STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255274	A. BUILDING _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOME	638 HIGHLAND COLONY PARKWAY RIDGELAND, MS 39157

(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 at the facility from 03/06/23 through 03/09/23. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited regulatory deficiencies at F623, F625, F636, F638, F640, F656, F695, and F758. The census at the time of the survey was 97. The facility was licensed for 120 beds.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		4/28/23

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

Electronically Signed | 03/24/2023

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F 623	Continued From page 1	F 623		

(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;
(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

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F 623	Continued From page 2 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 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 send a written notice of resident transfer, including the reason for transfer, to the hospital, to the resident or resident representative (RR) for two (2) of five (5) residents reviewed for transfer. Resident #25 and #73.	F 623	* Resident # 25 was assessed on 3/23/2023 by Director of Nursing (DON) with no adverse findings noted. Resident #73 was assessed on 3/23/2023 by Assistant Director of Nursing (ADON) with no adverse findings noted.	

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F 623	Continued From page 3 Findings include: Review of the facility policy titled, "Notice Of Hospital Transfer/Therapeutic Leave" with a review date of 08/21 revealed, "...#2. When a resident is transferred to the hospital, or goes out on therapeutic leave, a copy of the completed form (notice) is provided to the resident, specifying the duration of the bed-hold according to the state plan, and the facility's policy regarding bed-hold periods. In case of emergency transfer, notice "at the time of transfer" means that the family or resident representative are provided with written notification within 24 hours of the transfer. The requirement is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital. The staff member completing the transfer paperwork should complete the location, time, and date section of the form. A copy of the completed form should also be forwarded to the Accounts Manager. The Accounts Manager will contact the Resident Representative and complete the Verification of telephone notice within 24 hours. The Accounts Manager will also mail a copy of the Notice of Hospital Transfer/Therapeutic Leave form for signature by the Resident Representative if the Representative is not available to sign on the day they are contacted. A copy of the completed form should be retained in the resident's Administrative folder...". Resident #25 Review of Resident #25's record revealed she was transferred to the hospital on 1/16/23 due to facial drooping and inability to follow commands and returned to the facility on 1/23/23. Record	F 623	*All residents that discharge from the facility have the potential to be affected. *Nursing department staff and Business office staff were in-serviced by the Staff Development Coordinator (SDC) on 3/23/2023 regarding □Notice of Hospital Transfer/Therapeutic Leave.□ The facility Medical Director reviewed the policy □Notice of Hospital Transfer/Therapeutic Leave□ with no recommended changes to the policy on 3/23/2023. The facility Quality Assessment and Assurance Committee met on 3/24/2023 to review the plan of correction for F Tag 623. *Beginning 3/24/2023, the facility Administrator will monitor Hospital Transfer / Therapeutic Leave forms 3 times weekly for four weeks and then 4 times monthly for two months to ensure ongoing compliance with F tag 623 and will report to the Quality Assessment and Assurance Committee for 3 months. The first Quality Assessment and Assurance Committee meeting will be held on 4/28/2023.	

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review did not indicate a written transfer notification form was sent to the RR.

On 3/8/23 at 10:00 AM, an interview with Licensed Practical Nurse (LPN) #1 revealed the floor nurses are responsible for the completion of the transfer/discharge form and a copy is always sent with the resident to the hospital. She stated she is not sure who is responsible for mailing a copy to the RR.

On 03/08/23 at 10:30 AM, an interview with the Accounts Manager revealed that a notification of transfer/discharge form was not mailed to the RR of Resident #25. She stated the nurse on the floor would have prepared the transfer form and sent a copy with the resident to the hospital and she would have called the RR the following day and sent an e-mail notification to the Ombudsman.

On 3/08/23 at 11:05 AM, an interview with the Administrator revealed the facility does not mail out written notification of transfer/discharge. She stated that the nurses complete the form, and the form is always sent with the resident. She stated that the family is called and notified at the time of transfer and that the Accounts Office calls the RR the following day.

