STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255108	A. BUILDING _____ B. WING _____	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREND HEALTH & REHAB OF CARTHAGE LLC	1101 EAST FRANKLIN STREET CARTHAGE, MS 39051

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey from 1/3/23 to 1/5/23. During the annual recertification survey the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited F585, F623, F656, F658, F677, F686, F695, F812, and F880. The facility is certified for 99 beds, with a census of 88 during the survey.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the	F 585		2/9/23

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

Electronically Signed | 01/27/2023

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F 585	Continued From page 1	F 585		

provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source,

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F 585	Continued From page 2 and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident/resident representative and staff interviews, facility policy review, and record review the facility failed to resolve a grievance related to transportation to the dialysis center for one (1) of three (3) dialysis residents reviewed. Resident #25. Findings include: Review of the facility policy, titled, "Resident and Family Grievances /Complaints", undated,	F 585	The facility Plan of Correction is as follows: 1. Resident #25 began wheelchair accessible van transport to Dialysis appointments on 01/05/2023. In-service with all nursing staff on the facility's Policy and Procedure for transport via van of Residents for Dialysis appointments on 01/11/23. 2. All residents have the potential to be affected.	

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F 585	Continued From page 3 revealed it is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. Review of the facility policy titled, "Dialysis Policy", dated 3/21/2022 revealed "....Procedure, the facility will arrange for the residents to receive proper transportation per van or transport service..." An interview, on 01/03/23 at 11:30 AM, with Resident #25 revealed they (the staff) push her in the wheelchair to dialysis. She stated that the van can be outside the facility, and they will push her to dialysis even if it is raining. She stated that she gets wet even with an umbrella. An interview, on 1/4/23 at 5:10 PM, with Director of Nursing (DON) and the Administrator (ADM) revealed that Resident #25's husband had spoken to both of them concerning taking Resident #25 to dialysis in a wheelchair when the weather is bad and rainy. She stated that he felt they needed to build a pavilion over the walkway to the dialysis unit. The DON stated that they use the van if the weather is bad, but when questioned by the State Agency (SA) the DON admitted that they do push the residents in their wheelchairs to dialysis using an umbrella if it is raining. She stated that Resident #25's husband had called her and requested that his wife go by van if the weather is bad. The DON stated that she guessed they could try to schedule the van to be available on dialysis days. The DON stated they have at times shared vans with the senior care facility next door. She stated they do not have a transport service in this city. The DON stated that she referred Resident #25's husband	F 585	3. On 01/05/2023 the facility administrator requested permission from the resident council to attend and participate in the council meeting on 01/26/2023. The residents granted the administrator and the Director of Nursing (DON) request to attend. On 01/26/2023, in the resident council meeting, the residents were educated on the grievance process how to report concerns and to report any unresolved concerns to the administrator. The Administrator conducted the resident council meeting as an education for the Activities Director (AD) as well as residents on how to document, report, handle and follow-up to ensure grievances are reported, handled and are resolved to the residents satisfaction. The AD is to discuss in resident council any unresolved grievances from the previous meeting and report them to the Administrator within 24 hours. The grievance forms have been made available to all residents by placing forms in a reachable location for all residents. The forms are located at each nursing unit on counter clearly marked as Grievance Forms and are within easy reach of the residents. Any staff may complete an individual grievance form for a resident, to be given to the Administrator within 24 hours. The Administrator will meet with the appropriate department to determine a resolution. The resolution will be discussed with the resident and the resident will sign when resolution is satisfied as met. Beginning 01/11/2023 and on 01/23/2023 facility staff has been in-serviced by Staff	

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F 585	Continued From page 4 to the Administrator. The ADM confirmed that they probably need to have them (the residents) in a van if the weather is bad. He confirmed that he was sure the residents had probably gotten wet when it was raining outside. He confirmed the residents could get sick due to the exposure. He stated that he had spoken with Resident #25's husband one or two times concerning this issue. The ADM and the DON confirmed this would be considered a verbal grievance. The Administrator stated that he did not have a written record of his conversation with Resident #25's husband. He stated that it had been about two (2) weeks since he talked to the resident's husband and confirmed this issue would be considered an unresolved grievance. The ADM confirmed that their dialysis policy revealed that residents will receive proper transportation per facility van or transport service, but it does not mention anything about wheelchairs. A telephone interview on 01/05/23 at 10:25 AM, with Resident # 25's Resident Representative/husband revealed that he was concerned about his wife being pushed in her wheelchair to the dialysis center when the weather is bad outside. He stated that Resident #25 told him she gets wet going over there when it is raining. She complained about getting cold and her nose getting stopped up. She told him that many times the bus is there, but they won't use it. He stated that he had talked to the Director and the Administrator concerning this. He stated that he suggested that they get together with dialysis and possibly build a covered shed between the two buildings. He stated the Administrator said that he had not thought of that. He stated that he had not heard anything back from the administration and he felt like there	F 585	Development Nurse on documenting and handling resident grievances. Resident Grievance forms have been placed on each unit and have been placed in a easily accessible site for residents. 4. Administrator will monitor through resident interviews, at least three (3) interviews weekly x three (3) weeks beginning on 01/09/2023-02/08/2023, then monthly through resident council to ensure that grievances are resolved. Administrator will report findings to the Quality Assurance Performance Improvement (QAPI) committee for review on 02/08/23, for revisions or resolutions to the plan.	

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F 585	Continued From page 5 could be a danger to his wife especially if it was wet or icy and the nurse aide slipped down. During an observation, on 01/05/23 at 11:14 AM, the Maintenance staff measured the distance down the walkway from the front of the facility to the front of the dialysis building and the distance was 328 feet (109.3 yards). Review of the Order Summary Report for Resident #25 revealed an order dated 9/13/22 for dialysis 3 times a week on Tuesday, Thursday, and Saturday for hemodialysis. Record review of the Admission Record for Resident #25 revealed she was admitted to the facility on 8/31/2022 with diagnoses of End stage Renal Disease, Dependence on Renal Dialysis, Hemiplegia and Hemiparesis following Cerebral Infarction, Diabetes Type 2, and anxiety disorder. Review of Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/2/22 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #25 was cognitively intact.	F 585		
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	F 623		2/9/23

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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;
(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;

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F 623	Continued From page 7	F 623		

(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 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

