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	255329	A. BUILDING _____ B. WING _____	01/26/2023

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey along with a complaint investigation (CI MS #20440) at the facility from 1/23/23 to 1/26/23. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited regulatory deficiencies F584, F604, F636, and F656. The SA found the facility to not be in compliance related to CI MS# 20440 for misappropriation of medications and was cited F602. Census at the time of survey was 92 and the facility was licensed for 95 beds.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		2/21/23

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

Electronically Signed | 02/10/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff/resident interview, record review and facility policy review the facility failed to provide a safe, clean environment for three (3) of the eighteen residents sampled. Resident Resident #25, Resident# 49 and Resident #65. Findings include: Record review of the facility policy titled, "Resident Equipment Cleaning and Disinfection", undated revealed, " ... All equipment used for resident care shall be kept clean and in proper working condition..." Resident #25 An observation on 01/24/23 at 9:51 AM, revealed	F 584	A.1. A new gerichair was ordered for Resident #25 on 2/7/23 by the administrator to replace the current one in use. A sheepskin was placed over the footrests of the current gerichair for added protection until the new one arrives, with an expected arrival date of 02/24/23. A.2. The padded side rails for Resident #49 were discarded and replaced with padded side rails in good repair by the Director of Nurses (DON) on 1/25/23. A.3. The screw to the wheelchair armrest for Resident #65 was tightened on 1/25/23 by the Maintenance Supervisor. B. All residents have the potential to be affected by the deficient practice. C. Equipment including gerichairs, wheelchairs and padded side rails were	

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F 584	Continued From page 2 Resident #25 sitting in a geriatric-chair (geri-chair), the footrest noted with torn vinyl on both sides exposing tattered foam padding. A further observation on 01/24/23 at 4:40 PM, of Resident #25's geri-chair revealed the footrest vinyl was peeled back on both sides exposing tattered foam padding. The bilateral armrest was loose and moved back and forth when touched. A tan-colored substance was noted on the left armrest with a dried light brownish substance down both sides of the chair. The back of the chair was tattered at the top seam with foam exposed. In an interview on 01/25/23 at 9:20 AM, Licensed Practical Nurse (LPN) #1 confirmed the footrest vinyl was torn, the foam padding was exposed and the armrests were loose and needed to be fixed on Resident #25's geri-chair. She stated the resident could get a skin tear from the vinyl sticking up. She revealed the resident eats sitting up in her chair and the substance on the armrest was probably dried food. She reported that on Wednesdays, all equipment is cleaned on the 11-7 PM shift, but it doesn't look like this chair had been cleaned in a while. An interview and observation on 01/25/23 at 09:38 AM, the Director of Nursing (DON) confirmed Resident #25's geri-chair was tattered and could cause a skin tear. She revealed the resident's husband brought that chair from home. She confirmed that it was the facility's responsibility to ensure the equipment was in good repair and she would see if they could order a new footrest. She confirmed that the geri-chair was dirty and attempted to scratch off the brown substance on the left armrest. She stated the	F 584	inspected by the DON and Certified Nursing Assistant Coordinator to identify any problems. All identified areas were replaced or corrected by 02/15/23. The 11-7 shift will be educated by the DON on 02/10/23 on cleaning the wheelchairs, gerichairs and side rails weekly and forms will be provided for proper documentation of the cleaning schedule. D. The DON will inspect/monitor at least 10 wheelchairs, gerichairs and/or padded siderails every week beginning 01/30/23 for no less than three months until sustained compliance is achieved. Any findings will be reported for at least three months to the Quality Assurance and Performance Improvement Committee for resolution beginning 02/21/23.	

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chair was supposed to be kept clean.

An interview on 01/26/23 at 10:35 AM, with Resident #25's Resident Representative (RR) revealed he purchased her the geri-chair sometime after she was admitted to the facility. He revealed he has had it worked on before but couldn't afford a new chair and is ashamed of how the chair looks with all the food on it and how it is torn up. He revealed about three months ago he took it out of the facility one evening and cleaned it and when the weather warms up, he will take it outside and give it a good cleaning again.

In an interview on 01/26/23 at 12:05 PM, the DON revealed the Certified Nursing Assistants (CNAs) on the 11-7 PM shift are responsible for cleaning the geri-chairs. She revealed there is no sheet for the aides to sign off that the cleaning has been completed and sometimes they just initial a sheet by the room number. She confirmed that nothing had been signed on it and she wasn't sure of when the equipment had been cleaned.

