at F-561, F-644, F-761, F-812, and F-919. The facility was licensed for 58 beds and had a census of 55 at the time of survey.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to	F 561		1/5/23

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

Electronically Signed | 12/16/2022

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F 561	Continued From page 1 participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to honor a resident's right to choose health care by not administering the requested influenza vaccination to a resident upon admission for one (1) out of 6 (six) vaccination records reviewed. Resident #307 Findings include: Review of the facility's policy," Influenza Vaccination Policy (Patients and Residents)," dated 11/1/16, revealed, " ... For the health and safety of all patients and residents, influenza immunization is required on an annual basis, based on the risk presented to patients and residents through routine and direct exposure. Vaccination has been shown to reduce the transmission of influenza while reducing influenza related illness and death in health care centers ..." On 11/28/22 at 4:37 PM, in an interview with the son of Resident #307, he stated the resident wants a flu shot and no one has given it to her. On 11/29/22 at 2:00 PM, in an interview with Resident #307, she confirmed she has not gotten her flu shot yet. She revealed she gets it every year and the nurse told her she would get it. She stated she had double pneumonia in the past and ended up in Intensive Care, so her physician explained how important it is for her to get the flu vaccine every year as soon as it is available.	F 561	1. The influenza vaccine was originally scheduled for the week of the survey. Resident #307 was assessed by the Assistance Director of Nursing/Infection Control Preventionist for signs and symptoms of the flu and none were noted. The influenza vaccination was administered as planned 11/30/2022 by the Health Information Management Coordinator (HIM-C). 2. All residents in the center are at risk for the deficient practice. 3. 100% audit conducted by the HIM-C and Director of Nursing(DNS) and completed on 12/09/2022 of all resident's influenza consents on admission and verification of administration. No other discrepancies were identified in audit. In-service was conducted with all nursing staff on resident's rights by Assistant Director of Nursing (ADNS) on 12/9/2022. Going forward, the HIM-C will have immediate access to the vaccine consents on admission. The Interdisciplinary Team (IDT) will review each new admission during the morning clinical meetings to determine need for the vaccine and communicate this to nursing so that vaccines can be administered promptly by the nursing staff after admission. 4. DNS and HIM-C will monitor 100% of all admissions beginning 12/09/2022 for	

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F 561	Continued From page 2 On 11/30/22 at 04:14 PM, in an interview with Registered Nurse (RN) #3/Infectionist Preventionist, she confirmed residents are offered vaccinations upon admission and sign the consent electronically with the other admission paperwork. The consent is not readily assessable to the nursing staff, as the Director of Nursing (DON) must print the consent and give it to the Medical Records Nurse, who administers the vaccination. RN #3 revealed that the delay in resident's receiving the vaccination is related to the medical records nurse waiting on the DON to print the consent. RN #3 stated unless there is a delay, residents admitted in November usually get vaccines within the first few days of admission, as the facility has the influenza vaccine available at that time. On 11/30/22 at 4:36 PM, in an interview with the DON, she confirmed that the nursing staff are dependent upon her to provide the printed vaccination consents. She stated the Medical Records Nurse had contacted her Monday requesting a copy of the flu vaccination consent signed by Resident #307, but she was busy with other new admissions, and it wasn't done. The DON stated that the facility's immunization policy does not have a time frame for administration, but most of the time residents get the vaccination on the day they sign the consent or the next. She confirmed that Resident #307 has underlying health conditions and needs to receive the flu vaccine. On 11/30/22 at 4:54 PM, in an interview with the Medical Records Nurse/Licensed Practical Nurse (LPN) #1, she revealed that Resident #307 electronically signed a consent for a flu	F 561	completion and administration of influenza vaccinations as per resident's vaccination consent choice twice weekly for four weeks, then once weekly for two months to assure all resident's receive influenza vaccination as desired. Any variance will be corrected immediately and addressed in Quality Assurance and Performance Improvement (QAPI) on 1/04/2023. QAPI meeting will continue to address any variance findings for three months to ensure compliance.	