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F 623	Continued From page 8 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, record review and facility policy review, the facility failed to provide a resident or resident representative with a written notification for the reason of transfer/discharge to the hospital for one (1) of two (2) residents reviewed. Resident #67 Findings include: Review of the facility policy titled, "Transfers and Documentation" with a revision date of 11/2017 revealed "...F. When it becomes necessary to transfer or discharge a resident from the facility, the "Transfer/Discharge Report" must be completed in the electronic medical record (EMR) by a unit manager or staff nurse and forwarded with the resident..." An interview on 01/04/23 at 4:35 PM, with the Business Office Manager revealed she has been notifying the family by phone and was not aware that a written notice needed to be sent to the family/resident for transfers and discharges. She revealed she would have been the person responsible for sending the written notices of transfer/discharge to the residents or the resident representative. She confirmed that Resident #67 did not have a written notice sent to the resident representative following her transfer/discharge to the hospital on 10/25/22.	F 623	The facility plan of correction is as follows: 1. Resident #67 Responsible Party was verbally notified of transfer on 10/25/22. 2. All residents who are emergency transferred/discharged have the potential to be affected. 3. On, 1/5/23, the Administrator in-serviced the Business Office Manager (BOM) on written notification to the resident and the Residents Representative of an emergency transfer. 4. On, 1/9/23, the Administrator ran the Transfer Log. Nursing staff continues to notify Resident Representative via phone. The BOM is to mail a written notification of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand to Resident/Resident Representative within 24 hours (or next mail delivery day) beginning 1/6/23. BOM will make a copy of the notification and maintain on file. The list of all transfer/discharges will be logged and sent to the Ombudsman on a monthly basis. This log will be maintained by the BOM. The Administrator will monitor, by review of all transfer/discharges and review a copy of notification from BOM Mondays and Fridays while on duty. Administrator will	

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F 623	Continued From page 9 An interview on 01/05/23 at 9:40 AM, with the Administrator revealed he was aware that residents need to receive a written notice of transfer/discharge, but he was not aware that it was not being done. He revealed the loss of their Social Worker was probably the reason that they have failed to send the notices. An interview on 01/05/23 at 09:50 AM, with the Corporate Nurse revealed she was aware that residents were to receive a written notice of transfer/discharge but did not realize they were not sending it. Record review of the Resident #67's Admission Record revealed she was admitted to the facility on 02/11/22 with medical diagnoses that included Type 2 Diabetes Mellitus with unspecified complication and Acquired absence of right leg below knee. Record review of Resident #67's Progress Notes revealed the resident was admitted to the hospital on 10/25/22 due to no urine output and change in mental status and was readmitted to the facility on 10/28/22. Record review of Resident #67's electronic record and paper record revealed there was no written notice sent to Resident #67's resident representative following her transfer/discharge to the hospital on 10/25/22.	F 623	run a weekly report of all transfers/discharges x 3 months to ensure compliance. The Administrator will report findings to the Quality Assurance Performance Improvement committee monthly x 3 months for review, revision or resolution on 02/08/23.	
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		2/9/23

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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.
§483.21(b)(3) The services provided or arranged

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F 656	Continued From page 11 by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and facility policy review, the facility failed to implement comprehensive care plans for four (4) of twenty residents care plans reviewed. Resident #11, Resident #32, Resident #61 and Resident #67. Findings Include: A review of the facility's "Following the Care Plan Policy", dated 3/21/22, revealed, it is the policy of this facility to follow a written and approved care plan for each resident ...All employees will follow the written care plan that is developed in order to assure the resident's needs are met. Resident #11 Record review of Resident #11's care plans revealed the following care plan; printed date 1/4/23 revealed, "Focus: I have a physical function deficit related to: self-care impairment, mobility impairment, Range of Motion (ROM) limitations related to dx (diagnosis) of Cerebrovascular Accident (CVA) with left sided hemiplegia and Left extremity (LE) contracture. I need assistance with my Activities of Daily Living (ADL's)...Interventions... Nail care PRN (as needed)." On 01/03/23 at 11:40 AM, observation revealed Resident #11 sitting up in his wheelchair in front of the television. This observation revealed the resident is non-verbal but acknowledges when he	F 656	The facility plan of correction is as follows: 1. Resident #32 had body audit done on 1/4/22 then weekly. Resident #67 had body audit done 01/08/22 then weekly. All residents had body audits completed by 1/12/22 and will have body audits done weekly. Resident #11 and #61 had nails trimmed and filed on 1/6/22. All residents had nails trimmed/filed as needed by 1/12/22. Care plans for residents #61, #32, #11, #67 were reviewed and updated on 01/10/23 2. All residents have the potential to be affected. 3. The Staff Development Nurse in-serviced the licensed nurses 01/11/2023 on policy and procedure for completing body audits weekly. Staff development nurse in-serviced nursing staff on 01/11/2023 on nail care with trimming/filing included. 4. The Director of Nursing (DON), RN Supervisor or Staff Development Nurse will observe nails for six (6) resident twice weekly 01/09/23-02/08/23 x 3 months to ensure that nails are clean and trimmed. The Director of Nursing, Minimum Data Set (MDS) nurse/care plan coordinator or Wound Care Nurse will review nine (9) residents records twice weekly 01/09/23 - 02/08/23 then monitor monthly 03/09/23-05/09/23 x 3 months to ensure that body audits are done as ordered.	

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F 656	Continued From page 12 was spoken to and held up his right hand and showed his thumb nail and then used his other fingers on his right hand to rub his long thumb nail. The resident then held up his left thumb and showed his left thumb nail. The residents thumb nails were uncut, long, and the resident's right ring finger and pinky finger revealed fingernails that were uncut, long and jagged. On 01/04/23 at 11:00 AM, observation revealed Resident #11 lying in bed with nails uncut, long and jagged to hands bilaterally. On 01/04/23 at 11:10 AM, during an observation and interview with Licensed Practical Nurse (LPN) #2 revealed it is the responsibility of the 3 PM-11 PM shift Certified Nursing Assistants (CNAs) to do the nail care. An observation of the resident at this time revealed LPN #2 confirmed that the resident's nails were long and jagged and needed to be trimmed. She revealed the purpose for keeping the resident's nails trimmed were to prevent an injury to his skin. On 01/04/23 at 11:45 AM, in an interview with the Director of Nurses (DON) confirmed that it is the responsibility of the 3 PM-11 PM shift CNAs to do nail care unless the resident is a diabetic or they are having a challenge getting the nails clipped. She revealed if the resident is a diabetic or the CNA is having a challenge then they are to notify their nurse. She revealed that nail care is not documented anywhere but is expected to be done with baths and the trimming should be addressed at least once per week. She revealed the reason that nails need to be trimmed is to prevent injury. Record review of Resident #11's Admission	F 656	Director of Nursing will report findings to the Quality Assurance Performance Improvement committee on 02/08/23 and then monthly 03/09/23-05/09/23 monthly for review, revision and resolution to the plan to ensure sustainability of plan.	