Review of the 11-7 Shift Wheelchair/Geri-Chair Washing Schedule, undated, revealed there were no staff initials by any of the room numbers.

Record review of Resident #25's Face Sheet revealed the resident was admitted to the facility on 11/17/06 with diagnoses that include Hemiplegia following nontraumatic intracerebral hemorrhage affecting the right dominant side.

Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 10/6/22 revealed a Brief Interview for Mental Status (BIMS) score of 00 which indicated

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F 584	Continued From page 4	F 584		

Resident #25 had severe cognitive impairment.

Resident #49

An observation on 01/24/23 at 3:33 PM, revealed Resident #49 in bed with four side rails up with full-length side rail pads on each side of the bed. The pads were torn with foam exposed in the middle area of the pads. The torn edges were rough to the touch.

An observation on 01/25/23 at 9:00 AM, revealed Resident #49 in bed with four side rails up with torn side rail pads.

An observation and interview on 1/25/23 at 2:15 PM, with the DON confirmed Resident #49 had side rails up times four (4) with blue plastic covered foam pads the full length of both sides of the bed. The DON confirmed the pads were torn with rough edges at the middle section and stated she knew they needed to get new ones. The DON declined to feel the rough torn areas on the side rail pads.

Review of the facility Face Sheet for Resident #49 revealed an admission date of 10/04/13 with diagnoses that include Vascular Dementia, Unspecified Lack of Coordination and Unspecified Convulsions.

Review of the MDS Section C with an ARD of 11/30/22 revealed a BIMS score of 00 which indicated Resident #49 had severe cognitive impairment.

Resident #65

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F 584	Continued From page 5 An observation on 1/24/23 at 9:30 AM, revealed Resident #65 was sitting in a geriatric chair in the lobby area near the nurses' station. Resident #65 was moving her arms and legs freely and it was noted that the cushion to the right chair arm had moved towards the center of the chair exposing the metal part of the arm rest. The resident's right arm was noted to be near the metal area and occasionally rested on the unpadded area. An interview and observation of Resident #65's geriatric chair with Licensed Practical Nurse (LPN) #3 on 1/25/23 at 9:35 AM, revealed the area of exposed metal on the arm of the chair was due to a loose screw that held the cushion pad onto the metal arm. She stated she would ask maintenance to repair this to prevent an injury. An interview with the DON on 1/25/23 at 9:45 AM, revealed the metal on the chair arm was exposed due to the cushion being loose and repair was necessary. She stated all staff were responsible to monitor equipment for safety when being used. She confirmed the facility failed to properly maintain the resident's equipment and this could lead to a skin tear injury to the resident. Record review of Resident #65's Face Sheet revealed she was admitted to the facility on 11/1/21. Her diagnoses included Alzheimer's Disease and Dementia with Behavioral Disturbances. Record review of Resident #65's MDS with an ARD dated 10/18/22 revealed a BIMS score of zero (0) indicating severe cognitive impairment.	F 584		
F 604 SS=D	Right to be Free from Physical Restraints	F 604		2/21/23

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F 604	Continued From page 6 CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident representative interview, record review and facility policy review the facility failed to ensure residents were free from physical restraints for three (3) of eighteen residents on sample. Resident #25, #31,	F 604	A.1. A new bed rail assessment was completed by the Director of Nursing on 01/25/23 for Resident #31 and the 3/4 side rail was replaced with a half upper side rail for assistance with mobility.	