On 3/8/23 at 12:05 PM, an interview with the Administrator revealed that after speaking with the Business Office they have been mailing out written notifications of the transfer/discharge forms. She stated that they send them out first class mail not certified, therefore, they have no evidence that the form was mailed as a copy was not retained for the resident's administrative folder. The Administrator provided an incomplete form with no title that she stated was retained by

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the Business Office that listed Resident #25's name, the date, and the name of the hospital that the resident was transported to. The Administrator confirmed that this document was insufficient and lacking all the details the facility should have provided to the RR. She also confirmed that the form should have explained the reason for the transfer as well as listing the date it was mailed and the facility should have retained a copy for the resident's folder.

Record review of Resident #25's Face Sheet revealed she was admitted to the facility on 3/28/16 with the medical diagnoses that included displaced Intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, Anxiety unspecified, and Frequent falls.

Record review of Resident #25's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/23 revealed a Brief Interview for Mental Status (BIMS) score of one (1) which indicated the resident is severely cognitively impaired.

Resident #73

Record review of the nurses notes dated 12/29/22 revealed Resident #73 was transferred to the hospital on 12/28/22 and returned to facility on 1/2/23.

Record review of the notice of hospital/therapeutic leave form related to the hospitalization transfer revealed the form was not completed.

An interview, on 03/08/23 at 10:20 AM, with the

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Accounts Manager revealed they do mail the forms to the RR and call the family the next day. The nurses are responsible for filling out the forms and they are sent out with the resident to the hospital. The Accounts Manager confirmed that she had no proof that she had mailed the form to the RR. She stated that the nurses are supposed to fill out the form and get it to her, but she does not always get them. She stated that the form she mails out addresses transfers.

An interview on 03/08/23 at 10:30 AM, with the Nurse Manager confirmed the nurses are responsible for filling out the notice of hospital transfer form. She stated they should be filled out and given to the business office. She confirmed that Resident #73's transfer form was not filled out.

During an interview and record review, on 03/08/23 at 11:50 AM, the Administrator confirmed the notice of hospital transfer/leave form for Resident #73 was not filled out.

An interview on 03/09/23 at 09:14 AM, with the Administrator confirmed they have an issue with the transfer forms and are addressing the forms.

Record review of the facility Face Sheet for Resident #73 revealed an admission date of 3/24/21 with diagnoses including Acute Post Hemorrhagic Anemia, Cerebral Infarction with right dominant side Hemiplegia, Unspecified Dementia, Cognitive Communication Deficit.

Record review of the MDS with an ARD of 12/12/2022 revealed a BIMS score of 5 which indicated Resident #73's cognitive status was severely impaired.

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F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review , and facility policy review the facility failed to notify the resident or resident representative (RR) in writing of the bed hold for a resident transferred to an acute care facility for one (1) of five (5) residents reviewed for bed hold. Resident #73.	F 625	* Resident #73 was assessed on 3/23/2023 by Assistant Director of Nursing (ADON) with no adverse findings noted. * All residents that discharge from the facility have the potential to be affected.	4/28/23

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F 625	Continued From page 8 Findings include: Review of the facility policy titled, "Notice of Hospital Transfer/Therapeutic Leave", with a latest review date of 08/21 revealed when a resident is transferred to the hospital, or goes out on therapeutic leave, a copy of the completed form (notice) is provided to the resident, specifying the duration of the bed hold according to the state plan, and the facilities policy regarding bed-hold periods. In case of an emergency transfer, notice "at the time of transfer" means that the family or resident representative are provided with written notification within 24 hours of the transfer. The requirement is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital. The staff member completing the transfer paperwork should complete the location, time, and date section of the form. A copy of the completed form should also be forwarded to the Accounts Manager. The Accounts Manager will contact the Resident Representative and complete the Verification of phone notice within 24 hours. The Account Manager will also mail a copy of the Notice of Hospital Transfer/Therapeutic Leave form for signature by the Resident Representative if the Resident Representative is not available to sign on the day they are contacted. A copy of the completed form should be retained in the residents Administrative folder. Findings include: Record review review of the nurses notes dated 12/29/22 revealed Resident #73 was transferred to the hospital on 12/28/22.	F 625	*Nursing department staff and Business office staff were in-serviced by the Staff Development Coordinator (SDC) on 3/23/2023 regarding □Notice of Hospital Transfer/Therapeutic Leave.□ The facility Medical Director reviewed the policy □Notice of Hospital Transfer/Therapeutic Leave□ with no recommended changes to the policy on 3/23/2023. The facility Quality Assessment and Assurance Committee met on 3/24/2023 to review the plan of correction for F Tag 625. *Beginning 3/24/2023, the facility Administrator will monitor Hospital Transfer / Therapeutic Leave forms 3 times weekly for four weeks and then 4 times monthly for two months to ensure ongoing compliance with F tag 625 and will report to the Quality Assessment and Assurance Committee for 3 months. The first Quality Assessment and Assurance Committee meeting will be held on 4/28/2023.	