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Record revealed the resident was admitted to the facility on 06/09/05 and medical diagnoses that include Hemiplegia and Hemiparesis following Cerebral infarction affecting left non-dominant side.

Resident #32

Record review of Resident #32's comprehensive care plan with a print date of 1/4/23, revealed, "Focus: I am at risk for pressure ulcer formation r/t (related to) decreased mobility, assistance required with bed mobility, and incontinence of bowel and bladder... Interventions ... Weekly skin and body audit per assigned nurse with +/- (positive/negative) impairments documented."

On 1/4/23 at 11:00 AM, an interview with the Treatment Nurse confirmed that Resident #32 had a deep tissue injury that was facility-acquired to her left heel that was discovered on 12/9/22.

During an interview on 1/4/23 at 12:25 PM with Licensed Practical Nurse (LPN) #1 confirmed that weekly body audits are to be completed on all residents. She revealed that the body audit for Resident #32 was to be completed by the day shift nurse. She confirmed that there were no body audits completed for Resident #32 from 9/5/22 until 12/09/22 when it was discovered that Resident #32 had a deep tissue injury to her left foot.

On 1/4/23 at 3:17 PM, interview with the DON confirmed that each resident is to have a weekly body audit and that Resident #32 had not had a body audit from 9/5/22 until 12/09/22. The DON confirmed the suspected deep tissue injury was

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facility acquired and if the weekly body audits were being completed as they should have been, this wound could have possibly been prevented.

An interview on 01/05/23 at 9:33 AM, with the Minimum Data Set (MDS) nurse revealed she is one of the MDS nurses responsible for implementing the care plan. She revealed when a resident is admitted we do a baseline care plan within 48 hours. If there are any changes, they will be updated in the chart under the temporary care plan list. She revealed the MDS nurses will update the comprehensive care plan when there is a significant change and at least quarterly. She confirmed that the plan of care was not being followed and that Resident #32 was to have weekly skin audits, but they were not being done.

A record review of Resident #32's Admission Record revealed the resident was readmitted to the facility on 10/29/19 with diagnoses of Cerebral infarction, Hemiplegia, and Hemiparesis affecting left non-dominant side, Type 2 Diabetes Mellitus, and Hypertensive heart disease.

Resident #61

Record review of Resident #61's Care Plans with a print date 1/4/23 revealed "Focus: I require assistance with ADL's r/t (related to) self-care impairment due to Guillain-Barre, limited ROM to upper and lower extremities, obesity, and poor cognition...Goal- My needs will be met every shift & as needed with assist of staff thru the next 90 days...Interventions...Nail care as needed or scheduled..."

An observation on 01/03/23 at 12:50 PM, revealed Resident #61 lying in bed with hands

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drawn inward bilaterally and long, uncut fingernails were observed.

An observation on 01/04/23 at 8:53 AM, revealed Resident #61 lying in bed with hands in splints and long, uncut fingernails.

On 01/04/23 at 11:05 AM, during an interview and observation with CNA #3 revealed it is the responsibility of the 3 PM-11 PM shift CNAs to complete nail care. She confirmed that Resident #61's nails were too long and needed to be trimmed. She revealed she started working on the North end of the hallway yesterday and noticed that the resident's nails were long, but she did not trim them or say anything to her nurse.

On 01/04/23 at 11:25 AM, in an observation and interview with LPN #3 revealed she is Resident #61's nurse and confirmed that the resident's nails were too long and needed to be trimmed because she has contractures, and the nails could dig into her skin and cause an injury.

Record review of Resident #61's Admission Record revealed the resident was admitted to the facility on 03/17/21 with medical diagnoses that included Need for assistance with personal care.

Resident #67

Record review of Resident #67's care plan printed 1/4/23 revealed "Focus: I am at risk for pressure ulcer formation r/t decreased mobility, assistance required with bed mobility, and frequent incontinence of bowel and bladder...Goal... I will have no pressure ulcer formation through the

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review date... Interventions...Weekly skin and body audit per assigned nurse with +/- impairments documented and CNA to check skin daily during care and report all red areas to assigned nurse..."

On 01/04/23 at 4:15 PM, during an interview with the Treatment Nurse confirmed that Resident #67 had a facility acquired pressure ulcer to her left heel that was discovered on 07/22/22. She revealed that it is the responsibility of the LPN on the hall to do the resident's body audit's weekly. She revealed that if the body audits would have been done weekly like they are supposed to then the pressure ulcer could have been discovered at an earlier stage.

On 01/04/23 at 4:30 PM, during an interview with the Director of Nurses (DON) confirmed that Resident #67 has a facility acquired pressure ulcer to her left heel and a right leg amputation. She revealed that weekly body audits are supposed to be performed by the LPN's assigned to that resident. She confirmed the resident received a body audit on re-admission to the facility on 06/03/22 but did not receive weekly body audits after that date until 7/22/22 when the pressure ulcer to the left heel was first discovered.

On 01/05/23 at 2:30 PM, in an interview, LPN #2 reviewed Resident #67's "miscellaneous" section in the resident's electronic record and confirmed that no weekly body audits were documented on Resident #67 after the initial body audit was completed on re-admission on 06/03/22 and that she could not find another body audit until 7/21/22. She revealed she has no idea why this resident would not have had a weekly body audit

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F 656	Continued From page 17 completed and confirmed that the facility failed to complete her weekly body audit. An interview on 01/05/23 at 2:54 PM, with RN #1 revealed she does the skin assessments for Minimum Data Set (MDS) assessments and makes recommendations for changes to the plan of care based on those assessments. She revealed that Resident #67 had a skin assessment completed prior to the development of the current pressure ulcer by MDS that revealed the resident was high risk for pressure ulcers. She revealed the resident's skin assessment resulted in a score of 14 on 05/09/22 which indicates the resident is at high risk for pressure ulcers. She revealed she does not recall making any changes to the resident's care plan or treatment suggestions. Record review of Resident #67's Admission Record revealed the resident was admitted to the facility on 02/11/22 with medical diagnoses that included Type II Diabetes and Acquired absence of the right leg below the knee. Record review of Resident #67's electronic record for June 2022 and July 2022 revealed there were no weekly body audits documented between 06/11/22 and 07/21/22. Record review of Resident #67's Weekly Body Audits revealed an audit dated 07/22/22 that indicated the resident had a Stage II pressure ulcer to her left heel	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		2/9/23