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F 604	Continued From page 7 and #72. Findings include: Record review of the facility policy titled, "Guidelines and Policy" with no revision date revealed under, "Purpose...Physical restraints are defined as any manual method, physical or mechanical device, material or equipment attached to the resident's body that the resident cannot remove easily which restricts freedom of movement or normal access to one's body. The resident must be physically and cognitively able to self-release device such as Velcro lap-trays or tables, seat belt with Velcro, or snap seat belts, if a resident cannot mentally and physically self-release, then the device is considered a restraint ". Resident #31 An observation on 01/23/23 at 9:00 AM, revealed Resident #31 lying in bed with eyes closed, and three quarter (3/4) siderails up on both sides of the resident's bed with the bed in the lowest position. An interview on 01/25/23 at 8:15 AM, with Certified Nurse Assistant (CNA) #2 revealed she always works the Alzheimer/dementia care unit. She revealed that she thinks all of the residents need side rails to prevent them from falling. She revealed the facility has in-services about siderails and they have told us to make sure they are up and she believes they all need them for safety. She revealed Resident #31 has full side rails up when she is in bed, and she is unaware of any care plan that she is supposed to look at or orders to know who needs full side rails and who	F 604	A.2. A new bed rail assessment was completed on 01/25/23 by the Director of Nursing for Resident #72 and the bed was replaced by one that has half upper side rails only for assistance with mobility. A.3. Resident #25 has been assessed by the Assessment Nurse and a care plan was completed on 01/25/23 for a seat belt as a restraint on her gerichair. B. All residents had the potential to be affected by the deficient practice. C. A bed rail assessment was completed on all residents by 02/21/23 by the Assessment Nurse and/or Director of Nursing to ensure proper side rail use. All wheelchairs and gerichairs were also inspected by the Director of Nursing to ensure no restraint devices were being used without proper assessment, care plan and documentation. All nurses were inserviced by the Director of Nursing on 02/10/23 on the proper use and documentation for physical restraints. D. The Director of Nursing and/or Quality Assurance Nurse will inspect at least 3 beds and/or gerichairs on each hall weekly for three months beginning 01/30/23 for sustained compliance. Any findings noted will be reported to the Quality Assurance and Performance Improvement Committee beginning 02/21/23 for resolution.	

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does not.

An interview on 01/25/23 at 8:25 AM, with Licensed Practical Nurse (LPN) #2 revealed she is the nurse on the Alzheimer's/Dementia care unit. She revealed that full siderails are considered all four (4) split rails and if the bed only has long single rails on each side, then both sides up would be considered full rails. She revealed that the resident's that can let their own siderails down can get full siderails if they request them and they or the family signs a consent. She revealed she is aware that siderails could be considered a restraint, a siderail assessment is completed by the Registered Nurse (RN) and LPN on admission and if the resident has any changes in condition. She revealed that if the resident is a fall risk or cannot define the perimeters of the bed, then the staff talk to the resident's family, and if they want full side rails they sign a consent. She revealed that Resident #31 has a long side rail on each side of her bed and both are up when this resident is in the bed.

An interview on 01/25/23 at 8:57 AM, with CNA #3 revealed that some residents have two (2) full rails, and some have 4 half rails. She revealed she does not work the floor often, but when she does, and she sees that a resident has full side rails up then she leaves them up. She revealed if she had to put the resident to bed she determines if the resident needs full side rails based on if the resident can move around by their self. She revealed if the resident can move around on their own, they are at a higher risk of falling out of the bed, so in her judgement they need full side rails.

An interview and observation on 01/25/23 at 11:00 AM, with the Director of Nurses (DON)

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revealed there were 13 beds with ¾ siderails and one (1) bed with full side rails on the 100 hall with 22 total beds. She revealed the facility has been trying to get all new beds with just the upper half rails. She revealed that if a resident's bed had both ¾ side rails up then the resident could not let them down on their own and it could be considered a restraint.

An interview on 01/26/23 at 11:35 AM, with Registered Nurse-Minimum Data Set (RN-MDS) confirmed that Resident #31 has both 3/4 side rails up while she is in bed to help with bed mobility. She revealed the resident is able to move herself in the bed independently and needs limited assistance with walking. When the SA asked why the resident would need both 3/4 side rails up while in bed if the resident is able to move herself independently in bed, RN-MDS stated, "I see your point". She confirmed that if a resident had both 3/4 side rails up then the resident could not let them down or get out of their bed.

Record review of the facility restraint in-services revealed CNA #2 and CNA #3 and LPN #1 and LPN #2 had completed restraint in-services in 08/2022.

Record review of Resident #31's Face Sheet revealed the resident was admitted to the facility on 4/20/21 with medical diagnoses that included Unspecified dementia, unspecified severity with behavioral disturbance.

Record review of Resident #31's Physician's Orders revealed an order dated 4/20/21- Siderails, necessary to serve as an enabler to promote independence.

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Record review of Resident #31's Side Rail Consent revealed that left and right upper side rails were to be used and was signed by a resident representative on 4/19/21.

Record review of Resident #31's Bedrail/Assist Bar evaluation competed on 01/03/23 revealed that "bed rails are 3/4 rails and are only utilized when resident is in bed for promotion of bed mobility independence. Resident can reposition self in bed."