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Record review of the NOTICE OF HOSPITAL TRANSFER/THERAPEUTIC LEAVE form related to the hospitalization transfer of Resident #73 revealed the form was not completed. The form contained only the name of the resident and the resident representative at the top of the page and an undated signature of the resident representative near the bottom of the page following a statement, "I do not agree to pay for uncovered days."

An interview on 03/08/23 at 10:20 AM, with the Accounts Manager revealed they do mail the forms to the responsible party and call the family the next day. The nurses are responsible for filling out the forms and they are sent out with the resident to the hospital. The Accounts Manager confirmed that she had no proof that she had mailed the form. She stated that the nurses are supposed to fill out the form and get it to her but she does not always get them. She stated that the form she mails out addresses transfer.

An interview on 03/08/23 at 10:30 AM with the nurse manager confirmed the nurses are responsible for filling out the notice of hospital transfer form. She stated they should be filled out and given to the business office. She confirmed that Resident #73's transfer form was not filled out.

During an interview and record review, on 03/08/23 at 11:50 AM, the administrator confirmed the notice of hospital transfer form for Resident #73 was not filled out.

An interview on 03/09/23 at 9:00 AM, with the Accounts Manager confirmed she did not know what the bed hold rate was or that the family was

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F 625	Continued From page 10 to be informed the of amount and informed if there was a change. During an interview on 03/09/23 at 09:14 AM, the Administrator stated that they have an issue with the transfer forms and are addressing the forms. Record review of the facility Face Sheet for Resident #73 revealed an admission date of 3/24/21 with diagnoses including Acute Post Hemorrhagic Anemia, and Cerebral Infarction with right dominant side Hemiplegia. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/12/2022 revealed a Brief Interview for Mental Status (BIMS) score of 5 which indicated Resident #73's cognitive status was severely impaired.	F 625		
F 636 SS=E	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 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.	F 636		4/28/23

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(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.

§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

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F 636	Continued From page 12 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 interview, record review and facility policy review the facility failed to complete the residents Minimum Data Set assessments timely according to the Resident Assessment Instrument (RAI) guidelines for six (6) of 16 residents reviewed for annual assessment. Resident's #15, #32, #79, #88, #92, and #104. Findings include: A record review of the facility's policy titled "Resident Assessment", revealed, "An assessment will be completed on each resident utilizing the MDS ...The reason for the assessment, schedule and timeframe's will be according to the guidance of the Resident Instrument RAI Manual.." RESIDENT # 15 Record review of Resident #15's Annual Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 01/27/23 revealed the assessment closure was 03/07/23, which indicated the assessment closure date was late. Record review of Resident #15's Face Sheet revealed the resident was admitted to the facility on 03/19/15. RESIDENT# 32 Record review of Resident #32's Annual MDS with an ARD of 01/20/23 revealed the assessment was closed on 02/27/23, which indicated the assessment closure was late.	F 636	* Residents #15, 79 and 92 were assessed on 3/23/2023 by the Director of Nursing (DON) with no adverse findings noted. Residents 32, 88 and 104 were assessed on 3/23/2023 by the Assistant Director of Nursing (ADON) with no adverse findings noted. *All residents of the facility have the potential to be affected *The Minimal Data set (MDS) office was in serviced by the Staff Development Coordinator (SDC) on 3/23/2023 regarding □Resident Assessment.□ The facility Medical Director reviewed the policy □Resident Assessment□ with no recommended changes to the policy on 3/23/2023. The Director of Nursing (DON) reviewed the assessment summary on 3/24/2023 to ensure assessments were completed timely. The facility Quality Assessment and Assurance Committee met on 3/24/2023 to review the plan of correction for F Tag 636. *Beginning 3/24/2023, the Director of Nursing (DON) will review the assessment summary weekly for 12 weeks to ensure Minimum Data Set assessments are completed timely according to the Resident Assessment Instrument (RAI) guidelines to ensure ongoing compliance with F tag 636 and will report to the	