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F 658	Continued From page 18 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to provide services to meet professional standards as evidenced by failure to check percutaneous endoscopic gastrostomy (PEG) tube placement prior to peg tube medication administration for one (1) of six (6) residents observed during medication administration. Resident #137. Findings include: Review of the facility policy titled, "Medication Administration Via Tube Feeding", dated 2/2012, revealed..."5. Verify placement of feeding tube per aspiration/auscultation prior to instilling any fluid or medication..." During medication pass on 1/4/23 at 8:20 AM, Licensed Practical Nurse (LPN) #2 entered Resident #137's room to administer PEG medications. LPN #2 removed the plunger from the syringe, unplugged the PEG tube, attached the syringe and did not check tube placement before she administered water and medications to the resident. An interview on 1/4/23 at 2:55 PM, with LPN #2 confirmed she did not check tube placement before administering water and medications during the medication pass. She stated that she didn't know why she didn't check placement and that she didn't think about it until she was finished	F 658	The facility plan of correction is as follows: 1. Resident #137 is having Percutaneous endoscopic gastrostomy (PEG) tube placement checked prior to administration of all meds, fluids or feedings. Licensed Practical Nurse #2 had a one on one in-service on 01/05/23 on correct policy and procedure of checking placement of percutaneous endoscopic gastrostomy tube prior to administration of medication, fluid or feedings. In addition, further education on the proper procedure to check placement of the percutaneous endoscopic gastrostomy tube was completed and a return demonstration was observed on 01/09/23. 2. All residents with percutaneous endoscopic gastrostomy tubes have the potential to be affected. 3. Licenses nurses were in-serviced on 01/11/2023, by the Director of Nursing, in-service included policy & procedure on the proper placement check of peg tube prior to administration of meds, fluids or feeding. 4. The Director of Nursing (DON) or Staff Development nurse beginning 01/09/23 will observe medication administration for three (3) residents twice weekly x 3 weeks and will continue x 3 months to ensure that tube placement is being checked prior to administration. The	

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F 658	Continued From page 19 with the medications. LPN #2 stated if the tube was not in place, it causes stomach pain. An interview on 1/4/23 at 3:00 PM, with the Director of Nursing (DON) revealed that the PEG tube placement should always be checked every time before use, even if they have used it three times before. She stated there is an order to check placement and that not checking for tube placement could cause all kinds of issues like peritoneal abscess or fissures. An interview on 1/5/23 at 3:00 PM, with LPN #3 revealed that PEG tube placement should always be checked before using the tube by pulling back with a syringe or listening when putting air in with the syringe to be sure it is in the right place. Review of an in-service training dated 5/4/22 revealed LPN #2 attended the training that included medication administration via tube feeding. Review of the Order Summary Report dated 12/30/2022 revealed enteral feed order - check placement per aspiration/auscultation prior to instilling fluids/meds/formula. Review of the Admission Record for Resident #137 revealed an admission date of 12/30/22 with diagnoses that included Acute Respiratory Failure with hypoxia, Degenerative disease of Basal Ganglia, and Gastrostomy.	F 658	Director of Nursing will report findings to the Quality Assurance Performance Improvement committee on 02/08/23 and then monthly 03/09/23-05/09/23 for review x 3 months, revisions and resolutions to the plan.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		2/9/23

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F 677	Continued From page 20 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, record review and facility policy review, the facility failed to ensure residents who were dependent on staff for nail care received those services as evidenced by long, jagged nails on two (2) of nineteen residents reviewed. Resident #11 and Resident #61 Findings include: Review of the facility policy titled, "Fingernails/Toenails, Care of" with a revision date of 03/21/22 revealed "Policy ...The purposes of this policy is to clean the nail bed, to keep nails trimmed, and to prevent infections...Procedure ...6. Nail care includes daily cleaning and regular trimming; 7. Proper nail care can aid in the prevention of skin problems around the nail bed 8. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin". Resident #11 An observation on 01/03/23 at 11:40 AM, revealed Resident #11 sitting up in his wheelchair in his room. This observation revealed the resident is non-verbal but acknowledged when he was spoken to and held up his right hand and showed his thumb nail and used his other fingers on his right hand to rub his long, uncut thumb nail. The observation revealed the resident then held up his left thumb and showed his left thumb nail was long, uncut and the resident's right ring finger and little fingernails on both hands were	F 677	The facility plan of correction is as follows: 1. Resident #11 and #61 had nails trimmed and filed on 1/6/22. All residents nails were inspected and trimmed/filed as needed by 1/12/22. Licensed Practical Nurse #2 had a one on one in-serviced on the correct policy and procedure for nail management of all residents. Nail care for resident #11 was provided by Licensed Practical Nurse #2. 2. All residents have the potential to be affected. 3. The Staff Development Nurse in-serviced nursing staff 01/11/2023 on Policy and Procedure for trimming/filing nails as needed. 4. The Director of Nursing (DON), RN Supervisor or Staff Development Nurse will observe nails for six (6)) resident twice weekly beginning 01/09/23-02/09/23, then continue monitoring x 3 months to ensure that nails are clean and trimmed. The DON will report findings to the Quality Assurance Performance Improvement committee on 02/08/23 then monthly 03/09/23-05/09/23 for review, revision and resolution to the plan.	

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long, uncut, and jagged.

An observation on 01/04/23 at 11:00 AM, revealed Resident #11 lying in bed with nails long, uncut, and jagged to hands bilaterally.

An observation and interview on 01/04/23 at 11:10 AM, with Licensed Practical Nurse (LPN) #2 revealed it is the responsibility of the 3 PM-11 PM shift Certified Nursing Assistants (CNAs) to do the nail care. LPN #2 confirmed that the resident's nails were long and jagged and needed to be trimmed and filed. She revealed the purpose for keeping the resident's nails trimmed were to prevent injury and a skin tear.

Record review of Resident #11's Admission Record revealed the resident was admitted to the facility on 06/09/05 with medical diagnoses that included Hemiplegia and Hemiparesis following Cerebral infarction affecting left non-dominant side.

Record review of Resident #11's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated 11/28/22, revealed in Section C a Brief Interview for Mental Status (BIMS) with no score which indicates the resident is severely cognitively impaired and in Section G revealed the resident is totally dependent on staff for personal hygiene.

Resident #61

An observation on 01/03/23 at 12:50 PM, revealed Resident #61 lying in bed with hands drawn inward bilaterally with long, uncut, fingernails.