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F 561	Continued From page 3	F 561		

vaccination upon admission. LPN #1 confirmed that she must wait upon the DON to print the consent for the vaccinations and at times, there may be a delay in her receiving the consents. The nurse stated that the facility's policy does not have a time frame for administration of the vaccination once the consent is signed, but that she normally tries to give the resident the vaccination within 2 (two) weeks. LPN #1 confirmed that if a resident is not given the flu vaccine, their chances of getting the flu increase.

On 11/30/22 at 05:27 PM, in an interview the Administrator stated all admission paperwork, which contains the vaccination consent form, is signed electronically. The Administrator confirmed the DON gives the vaccination consent forms to the Medical Records Nurse, who then administers the vaccination to the resident.

Record review of the facility's "Admission Record" for Resident #307, revealed the facility admitted the resident on 11/11/22, with diagnoses that included Type 2 Diabetes Mellitus, Hypertension, and Coronary Artery Disease.

Record review of the Admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/18/22, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated resident was cognitively intact.

Record review of the facility's "Patient/Resident Declination /Authorization Form (Flu)" signed by Resident #307, revealed the consent was signed on 11/11/22. However, as of the State Agency's entry into the facility on 11/28/22, the flu vaccination had not been administered to Resident #307.

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F 561	Continued From page 4 Record review of the facility's "Order Summary Report," for Resident #307, revealed 12/1/22 active orders included an order for the resident is to receive an annual influenza vaccine, with an order date of 11/10/22.	F 561		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to ensure a PASRR (Pre-Admission Screening and Resident Review) Level II was obtained for a resident after a diagnosis of a serious mental disorder was received for one (1) of five (5) resident records reviewed. Resident #20.	F 644	1. A Preadmission Screening and Resident Review (PASARR) Level II referral was completed by the Director of Nursing (DNS) and submitted to Ascend on 12/02/2022 for identified Resident #20. 2. All residents with a diagnosis of or history of a serious mental disorder in the center are at risk for the deficient practice.	1/5/23

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F 644	Continued From page 5 Findings include: Review of the facility's policy, "PASRR," (undated), revealed " ... 2. A subsequent PASRR Level II is defined as any PASRR Level II completed after an initial PASRR Level II when there is a significant change in the physical, mental, or emotional condition of and NF (nursing facility) resident. a) The significant change is for persons with previously identified MI (Mental Illness), ID/DD (Intellectual Disability/Developmental Disability) and/or RC (Related Condition) whose needs have changed as well as for persons with newly discovered or suspected MI, ID/DD and/or RC. b) The purpose of a subsequent PASRR Level II is to assess whether the resident is still appropriate for the NF level of care and/ or if a change in the need or type of specialized services is required ..." Record review of the "Admission Record" of Resident #20 revealed the facility initially admitted the resident on 4/18/17, with diagnoses including Type 2 diabetes Mellitus, Chronic Obstructive Pulmonary Disease, and Acquired Absence of Left Leg Above Knee. Record review of the facility's current "Diagnosis Report," dated 12/2/22, revealed Resident #20 was diagnosed with Schizoaffective Disorder, Bipolar Type and Narcissistic Personality Disorder on 6/25/21. Record review of the facility's "Order Summary Report," dated 12/1/22, for Resident #20, revealed an active order for Geodon (Ziprasidone HCL) Capsule 80 mg (milligrams) Give 1 (one) capsule by mouth at bedtime related to Schizoaffective Disorder, Bipolar Type.	F 644	3.100% audit conducted by DNS on 12/12/2022 of all resident's with diagnosis requiring a PASARR Level II. No other discrepancies were identified in audit. Interdisciplinary Team (IDT) will review all newly admitted or readmitted resident diagnosis and all significant changes in status in Daily Clinical Start Up meeting beginning 12/14/2022. Any new psychiatric diagnosis will trigger the team to initiate a referral to Ascend for an updated level II. Education was provided to the Social Services Director (SSD) and the Director of Clinical Coordination (DCC) by the DNS on 12/14/2022 regarding the Level II process. 4. DNS, SSD, And DCC will monitor all residents beginning 12/14/2022 for PASARR Level II review as indicated for admission, newly evident or possible serious mental disorder, intellectually disability, or significant change in status assessment each week for four weeks, then monthly for two months to identify any discrepancies. Any variance will be corrected immediately addressed in Quality Assurance and Performance Improvement (QAPI) on 1/04/2023. QAPI meeting will continue to address any variance findings for three months to ensure compliance.	