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F 636	Continued From page 13 Record review of Resident #32's Face Sheet revealed the resident was admitted to the facility on 09/05/18. RESIDENT# 79 Record review of Resident #79's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/24/23, revealed the assessment was closed on 3/8/23, which indicated the assessment was more than 14 days after the ARD. Record review of Resident #79's Face Sheet revealed an admit date of 2/20/20. RESIDENT # 88 Record review of Resident 88's Annual MDS with an ARD of 01/25/23, revealed the assessment was closed on 02/23/23 , which indicated the assessment completion date was more than 14 days after the ARD. Record review of Resident # 88's Face Sheet revealed an admit date of 2/01/22. RESIDENT #92 Record review of Resident #92's Annual MDS with an ARD of 01/20/23 revealed the assessment was closed on 02/22/23 and transmitted on 03/03/23, which indicated that the assessment closure was late. Record review of Resident #92's Face Sheet revealed the resident was admitted to the facility on 02/05/21. RESIDENT #104 Record review of Resident #104's Annual MDS	F 636	Quality Assessment and Assurance committee for 3 months. The first facility Quality Assessment and Assurance Committee meeting will be held on 4/28/2023.	

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F 636	Continued From page 14	F 636		

with an ARD of 01/24/23 revealed the assessment was closed on 3/7/23 which indicated the assessment closure was late.

Record review of Resident #104's Face Sheet revealed the resident was admitted to the facility on 02/01/22.

On 3/9/23 at 11:15 AM, during an interview with the MDS Coordinator, MDS Assessment Nurse #1 and MDS Nurse #2 confirmed they were behind on their MDS assessments. The MDS coordinator reviewed the MDS validation reports with State Agents (SA) present and confirmed that according to the dates of the assessment completion they were late. The MDS Coordinator revealed that at one point they had five staff members, went down to four staff members and about two months ago one of their staff members went out on medical leave which left them with three staff members. The MDS Coordinator revealed that they have 6 or 7 admissions a day and have to do those assessments along with completing Medicare charting on all skilled residents daily with the facility currently having 40. The MDS Coordinator revealed that she had not told anyone that they were behind on their MDS assessments but should have. She revealed that the purpose of the MDS assessment was to capture all of the information on the resident's that help indicate what care is needed for the residents and payment for the facility. She revealed that if the MDS was not completed timely then the resident might not get proper care. MDS Nurse #2 revealed that she had a conversation on Monday 3/6/23 with the Director of Nurse (DON) regarding getting some overtime so she can come in and get caught up on some work. MDS Nurse #2 revealed that the DON ask

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F 636	Continued From page 15 what they could do to help and that they would need to be looking for someone to help them get caught up. On 3/9/23 at 11:45 AM, during an interview with the DON and the Administrator revealed that the DON denied having a conversation with MDS Nurse #2 regarding the MDS department being behind and needing help. The DON revealed no one had ever mentioned being late with their assessments. The DON revealed that she had conversations in passing with MDS Nurse #2 regarding MDS being busy but had no idea they were that bad behind and if she had known she would have gotten them some help. The DON confirmed that the MDS nurses also do daily Medicare charting on all skilled residents, which is time consuming. The Administrator revealed that the MDS coordinator attends the morning stand up meetings and had never mentioned that they were behind. The Administrator stated, "I can't deny they are short staffed in the MDS department." The Administrator confirmed they had four (4) staff members in MDS until about two months ago, but stated, "I've never done MDS and Medicare charting, so I do not know how long it would take to get it done". The DON stated, "I am no MDS guru". She confirmed they were short staffed in the MDS department.	F 636		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced	F 638		4/28/23