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An observation on 01/04/23 at 8:53 AM, revealed Resident #61 lying in bed with hands in splints and long, uncut, fingernails.

An interview and observation on 01/04/23 at 11:05 AM, with CNA #3 revealed it is the responsibility of the 3 PM-11 PM shift CNAs to complete nail care. She confirmed that Resident #61's nails were too long and needed to be trimmed and stated that she started working on the north end hallway yesterday and noticed that her nails were long and uncut, but she did not trim them or say anything to Resident #61's nurse.

An observation and interview on 01/04/23 at 11:25 AM, with LPN #3 revealed she is Resident #61's nurse and confirmed that the resident's nails are too long and needed to be trimmed because she has bilateral hand contractures, and the nails could dig into her skin and cause an injury.

Record review of Resident #61's Admission Record revealed the resident was admitted to the facility on 03/17/21 with medical diagnoses that included Need for assistance with personal care.

Record review of Resident #61's Minimum Data Set with an Assessment Reference Date (ARD) of 10/13/22 revealed in Section G that the resident is totally dependent on staff for personal hygiene and bathing and in Section C revealed a BIMS score of 05, which indicates the resident is severely cognitively impaired.

An interview on 01/04/23 at 11:45 AM, with the Director of Nurses (DON) confirmed that it is the responsibility of the 3 PM-11 PM shift CNAs to do

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TREND HEALTH & REHAB OF CARTHAGE LLC	1101 EAST FRANKLIN STREET CARTHAGE, MS 39051

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F 677	Continued From page 23 nail care unless the resident is a diabetic or they are having a challenge and if they are then they are to notify their nurse. She revealed that completed nail care is not documented anywhere but is expected to be done with baths and the trimming should be addressed at least once per week. She revealed the reason that nails need to be trimmed is to prevent injury and infection.	F 677		
F 686 SS=G	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 by: Based on observation, staff interview, record review and facility policy review, the facility failed to perform physician ordered weekly body audits as evidenced by two (2) high risk residents developing an avoidable facility acquired pressure ulcer for two (2) of 10 residents with pressure ulcers reviewed. Resident #32 and Resident #67. Findings include: Record review of the facility policy titled, "	F 686	The facility plan of correction is as follows: 1. Resident #32 had body audit done on 1/4/22 then weekly. Resident #67 had body audit done 01/08/22 then weekly. 2. All residents have the potential to be affected. 3. The Director of Nursing in-serviced the licensed nurses 01/11/2023 on policy and procedure for completing body audits weekly. Body audits are being done	2/9/23

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F 686	Continued From page 24 Instructions For Pressure Wound Documentation and Photographing Procedure for Wounds Via PCC (Point Click Care) Skin/Wound APP with a revision date of 09/07/22" revealed "...8. Review body audits daily to ensure they are completed as scheduled. This can be completed as you review your dashboard daily". Resident #32 An observation on 1/3/23 at 11:05 AM, revealed Resident #32 lying in bed, Heel protectors to bilateral feet. An interview on 1/4/23 at 11:00 AM, with the Treatment Nurse confirmed that Resident #32 had a facility-acquired pressure ulcer to her left heel that was discovered on 12/9/22. She confirmed that it was a suspected deep-tissue injury. The Treatment Nurse revealed she had already done the treatment for today but did show the pressure ulcer to the SA. SA observed a dry, blackened area with no opened areas to left heel. An interview on 1/4/23 at 12:25 PM, with Licensed Practical Nurse (LPN) #1 confirmed that weekly body audits are to be completed on all residents. She revealed that the body audit for Resident #32 was to be completed by the day shift nurse. She confirmed that there were no body audits completed for Resident #32 since 9/5/22 and Resident #32 has a deep tissue injury to her left foot. An interview on 1/04/23 at 2:50 PM, with Certified Nurse Assistant (CNA) #1 revealed that she has been assigned Resident #32. She stated "if we notice any skin issues with our residents, we are to notify the nurse. When I put her back in bed	F 686	weekly per the assigned nurses. The Director of Nursing (DON), Staff Development Nurse or Wound Care Nurse will review nine (9) records twice weekly 01/09/23 - 02/08/23 then monthly 03/09/23-05/09/23 x 3 months to ensure body audits are being completed as ordered. 4. All residents had body audits completed by 1/12/22 and will have body audits done weekly. The Director of Nursing will bring findings to Quality Assurance Performance Improvement committee on 02/08/23 then monthly 03/09/23-05/09/23 for review x 3 months, revisions and resolutions to the plan, and evaluation of the plan as a sustainable solution.	

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today, I put her heel protectors on, but I don't think she has any sores on her feet."

An interview on 1/4/23 at 3:17 PM, with the Director of Nurses (DON) confirmed that each resident is to have a weekly body audit and that Resident #32 had not had a body audit since 9/5/22. The DON confirmed the suspected deep tissue injury was facility acquired and if the weekly body audits were being completed as they should have been, this wound could have possibly been prevented.

An interview on 1/5/23 at 03:40 PM, with Registered Nurse (RN) #1 revealed the resident had a stroke in 2019 and was readmitted to the facility. She revealed that the Skin at Risk score was 14, and the resident was at high risk for skin breakdown. Registered Nurse #1 confirmed the only order in place at that time was for the resident to be turned every two hours.

A record review of the last weekly body audit completed dated 9/5/2022 revealed there were no skin issues or wounds present. Preventative interventions ...Turn every two hours.

A record review of the Skin & Wound Evaluation effective date 12/9/22 revealed the type of wound was Pressure, the stage was Deep Tissue Injury: Persistent nonblanchable deep red, maroon or purple discoloration. Location, Left Heel. In-house acquired. Wound measurements Area 11.8 centimeters (cm), Length 4.3 cm, Width 3.7 cm.

A record review of Resident #32's Admission Record revealed the resident was readmitted to the facility on 10/29/19 with diagnoses of Cerebral infarction, Hemiplegia, and Hemiparesis affecting

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left non-dominant side, Type 2 Diabetes Mellitus and Hypertensive heart disease.

A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/6/22 revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident was moderately impaired.

Resident #67

An observation on 01/03/23 at 11:52 AM, revealed Resident #67 sitting up in her reclining wheelchair in the day room.

An observation on 01/04/23 at 4:02 PM, with the Treatment Nurse revealed a Stage 3 pressure ulcer to Resident #67's left heel with scar tissue and no drainage noted.