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F 644	Continued From page 6 Record review of the "PAS (Pre-Admission Screening) and Physician Certification," dated 6/2/17, revealed Resident #20 did not have a diagnosis of a major mental illness upon admission to the facility. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/29/22 revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. In an interview on 11/30/22 at 1:49 PM, with the Director of Nursing (DON), she stated that she was aware that they should have obtained a PASRR Level II on the resident when he was diagnosed on 6/25/21 with a serious mental illness. The DON revealed that although she and their previous Social Worker had discussed the need for the Level II, the Social Worker was no longer employed at the facility and there was no documentation indicating that it was done. The DON confirmed the reason for doing the Level II is to ensure that the resident is appropriately placed and receives the care they need. She stated that Resident #20 sees a Psychiatric Nurse Practitioner and takes medication for Schizoaffective Disorder, Bipolar Type.	F 644		
F 761 SS=D	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		1/5/23

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F 761	Continued From page 7 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 observations, record reviews, interviews, and facility policy review, the facility failed to store the Flonase belonging to Resident #109 in a locked compartment to prevent possible overdose of a medication for one (1) of five (5) medication observations. Resident #109 Findings Include: Record review of the facility's, "Medication Administration Competency Checklist," reveals the facility uses Perry and Potter, Clinical Nursing Skills & Techniques, 8th Edition, as their medication administration policy and procedure. Review of the checklist revealed ... "2. Administered medications: p. Stayed with the resident until the resident completely took all	F 761	1. The Flonase was removed from the room immediately. Resident #109 was assessed by the Director of Nursing (DNS) on 11/29/2022. There were no negative findings for this resident including no evidence that he had taken additional puffs of the Flonase. The nurse was provided one on one education by the Assistant Director of Nursing (ADNS) on 11/30/2022 regarding proper storage of medication including that they should never by left at the bedside. 2. All residents in the center are at risk of the deficient practice. 3.The DNS and ADNS initiated and completed an audit of 100% of the resident rooms to assure that no other	

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F 761	Continued From page 8 medication by the prescribed route, ..." Review of the facility's, "Licensed Nurse Core Clinical Competency," revealed RN #1 was checked off on Medication Administration on 10/29/22. An observation on 11/29/22 at 1:17 PM, revealed a bottle of Flonase on the bedside table of Resident #109. In an interview on 11/29/22 at 1:17 PM, Registered Nurse (RN) #2 confirmed there was a bottle of Flonase on the bedside table of Resident #109. RN #2 stated the medication nurse must have left it in the room. In an interview on 11/29/22 at 1:33 PM, Resident #109 confirmed that the bottle of Flonase on his bedside table belonged to him, and that he would use it when he gets ready. The resident stated that he could not remember whether or not he had used the Flonase. During an interview on 11/29/22 at 01:40 PM, with RN #1, she confirmed the Flonase was left on the bedside table of Resident #109. RN #1 confirmed that she should not have left the medication in the resident's room. The nurse revealed that she was unsure as to whether the resident had taken an extra dose because he has periods of confusion and forgets. Review of the "Admission Record" for Resident #109 revealed, the facility admitted the resident on 11/21/22, with diagnoses that included Allergic Rhinitis, Kidney Failure, and Hypertension. Record review of the "Quarterly Minimum Data	F 761	resident had medications at the bedside. No additional medications were found. Direct training/In-service with Registered Nurse (RN) #1 completed by ADNS on 11/30/2022 on Medication Administration Competency with emphasis on returning medications to a locked medication cart for storage. The DNS/ADNS initiated an inservice regarding observation of medication administration, not limited to returning medication to cart for storage on 11/30/2022. Competency evaluations will be completed at the time of hire and yearly thereafter by ADNS or licensed nurse. 4. DNS and ADNS will perform audits of licensed nurses performing medication administration, not limited to medication storage after administration, for five times weekly for two weeks, three times weekly for two weeks, then weekly for two months to assure medication administration is performed in accordance of medication administration guidelines beginning 12/12/2022. All variances to procedure will be immediately corrected and addressed in Quality Assurance and Performance Improvement (QAPI) on 1/04/2023. QAPI meeting will continue to address any variance findings for three months to ensure compliance.	