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F 638	Continued From page 16 by: Based on staff interview, record review and facility policy review the facility failed to complete the residents Minimum Data Set (MDS) assessments timely according to the Resident Assessment Instrument (RAI) guidelines for nine (9) of 16 residents reviewed for quarterly assessment. Resident's #6, 20, 31, 36, 39, 49, 58, 60, and 93. Findings include: A record review of the facility's policy titled " Resident Assessment" revealed an assessment will be completed on each resident utilizing the MDS ...The reason for the assessment, schedule and timeframe's will be according to the guidance of the Resident Instrument RAI Manual. Resident # 6 Record review of Resident # 6's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/24/23, revealed the assessment was closed on 2/22/23 , which indicated the assessment completion date was more than 14 days after the ARD. Review of Resident #6's Face Sheet revealed an admit date of 8/5/21. Resident #20 Record review of Resident #20's Quarterly MDS with an ARD of 01/20/23 revealed the assessment was closed on 02/22/23, which indicated the assessment closure was late.	F 638	*Residents #6, 31,39, 58 and 93 were assessed on 3/23/2023 by the Director of Nursing (DON) with no adverse findings noted. Residents #20, 36, 49 and 60 were assessed on 3/23/2023 by the Assistant Director of Nursing (ADON) with no adverse findings noted. *All residents of the facility have the potential to be affected *The Minimal Data set (MDS) office was in-serviced by the Staff Development Coordinator (SDC) on 3/23/2023 regarding □Resident Assessment.□ The facility Medical Director reviewed the policy □Resident Assessment□ with no recommended changes to the policy on 3/23/2023. The Director of Nursing (DON) reviewed the assessment summary on 3/23/2023 to ensure the MDS was completed timely. The facility Quality Assessment and Assurance Committee met on 3/24/2023 to review the plan of correction for F Tag 638. *Beginning 3/24/2023, the Director of Nursing (DON) will review the assessment summary weekly for 12 weeks to ensure Minimum Data Set assessments are completed timely according to the Resident Assessment Instrument (RAI) guidelines to ensure ongoing compliance with F tag 638 and will report to the Quality Assessment and Assurance committee for 3 months. The first facility Quality Assessment and Assurance Committee meeting will be held on	

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F 638	Continued From page 17 Record review of Resident #20's Face Sheet revealed the resident was admitted to the facility on 11/06/20. Resident #31 Record review of Resident 31's Quarterly MDS with an ARD of 01/24/23, revealed the assessment was closed on 03/06/23, which indicated the assessment completion date was more than 14 days after the ARD. Review of Resident #31's Face Sheet reveled an admit date of 5/21/20. Resident # 36 Record review of Resident #36's Quarterly MDS with an ARD of 01/23/23 revealed the assessment was closed on 03/02/23 which indicated the assessment closure was late. Record review of Resident #36's Face Sheet revealed the resident was admitted to the facility on 05/06/21. Resident #39 Record review of Resident #39's Quarterly MDS with an ARD of 01/25/23, revealed the assessment was closed on 2/22/23, which indicated the assessment completion date was more than 14 days after the ARD. Record review of Resident #39's Face Sheet revealed an admit date of 11/16/17. Resident # 49	F 638	4/28/2023.	

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F 638	Continued From page 18	F 638		

Record review of Resident # 49's Quarterly MDS with an ARD of 01/24/23, revealed the assessment was closed on 3/01/23, which indicated the assessment completion date was more than 14 days after the ARD.

Record review of Resident # 49's face sheet revealed an admit date of 11/3/20.

Resident #58

Record review of Resident #58's Quarterly MDS with an ARD of 01/18/23 revealed the assessment was closed on 02/22/23, which indicated the assessment closure was late.