Record review of Resident #31's MDS with an AR of 01/03/23 revealed under Section C a BIMS score of 00 which indicates the resident is severely cognitively impaired, under Section G indicated the resident needed limited assistance with bed mobility, transfer, moving from seated to standing position, walking, moving on and off toilet and surface-to-surface transfer and in Section P that bed rails were not being used,

Resident #72

An observation on 01/23/23 at 7:20 PM, revealed Resident #72 lying in bed with a wood head and foot board and full wooden siderails up.

An observation on 01/24/23 at 8:50 AM, revealed Resident #72 lying in bed with full side rails up.

An observation on 01/24/23 at 3:00 PM, revealed Resident #72 lying in bed with full side rails up.

An observation on 01/24/23 at 5:00 PM, revealed Resident #72 lying in bed with full side rails up and with eyes closed.

An interview on 01/24/23 at 5:10 PM, with

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Resident #72's Resident Representative revealed she guesses she is ok with the siderails and revealed the staff may have discussed the risk and benefits of side rails, but she cannot remember.

An interview and observation on 01/25/23 at 9:00 AM, with LPN #1 revealed she is the nurse for Resident #72. She revealed that full side rails are a precaution to keep them from falling out of the bed. She revealed if the resident moves a lot in the bed, then they have full side rails. She revealed that Resident #72 does not walk, but she can stand and pivot. An observation at this time with LPN #1 confirmed that Resident #72 has 4 split rails up. She revealed that she is not sure why Resident #72 has full side rails, because she should not need them.

An interview and observation on 01/25/23 at 9:15 AM, with CNA #4 confirmed that Resident #72 has full side rails up on her bed. She revealed that Resident #72 has just come out of the stage of walking on her own and now she does not, so she might think she can still get up and that is why her full siderails are up. She revealed that Resident #72 has never tried to get out of bed as far as she knows. She revealed that residents that are total care all have full side rails to keep them from falling. She revealed that siderails can be considered a restraint.

An interview and observation on 01/25/23 at 10:20 AM, with LPN-MDS with RN-MDS present revealed that Resident #72 has a consent on her record for left and right upper rails, signed by her resident representative on admission 11/3/22. An observation with LPN-MDS confirmed that Resident #72 has a bed with 4 half rails and all 4

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON CO NH	1421-A EAST PEACE STREET CANTON, MS 39046

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rails were up. She revealed she would consider the resident a fall risk, but she has never known her to try and get out of the bed. She revealed Resident #72 needs a new bed that goes lower to the floor, and she plans to have it replaced. She revealed that Resident #72's siderail consent does not match what the resident has in use.

An interview on 01/25/23 at 10:30 AM, with RN-MDS revealed that she and LPN-MDS does the bedrail assessments on everyone. She revealed that Resident #72 had a bedrail assessment on 12/22/22 due to a significant change in the same bed she currently is in. She confirmed that Resident #72's consent indicates left and right upper side rails and that did not match what the resident currently had in use, which was 4 half rails. She revealed that after she completed her bedrail assessment on 12/22/22 she did not get a new consent signed for full side rails.

An observation on 01/25/23 at 1:00 PM, revealed that Resident #72's bed had been changed to a bed that goes lower and has bilateral 3/4 rails and the resident is sitting up in a reclining mobile chair out by the nurse's desk.

An interview on 01/26/23 at 10:35 AM, with the DON revealed that Resident # 72 did not have an order for side rails and if a resident has siderails in use they should have an order.

An interview on 01/26/23 at 11:30 AM, with RN-MDS confirmed that Resident #72's bed was changed and stated, "Her bed was changed because apparently it was not a suitable bed". She also confirmed that the resident did not have an order for siderails but should have.

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Record review of Resident #72's Face Sheet revealed the resident was admitted to the facility on 11/3/22 with medical diagnoses that included Chronic obstructive pulmonary disease.

Record review of Resident #72's Physician's Orders revealed there was no order for side rail use.

Record review of Resident #72's "Bedrail/Assist Bar Evaluation" completed 12/22/22 by RN-MDS revealed the assessment was completed due to a significant change. This assessment indicated that the resident had not expressed a desire to have side rails raised and is unable to release bed rails. This assessment revealed under "Evaluation Factors...Bilateral upper and lower rails are needed for resident's bed mobility independence and for safety to prevent resident from slipping or rolling onto floor with the diagnosis to be considered with bed rails/assist bar being Unspecified Dementia".

Record review of Resident #72's Side Rail Consent dated 11/3/22 revealed it read "Prior to the completion of the side rail assessment "I request the staff of Madison County Nursing Home to raise the protective side rails indicated below for my safety" and the indicated side rails were marked as left and right upper side rail.