An interview on 01/04/23 at 3:33 PM, with Licensed Practical Nurse (LPN) #3 confirmed that the LPN's are assigned the weekly body audits on the residents. She revealed it is triggered on the Electronic Treatment Administration Record (ETAR) and there is also an electronic form that has to be completed. She does not recall whether she ever was assigned Resident #67, but when she does a body audit, she takes the resident's clothes off and checks from head to toe for any skin issues.

An interview on 01/04/23 at 4:15 PM, with the Treatment Nurse confirmed that Resident #67 currently has a facility acquired Stage 3 pressure ulcer to her left heel that was discovered on 07/22/22 as a Stage 2. She revealed that it is the responsibility of the LPN on the hall to do the

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resident's body audit's weekly. She stated the only preventative measure the resident had in place prior to the development of this pressure ulcer was turning and repositioning every two hours. She reported that in hindsight preventative measures being put into place prior to the development of this pressure ulcer might have prevented the development of it. She revealed that if the body audits would have been done weekly like they are supposed to then the pressure ulcer could have been discovered at an earlier stage.

An interview on 01/04/23 at 4:30 PM, with the DON confirmed that Resident #67 has a facility acquired pressure ulcer to her left heel and a right leg amputation. She revealed that weekly body audits are supposed to be performed by the LPN's assigned to that resident. She revealed that this resident was in the hospital from around the first of May and returned to the facility on 6/3/22. She revealed that the re-admission body audit did not show any issues with the resident's left foot or heel. She confirmed the resident did not get a weekly body audit after her re-admission to the facility on 6/3/22 but received one on 7/22/22 and that was when the pressure ulcer to her left heel was discovered. She confirmed that the resident did not have any preventative measures in place besides being turned or repositioned every two hours prior to the development of the pressure ulcer. She revealed that the resident only had one foot and should have had preventative measures in place to protect the left foot prior to the development of the current pressure ulcer. She confirmed that if the resident would have had her weekly body audits, then the pressure ulcer might have been discovered earlier.

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An interview on 01/05/23 at 2:30 PM, with LPN #2 confirmed that weekly body audits are supposed to be completed on all residents to make sure they have no skin issues and different nurses, and different shifts are assigned the body audits. She revealed that the body audits are documented as complete on the ETAR and a form titled "Weekly Body Audit" is completed on the computer and would be under "miscellaneous" on the resident's electronic record. During this interview, LPN #2 reviewed Resident #67's "miscellaneous" section in the resident's electronic record and confirmed that no weekly body audits were documented on Resident #67 from 6/4/22 until 7/21/22. She revealed she has no idea why this resident would not have had a weekly body audit completed, but should have.

An interview on 01/05/23 at 5:00 PM, with the Treatment Nurse revealed she had not been made aware of the MDS skin assessments that indicated that Resident #67 was at high risk for pressure ulcers.

Record review of Resident #67's Admission Record revealed the resident was admitted to the facility on 02/11/22 with medical diagnoses that included Type II Diabetes and Acquired absence of the right leg below the knee.

Record review of Resident #67's Order Summary Report revealed the following orders:
02/11/22 Weekly body audits per assigned nurse on Fridays, in the morning every Friday. This review revealed there were no pressure ulcer preventative orders noted.

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Record review of Resident #67's electronic record for 06/22 and 07/22 revealed there were no Weekly Body Audits documented between 06/4/22 and 07/21/22, and from 07/25/22 to 12/7/22. This review revealed that the Left heel pressure ulcer measurements on 7/25/22 were 4.0 cm x 5.0 cm x 0.0 cm indicating it was a Stage 2 and the measurements on the Weekly Wound Observation Report dated 12/7/22 were 5.0 cm x 6.5 cm x 0.1 cm indicating it was a Stage 3.

Record review of Resident #67's Minimum Data Set (MDS) assessments revealed an assessment on 9/8/22 that indicated the resident had a Stage 2 pressure ulcer with no measurements noted and on the 9/14/22 MDS assessment it indicated the resident had a Stage 3 with no measurements noted.

Record review of Resident #67's Progress Notes revealed the resident was re-admitted to the facility on 6/3/22 after a stay in the hospital. This review revealed that the resident did not have any issues related to the left heel on re-admission.

Record review of Resident #67's Weekly Body Audits (V3.1-V4) revealed an audit dated 07/22/22 that indicated the resident had a Stage II pressure ulcer to her left heel.

Record review of Resident #67's Skin and Wound Evaluation (V5.0) audits included the following measurements:
07/22/22 4.0 cm x 5.0 cm x 0.0 cm no drainage Stage II.

Record review of Resident #67's Minimum Data Set with an Assessment Reference Date of

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F 686	Continued From page 30 10/18/22 revealed in Section C a Brief Interview for Mental Status of 05, which indicates the resident is severely cognitively impaired and Section M revealed the resident has an unhealed Stage 3 pressure ulcer.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review the facility failed to post "Oxygen in Use" signs on the room doors of resident's using oxygen for two (2) of 10 residents reviewed. Resident #11 and #187. Findings include: Review of the facility policy titled, "Oxygen Safety" with no revision date revealed "Policy Explanation and Compliance Guidelines: ...4.... j. Precautionary signs readable from 5 feet shall be maintained on the door or gate where oxygen is used or stored. (Example: OXYGEN STORE WITHIN-NO SMOKING)..." Resident #11 An observation on 01/03/23 at 12:25 PM,	F 695	The facility plan of correction is as follows: 1. On 01/05/23 Oxygen in use signs were placed on Residents #11 and #187 door for oxygen use. All residents on Oxygen had Oxygen in use signs placed on their doors by a Registered Nurse. 2. All residents who use oxygen have the potential to be affected. 3. Licensed nurses were in-serviced on 01/11/2023 by Director of Nursing covering policy concerning Oxygen in Use signs for oxygen use with signage on door. 4. The Director of Nursing (DON) or Staff Development Nurse will monitor all residents who use oxygen weekly 01/08/23-02/08/23 and monitoring will continue x 3 months to ensure that	2/9/23

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F 695	Continued From page 31 revealed Resident #11 sitting up in her reclined wheelchair in the day room with portable Oxygen (O2) delivering O2 @ 2 Liters per Minute (LPM) via nasal canula. An observation on 01/03/23 at 12:45 PM, revealed Resident #11's room did not have an O2 usage sign on the resident's room door. An observation on 01/04/22 at 08:08 AM, revealed Resident #11 sitting up in her reclining wheelchair in her room with O2 being delivered via nasal canula at 2 LPM with no O2 in use sign on the resident's door. An interview on 01/04/23 at 1:41 PM with the Director of Nurses (DON) confirmed that it is the policy of this facility that any resident that is on O2 has to have an "O2 in Use" sign on their door for safety purposes, because it is combustible. Record review of Resident #11's Admission Record revealed she was admitted to the facility on 10/10/18 and had medical diagnoses that included Alzheimer's and Pneumonia. Record review of Resident #11's "Order Summary Report" revealed an order dated 9/12/22 "O2 continuous @ 2L (liters) related to low O2 saturation (SATS) every shift for low O2 SATS." Record review of Resident #11's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/07/22 revealed in Section C a Brief Interview for Mental Status score of 03 which indicates the resident is severely cognitively impaired and revealed in Section O that the resident is receiving O2.	F 695	oxygen signs are on doors. The findings will be brought to the Quality Assurance Performance Improvement committee by DON on 02/08/23 and then monthly 03/09/23-05/09/23 x 3 months for review, revision and resolution to the plan, to ensure the solutions are sustained.	