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F 761	Continued From page 9 Set" (MDS) with the Assessment Reference Date (ARD) of 11/28/22, revealed Resident #109 had a Brief Interview for Mental Status (BIMS) score of 09, that indicated Resident #109 had moderate cognitive impairment. Record review of the facility's, "Order Summary Report," dated 12/1/22, for Resident #109, revealed an active order for Fluticasone Propionate Suspension (Flonase) 50 mcg/act (micrograms/actuation) 1 (one) spray in both nostrils one time a day related to Allergic Rhinitis. During an interview on 11/29/22 at 02:20 PM, with the Director of Nursing (DON), she confirmed the nurse should not have left the Flonase on the bedside table, because the resident could forget that he took the medication and take another dose. The DON admitted said she did not know what harm it could cause by spraying extra doses of Flonase. During an interview on 11/29/22 at 03:07 PM, with the Pharmacy Consultant, the consultant confirmed the nurse should not have left medication on the bedside table of the resident. The Pharmacy Consultant confirmed the medication should be observed when given and placed back into a locked cart.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812		1/5/23

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F 812	Continued From page 10 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review, the facility failed to ensure cookware was properly sanitized for one (1) of two (2) kitchen tours. All 55 residents residing in the facility had the potential to be affected. Findings Include: A review of the Facility's policy, "Manual Warewashing" Policy, revised 09/2017, revealed, " ... All cookware, dishware, and serviceware that is not processed through the dish machine will be manually washed and sanitized. Procedures 1. The Dining Service staff will be knowledgeable in proper technique including ...chemical sanitizer testing and concentrations. 2. Appropriate test strips will be utilized to measure the concentration of the sanitizer solution. Results will be recorded on the Three-Compartment Sink Log ..." An observation on 11/30/22 at 10:52 AM, revealed the chemical sanitizer in the three-compartment sink was checked with the assistance of the Dietary Manager (DM). The DM	F 812	1. Auto-Chlor came to the facility on 11/30/2022. The three compartment sink sanitation was inspected and corrected. Auto-Chlor to maintain on a monthly basis. 2. All residents in the center are at risk for the deficient practice. 3. In-service with all dietary staff by Account Manager on the proper technique of testing of testing chemical sanitizer and concentrations on 11/30/2022. Appropriate test strips will be utilized to measure the concentration of the sanitizer solution. Results will be recorded on the three compartment sink log. 4. Account Manager or staff member will check the logs and concentration of the sanitizer of the three compartment sink log every day for one month, then three times a week for three months beginning 11/30/2022. The compartment sink will be checked at a minimum of three times a day before use daily. All variances to procedure will be immediately corrected	

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F 812	Continued From page 11 placed a sanitizer test strip into the compartment that should have held the sanitizer, removed it, and compared it to the color chart on the test strip container. The test strip indicated that the chemical sanitizer measured zero (0) parts per million (ppm), instead of the acceptable range of 100 to 200 ppm. There were no items in the sink compartment during the observation. The DM ran more water that should have contained the chemical sanitizer into the compartment. She placed another test strip into the same compartment and compared it to the color chart on the container. The test strip again measured 0 ppm. On 11/30/22 at 11:11 AM, in an interview with the DM, she stated that she did not know why the sanitizer in the three-compartment sink was not working and commented that the sanitation had recently been checked by the "Auto-Chlor" (name brand of chemical sanitizer) Technician. She pointed out that the container of chemical sanitizer was almost full. Observation of the "Auto-Chlor Pots and Pans Sanitizer" container revealed there was a five (5)-gallon container that contained approximately three (3) gallons of the chemical sanitizer. The DM explained that the three-compartment sink is used to wash and sanitize the pots and pans used to cook meals for the residents. She commented that the water gets hot enough to clean the dishes but confirmed that the residents could get sick if the pots and pans are not sanitized properly. On 11/30/22 at 11:20 AM, in an interview with the Administrator, she stated that the residents could get sick from not sanitizing the dishes and that she expected any equipment that is not functioning properly to be repaired promptly.	F 812	and addressed in Quality Assurance and Performance Improvement (QAPI) on 1/04/2023. QAPI meeting will continue to address any variance findings for three months to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255175	A. BUILDING _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 12 On 11/30/22 at 12:30 PM, the Dietician stated in an interview that the sanitation was not flowing from the sanitation container properly because the filter needed to be changed. The Dietician confirmed that the filter has been changed and the sanitation is working properly.	F 812		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(1)(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 from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and facility policy review the facility failed to maintain a properly functioning call system for one (1) of four (4) halls observed. B Hall Findings Include: Review of facility's policy titled, "Nurse Call System," dated September 1, 2014, revealed "Purpose: To maintain center 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	F 919	1. All identified residents residing on B Hall were observed by Administrator, Director of Nursing (DNS), and Assistant Director of Nursing (ADNS), and Health Information Management Coordinator (HIM-C) on 11/28/2022. There were no negative findings. On 11/28/2022, the call system phone receiver at the nurses station was replaced by the Maintenance Director. 2. All residents of the center have the potential for being affected by this practice. 3.On 11/28/2022, the Maintenance Director completed an audit of 100% of the halls to assure that staff were able to hear the call bells on each hallway. The	1/5/23