Record review of Resident #72's MDS with an ARD dated of 12/22/22 revealed under Section C that there was a BIMS score of 00 which indicates the resident is severely cognitively impaired; Section G indicated the resident needed limited assistance for moving from seated to standing position and surface to surface

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transfer and in Section P indicated bed rails were not in use.
Resident #25

An observation on 01/24/23 at 9:51 AM, of Resident #25 sitting in a Geri chair with a black lap belt fastened around her waist.

An observation on 01/24/23 at 11:26 AM, of Resident #25 sitting in a Geri-chair with a black waist belt in place.

An interview and observation on 01/25/23 at 9:20 AM, with LPN #1 confirmed Resident #25 had a lap belt on and was unable to unfasten it. She revealed it's used so she won't slide out of the chair. She revealed she has never witnessed her sliding down in the chair.

An interview and observation on 01/25/23 at 9:38 AM, the DON confirmed that Resident #25 had a lap belt in place. The DON encouraged Resident #25 to release the belt and Resident #25 was unable to release the belt. The DON then revealed she's not supposed to have this waist belt on. I don't know why she has it on.

An interview on 01/25/23 at 10:56 AM, with CNA #1 revealed they have been using the waist belt while the resident was up in the Geri chair to aid in her not sliding down and have been using the belt for a long time.

An interview on 01/25/23 at 11:16 AM, with the DON revealed there was no restraint assessment for the waist belt or physician's order or care plan because she wasn't aware it was being used.

An interview on 01/25/23 at 2:30 PM, with LPN #1

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F 604	Continued From page 15 revealed Resident #25's husband was in today and signed a restraint consent form and wanted to keep the seat belt on her. An interview on 01/26/23 at 10:00 AM, with Resident #25's husband/Resident Representative revealed I'm the one who bought the geriatric chair for her, he revealed the staff would put her safety belt on her to keep her from sliding out of the chair. He revealed he never signed a consent for the belt until he came in yesterday and the nurse told him he needed to sign the form. An interview on 01/26/23 at 12:08 PM, with CNA #1 revealed she has been working in the facility for seven years and the resident has always had the lap belt and everyone knows that she has it. She revealed when I came to work here the aide training me told me the belt needed to be on her when she is up in the chair, so she doesn't slide out. Review of Resident #25's Face Sheet revealed the resident was admitted to the facility on 11/17/06 with diagnoses that include Hemiplegia following nontraumatic intracerebral hemorrhage affecting the right dominant side. Review of the MDS Section C with an ARD of 10/6/22 revealed a BIMS score of 00 which indicated Resident #25 had severe cognitive impairment.	F 604		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized	F 636		2/21/23

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reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

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F 636	Continued From page 17 §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code the Minimum Data Set (MDS) for one (1) of eighteen residents sampled. Resident #25 Findings include: Record review of an unsigned, undated statement on facility letterhead revealed, " It is Madison County Nursing home protocol to follow the Resident Assessment Instrument (RAI) Manual for MDS's and Care Plans." Resident #25 An interview and observation on 01/25/23 at 9:38 AM, the Director of Nurses (DON) confirmed that Resident # 25 had a lap belt in place. The DON encouraged Resident # 25 to release the belt and	F 636	A. Resident #25 was assessed by the Assessment Nurse and a plan of care was developed on 01/25/23 for use of a lap belt as a restraint. B. All residents in wheelchairs or gerichairs have the potential to be affected by the deficient practice. C. All wheelchairs and gerichairs were inspected for lap belts. Any identified restraints such as lap belts have been removed or care planned with proper documentation as a restraint. All nursing staff were inserviced an 02/10/23 on restraints with an emphasis on lap belts, proper coding for the MDS Assessment, care planning and documentation. D. The Director of Nursing will inspect a minimum of 5 chairs per week beginning 01/30/23. If any restraints are noted, the resident's chart will be checked to ensure proper documentation and care planning	