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F 695	Continued From page 32 Un-sampled Resident #187 An observation and interview on 01/03/23 at 11:22 AM, revealed Resident #187 sitting on the side of the bed receiving O2 via nasal canula at 3 LPM. An interview with the resident at this time revealed that he wears the O2 continuously and it helps him breath better. This observation revealed there was no "O2 in Use" signage on the resident's room door. An interview on 01/05/23 at 2:40 PM, with Registered Nurse (RN) #1 revealed since Resident #187 is a new admission his MDS assessment has not been completed. Record review of the Admission Record revealed Un-sampled Resident #187 was admitted to the facility on 12/29/22 with medical diagnoses that included Malignant neoplasm of unspecified main bronchus and Acute respiratory failure with hypoxia. Record review of Un-sampled Resident #187's "Order Summary Report" revealed the following order dated 12/29/22, O2 @ 3L continuous everyday related to shortness of breath (SOB). An observation and interview on 01/04/23 at 10:50 AM, with Licensed Practical Nurse (LPN) #2 confirmed that Resident #11 and Resident #187 receives continuous O2 and does not have an O2 in use sign on their resident room door. She revealed it is the responsibility of the nurse starting the O2 to put the sign on the door. She revealed the purpose of the sign is to alert people that O2 is in use, so they know to take caution.	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		2/9/23

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F 812	Continued From page 33 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review, and record review the facility failed to prevent the possibility of food borne illness as evidenced by improper thawing of raw chicken, improper storage of two (2) bags of opened flour, and black substance on the inner door panel of the ice machine. This had the potential to affect 77 of 88 residents who receive food or ice from the kitchen. Findings include: Record review of Facility Policy dated for 02/11/2022 titled, "Food Service Operational Standards For Purchasing, Receiving, Cooking and Storage of Food", revealed "Policy: "The	F 812	1.) On January 6th, 2023, The Dietary Manager and Maintenance Supervisor emptied the ice machine located in the Kitchen and deep cleaned the inside holding area. An in-service was done at this time with the Administrator, Dietary Manager and Maintenance Supervisor regarding Ice Machine Cleaning Policy. On January 11th, 2023, the Dietary Manager turned on the water over the pan of frozen, raw chicken that was in sink as to completely submerge under potable water at 70 degrees or below with sufficient water pressure to remove loose food bits into the drain. All Dietary	

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F 812	Continued From page 34 facility receives, stores, prepares, distributes and serves food under sanitary conditions to prevent the spread of food borne illness and to reduce those practices that result in food contamination and compromised food safety...Procedure...3. Storage...b. Foods should be stored above the floor....d. Keep foods in leak proof, non-absorbent, sanitary wrapping...4. Thawing...b. If time and space do not allow for refrigerator thawing, thaw frozen foods under potable (drinkable), running water at a temperature of 70 degrees or lower..." Record review of Facility Policy, "Ice Machine Maintenance and Cleaning" dated 06/06/2022 revealed "Policy: The facility ice machine will be deep cleaned and sanitized once every six months and cleaned with bleach solution weekly..." On 01/03/23 at 10:35 AM, an observation during the initial kitchen tour revealed 14 raw chicken wings thawing in one side of the two (2) compartment sink. The chicken wings were submerged in a sink full of water and no water was running over the chicken to thaw it out. The observation also revealed 2 opened, twenty-five-pound bags of flour in the dry storage room. The top of each bag of flour was rolled down and was not sealed shut. One bag of flour with about five (5) pounds remaining inside, was located directly on the floor, and was not dated. The other bag of flour with approximately 20 pounds remaining, was dated, and was located on the bottom shelf about a foot off of the floor. On initial tour of the kitchen, the State Agency (SA) also observed a black substance, numerous spots about the size of a pencil eraser, scattered along the inner door panel of the ice machine and	F 812	Workers were promptly in-serviced on the facility policies title Thawing Foods and Food Service Operational Standards for Purchasing, Reviewing, Cooking and Storage of Foods on January 11th, 2023. 2.) The Facility has determined that all residents who consume food and liquids by mouth have the potential to be affected. 3.) On January 25th, 2023, the Dietary Manager in-serviced all dietary staff on the facility policies titled Thawing Foods and Food Service Operational Standards for Purchasing, Reviewing, Cooking and Storage of Foods The Dietary Manager will continue to in-service all dietary staff monthly x3 months beginning in February 2023, on hire, annually and as needed on food safety policies and precautions in accordance with professional standards for food service safety. Beginning January 11th 2023, the Dietary Manager will monitor dietary staff for proper thawing procedures weekly x3 months or until consistent substantial compliance is met to ensure food safety. In addition, Beginning January 11th 2023, the Dietary Manager and Administrator will monitor the cleanliness of the ice machine and the kitchen and storage areas to ensure no items are left on the floors weekly x 3 months or until consistent substantial compliance is met to ensure food safety. The Facility has also contacted our Dietary Manager Consultant to be in the building 1 day a week for the months of January 2023 and February 2023, starting	

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	255108	A. BUILDING _____ B. WING _____	01/05/2023