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F 919	Continued From page 13 monthly. Any non-operating components should be repaired as soon as practically feasible." An observation on 11/28/22 at 03:45 PM, revealed the call light above the door of Room #8 on B Hall was on, but there was no audible sound in the hall or at the nurse's desk. In an interview on 11/28/22 at 03:45 PM, with Licensed Practical Nurse (LPN) #3, she stated that the call lights make a sound outside in the hallway. However, LPN #3 was observed entering Room #4 on B Hall and pressing the resident's call system button, and the light above the door was on, but there was no audible sound in the hallway or at the nurse's station. LPN #3 stated the Certified Nurse Aides (CNA's) are usually on the floor and can see the call lights. She revealed that at one time there was a call system control box at the nurse's station that would sound when a call light was activated, but the nurse had not seen it lately. On 11/28/22 at 3:50 PM, an observation of all the resident rooms on B Hall, revealed that when the light was on above the resident's doors, there was no audible sound either in the hall or at the nurse's desk. On 11/28/22 at 4:00 PM, the Maintenance Director was observed working on the call light system. On 11/29/22 at 10:00 AM, an observation of the call light system revealed the call light system was audible on all halls and at the nurse's desk. A working call light control box was observed on the nurse's desk.	F 919	call system worked properly on each hallway. On 11/30/2022, the ADNS completed an In-service/education with nursing staff on call system phone receiver to remain at nurse's station at all times and attached to system cord adaptor and to report all functionality issues or malfunctions to the Maintenance Director or Administrator as soon as possible. The Maintenance Director secured the call system phone receiver to the nurse's station desk. 4. The Maintenance Director, Administrator, or staff member will perform audits to ensure call system phone receiver is present at the nurse's station and properly functioning five times a week for two weeks, three times a week for two weeks, then once weekly for two months beginning 12/12/2022. All variances identified will be immediately corrected and addressed in Quality Assurance and Performance Improvement (QAPI) on 1/04/2023. QAPI meeting will continue to address any variance findings for three months to ensure compliance.	

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F 919	Continued From page 14	F 919		

During an interview on 12/01/22 at 3:00 PM, the Director of nursing (DON) confirmed the facility had not discovered the problem with the call lights until Monday when the State Agency (SA) brought it to their attention. It was at that time that the facility discovered the call system control box was missing from the nurse's desk. The DON revealed that she wasn't sure how long the control box had been missing, but the staff had narrowed the time frame down to the preceding weekend. The DON said that the CNA's are always stationed on the halls and are trained to watch for the lights above the doors.

During an interview on 12/01/22 at 3:10 PM, with the Maintenance Director, he confirmed the call light control box had been replaced as soon as the facility was made aware of the issue with the system. He confirmed that the Administrator had given him permission to purchase the replacement call system control box that same evening at a local electronic store.

During an interview on 12/01/22 at 3:21 PM, the Administrator confirmed the call light system had been compromised and that it's important for residents to have a properly functioning call light system to ensure that they are able to notify the staff of their needs and concern.