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F 636	Continued From page 18 Resident # 25 was unable to release the belt. The DON revealed she's not even supposed to have this waist belt on. I don't know why she has it on. An interview on 01/25/23 at 11:16 AM, with the DON revealed there was no restraint assessment for the waist belt or physician's order or care plan because she wasn't aware it was being used. An interview on 01/26/23 at 11:40 AM, the Minimum Data Set (MDS) nurse confirmed that the MDS Section P was not coded correctly and the careplan was not reflective of the waist belt. An interview on 01/26/23 at 12:45 PM, the DON revealed upon admission the admitting nurse or the Minimum Data Set (MDS) nurse completes the 24-hour baseline care plan then the MDS nurse does the updating of any changes to their care plan. She revealed that she wasn't aware that Resident #25 was using the seat belt and that's why she didn't have a care plan. She revealed she was aware that the resident has been here for a long time and that the staff should have communicated that the waist belt was being used and revealed it was just bad communication. Review of the MDS Section P (Restraints) with an Assessment Reference Date (ARD) of 10/6/22 Coding: (0. Not Used) Review of Resident #25's Face Sheet revealed the resident was admitted to the facility on 11/17/06 with diagnoses that include Hemiplegia following nontraumatic intracerebral hemorrhage affecting the right dominant side. Review of the Minimum Data Set (MDS) Section	F 636	for such at least three months to ensure substantial compliance is achieved. Any findings will be reported to the Quality Assurance and Performance Improvement Committee beginning 02/21/23 for resolution.	

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F 636	Continued From page 19 C with an Assessment Reference Date (ARD) of 10/6/22 revealed a Brief Interview for Mental Status (BIMS) score of 00 which indicated Resident #25 had severe cognitive impairment.	F 636		
F 656 SS=D	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 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	F 656		2/21/23

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F 656	Continued From page 20 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 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 interview, record review and facility policy review the facility failed to develop a comprehensive care plan for physical restraints for one (1) of eighteen residents sampled. Resident #25 Findings include: Record review of the facility policy "Care Plans-Comprehensive" undated, revealed "Policy Statement: A comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs shall be developed for each resident. Policy Interpretation and Implementation...2. The comprehensive care plan has been designed to: a. Incorporate identified problem areas. b. Incorporate risk actors associated with identified problems...d. Reflect treatment goals and objectives in measurable outcomes.e. Identiy the professional services that are responsible for each element of care...3.The resident's comprehensive care plan is developed	F 656	A. Resident #25 was assessed by the Assessment Nurse and a plan of care was developed on 01/25/23 for a lap belt as a restraint. B. All residents who use wheelchairs or gerichairs have the potential to be affected by the deficient practice. C. All wheelchairs and gerichairs were inspected for lap belts on 01/26/23 by the Director of Nursing. Any lap belts noted have been removed or identified as restraints with a care plan and proper documentation. C. All nursing staff were inserviced an 02/10/23 by the Director of Nursing on restraints with an emphasis on lap belts with proper documentation and care planning when a restraint is in use. D. The DON will inspect a minimum of 5 care plans per week beginning 01/30/23. If any restraints are noted, the resident's chart will be checked for the proper assessment and documentation to ensure proper coding for at least three months to	

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F 656	Continued From page 21 with seven (7) days of the completion of the resident's comprehensive assessment..." Resident #25 An interview and observation on 01/25/23 at 9:38 AM, the Director of Nurses (DON) confirmed that Resident # 25 had a lap belt in place. The DON revealed she's not even supposed to have this waist belt on. I don't know why she has it on. An interview on 01/25/23 at 11:16 AM, with the DON revealed there was not a care plan because she wasn't aware it was being used. An interview on 01/26/23 at 11:40 AM, the Minimum Data Set (MDS) nurse confirmed that the care plan was not reflective of the waist belt. She revealed " I just found out about the belt." An interview on 01/26/23 at 12:45 PM, the DON revealed upon admission the admitting nurse or the Minimum Data Set (MDS) nurse completes the 24-hour baseline care plan then the MDS nurse does the updating of any changes to their care plan. She revealed that she wasn't aware that Resident #25 was using the seat belt and that's why she didn't have a care plan. She revealed she was aware that the resident has been here for a long time and that the staff should have communicated that the waist belt was being used and revealed it was just bad communication. Record review of Resident #25's Care plan Problem Onset: dated 11/17/2006 Falls: At risk for falls/injury and further contractures related to impaired mobility. Approaches: geri-chair primary	F 656	ensure substantial compliance is achieved. Any findings will be reported to the Quality Assurance and Performance Improvement Committee for at least three months beginning 02/21/23 for resolution.	

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F 656	Continued From page 22 mode of locomotion. No care plan developed addressing the lap belt or the use of a restraint. Review of Resident #25's Face Sheet revealed the resident was admitted to the facility on 11/17/06 with diagnoses that include Hemiplegia following nontraumatic intracerebral hemorrhage affecting the right dominant side.	F 656		