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F 812	Continued From page 35 about eight (8) black spots located along the right inner gray side panel just inside the machine. On 01/03/23 at 10:40 AM, an interview with the Dietary Manager (DM) confirmed that raw chicken was not supposed to be thawed with water that was not running continuously. The DM revealed that the raw chicken was not being thawed correctly and could cause residents to get sick. The DM revealed that he had completed in-services with the employees on proper food handling, thawing, and storage of food. The DM also confirmed that the two sacks of self-rising flour should have had dates on them and should have been stored in a storage container with a lid to prevent exposure to possible contaminants. On 01/03/23 at 10:45 AM, an interview with the DM revealed that the black substance in the ice machine could be dirt or mold and that this could cause the residents to get sick. He also revealed that he cleaned the ice machine a week or two ago and that there was no certain person responsible for this task. The DM could not produce a cleaning schedule for the ice machine when asked for by the SA. On 01/03/23 at 10:50 AM, the SA observed the DM disposed of the bag of flour that was stored on the floor and the 14 chicken wings that were improperly thawing. On 01/05/23 at 11:00 AM, an interview with Administrator (ADM) revealed that he was the Supervisor who was directly over the DM. ADM also confirmed that the opened bags of flour could cause contamination which could make the residents sick. ADM stated that he would order a storage container with a lid to fix this issue. The	F 812	on January 10th, 2023 to mentor the Dietary Manager. 4.) Beginning January 11th 2023, the Dietary Manager and Administrator will monitor the cleanliness of the ice machine and the kitchen and storage areas to ensure no items are left on the floors weekly x 3 months or until consistent substantial compliance is met to ensure food safety. The Facility has also contacted our Dietary Manager Consultant to be in the building 1 day a week for the months of January 2023 and February 2023, starting on January 10th, 2023 to mentor the Dietary Manager. Beginning February 8th, 2023, the Dietary Manager and Administrator will bring any adverse findings to the monthly Quality Assurance Committee meeting for a period of three (3) months or until such time consistent substantial compliance has been met. Any issues found will be discussed for further recommendations and oversight.	

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F 812	Continued From page 36 ADM also confirmed that the black substance seen in the ice machine could have been mold which could cause the residents to get sick and their policy was to have the ice machine cleaned on a regular basis. On 01/05/23 at 11:40 AM, an interview with Dietary Aid #2, revealed that they received training on food handling, food thawing, and food storage when hired and that they were required to attend in-services monthly with DM. Dietary Aid #2 confirmed that the in-services were held in-person, topics were discussed verbally by DM and that the kitchen/dietary staff had to sign when completed. On 01/05/23 at 2:00 PM, an interview with Assistant Director of Nursing (ADON), revealed that there had been no recent facility outbreaks of food borne illness and no significant stomach issues. ADON confirmed that the brown substance in the ice machine could have been mold and that this could cause sickness throughout the residents in the facility. ADON also confirmed that the chicken wings thawing in the sink without running water could cause Salmonella or other illnesses to the residents and that this was unacceptable.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		2/9/23

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F 880	Continued From page 37 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 38 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review, and record review the facility failed to prevent the likelihood of infection as evidenced by failure to use a barrier when administering eye drops for one (1) of six (6) residents observed during medication pass, Resident #1. Findings include: Review of the facility policy titled, "Administration of Eye Drops or Ointments", dated 2/12/20 revealed "Policy: Eye medications are administered as ordered by the physician and in accordance with professional standards of practice to lubricate the eye or treat eye conditions. Policy Explanation and Compliance Guidelines: 5. Administration: a. Remove medication cap and place on clean dry surface as a protective barrier (i.e. tissue or paper towel) to	F 880	The facility plan of correction is as follows: 1. Resident #1 eye drops are being administered with proper infection control procedures in place with the use of a barrier to prevent the spread of infection. Licensed Practical Nurse #3 received a one on one in-service by The Director of Nursing on 01/05/23 on Policy and Procedure of administration of eye drops. The Director of Nursing assessed resident #1 for negative outcomes related to the break in technique for infection control in eye drop administration on 01/05/23 and 01/06/23. No negative outcomes were identified. 2. All residents have the potential to be affected. 3. The licensed nurses were in-serviced	

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F 880	Continued From page 39 prevent contamination..." An observation during medication pass on 1/4/23 at 8:45 AM, revealed Licensed Practical Nurse (LPN) #3 entered Resident #1's room with two (2) bottles of eye drops ordered for the resident. LPN #3 placed the eye drops on the overbed table without a barrier or disinfecting the table. She opened the first bottle and placed the cap with the open end down on the table. After she administered the two eye drops, she picked the bottles up and moved them to the dresser while she removed her gloves and went into the bathroom to wash her hands. LPN #3 then returned the bottles to the medication cart drawer. An interview on 1/4/23 at 2:50 PM, with LPN #3 revealed she should have had a clean field to put the bottles on to prevent germs and placing them back in the drawer could contaminate the cart. An interview, on 1/4/23 at 3:00 PM, with the Director of Nursing (DON) revealed that LPN #3 should have used a barrier and placing the cap like she did could contaminate the eye drops. Record review of Resident #1's Order Summary Report, with active orders as of 1/5/23 revealed an order for Artificial Tears Solution, one (1) drop in both eyes, 2 (two) times a day dated 2/24/22, and an order dated 10/10/18 for Cosopt Solution, instill 1 drop in both eyes, 1 time a day. Record review revealed LPN #3 had attended an in-service education dated 5/4/22 on administration of eye drops or ointments. Review of the Admission Record for Resident #1 revealed an admission date of 10/10/18 with	F 880	on 01/11/2022 by IP (infection preventionist) on Infection Prevention in eye drop administration including the use of a barrier per facility policy. All staff will have watched the video "Sparkling Surfaces" by 02/09/2023. The remaining PRN employees will be required to watch the video during an in-service before they can work a shift. A Root Cause Analysis has been conducted by The Quality Assurance Performance Improvement Committee, a Corporate Compliance Nurse, and 1 Licensed Practical Nurse from each of 2 units. The Root Cause Analysis was completed 01/30/23. The Attestation letter is attached as well as the root cause analysis. 4. The Infection Preventionist Nurse (IP) will observe eye drop administration for three (3) residents weekly beginning 01/09/23-02/09/23 and continue monitoring x 3 months for proper eye drop administration with barrier use. IP nurse will bring findings to the Quality Assurance Performance Improvement committee for review on 02/08/23, to include revision or resolution to the plan. Monitoring will continue monthly 03/09/23-05/09/23 x 3 months to ensure sustainable adherence to the Policy and Procedure and Infection Control All staff will have watched the video "Sparkling Surfaces" by 02/09/2023. The remaining PRN employees will be required to watch the video during an in-service before they can work a shift. Observations will be presented to Quality Assurance Improvement Committee on 02/08/23 then every month 03/09/23-05/09/23 x 3 months to make	

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F 880	Continued From page 40 diagnoses which include unspecified Glaucoma and unspecified Macular Degeneration. Review of Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/7/22 revealed a Brief Interview for Mental Status (BIMS) score of three (3) which indicated Resident #1 was severely cognitively impaired.	F 880	sure solutions are sustainable.	