Record review of Resident #58's Face Sheet revealed the resident was admitted to the facility on 04/21/22.

Resident #60

Record review of Resident # 60 's Quarterly MDS with an ARD of 01/25/23, revealed the assessment was closed on 2/22/23, which indicated the assessment completion date was more than 14 days after the ARD.

Review of Resident # 60's Face Sheet revealed an admit date of 12/02/19.

Resident #93

Record review of Resident #93's Quarterly MDS with an ARD of 01/27/23 revealed the assessment was closed on 03/01/23, which indicated the assessment closure was late.

Record review of Resident #93's Face Sheet

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F 638	Continued From page 19	F 638		

revealed the resident was admitted to the facility on 07/28/22.

During an interview on 3/9/23 at 11:15 AM, with the MDS Coordinator, MDS Assessment Nurse #1 and MDS Nurse #2 confirmed they were behind on their MDS assessments. The MDS coordinator reviewed the MDS validation reports with State Agents (SA) present and confirmed that according to the dates of the assessment completion and transmission that they were late. The MDS Coordinator stated that at one point they had five staff members, went down to four staff members and about two months ago one of their staff members went out on medical leave which left them with three staff members. The MDS Coordinator stated that they have six or seven admissions a day and have to do those assessments along with completing Medicare charting on all skilled residents daily with the facility currently having 40. The MDS Coordinator revealed that she had not told anyone that they were behind on their MDS assessments but should have. She stated that the purpose of the MDS assessment was to capture all of the information on the resident's that help indicate what care is needed for the residents and payment for the facility. She revealed that if the MDS was not completed timely then the resident might not get proper care. MDS Nurse #2 revealed that she had a conversation on Monday 3/6/23 with the Director of Nurse (DON) regarding getting some overtime so she can come in and get caught up on some work. MDS Nurse #2 stated that the DON asked what they could do to help and that they would need to be looking for someone to help them get caught up.

During an interview on 3/9/23 at 11:45 AM with

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F 638	Continued From page 20 the DON and the Administrator revealed that the DON denied having a conversation with MDS Nurse #2 regarding the MDS department being behind and needing help. The DON stated no one had ever mentioned being late with their assessments. The DON revealed that she had conversations in passing with MDS Nurse #2 regarding MDS being busy but had no idea they were that far behind and if she had known she would have got them some help. The DON confirmed that the MDS nurses also do daily Medicare charting on all skilled residents, which is time consuming. The Administrator revealed that the MDS coordinator attends the morning stand up meetings and had never mentioned that they were behind. The Administrator stated, "I can't deny they are short staffed in the MDS department". The Administrator confirmed they had 4 staff members in MDS until about 2 months ago, but stated, "I've never done MDS and Medicare charting so I do not know how long it would take to get it done". The DON stated, "I am no MDS guru" and confirmed they were short staffed in the MDS department. The DON revealed that MDS assessments are how the facility gets reimbursed.	F 638		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments.	F 640		4/28/23

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(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.

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F 640	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to transmit the residents Minimum Data Set assessments timely according to the Resident Assessment Instrument (RAI) guidelines for 16 of 16 residents reviewed for assessment. Resident's 6, 15, 20, 24, 31, 32, 36, 39, 49, 58, 60, 79, 88, 92, 93, and 104. Findings include: A record review of the facility's policy titled, " Resident Assessment" revealed an assessment will be completed on each resident utilizing the MDS ...The reason for the assessment ,schedule and timeframes will be according to the guidance of the Resident Instrument RAI Manual". Resident #6 Record review of Resident # 6's Quarterly MDS with an Assessment Reference Date (ARD) of 01/24/23, revealed the assessment was transmitted on 3/03/23, which indicated the assessment transmission date was more than 14 days after the ARD. Reviw of Resident # 6's Face Sheet revealed an admission date of 8/5/21. Resident # 15 Record review of Resident #15's MDS with an Assessment Reference Date (ARD) of 01/27/23 revealed that the assessment closure was 03/07/23 and transmitted on 03/08/23, which indicated the assessment closure date and transmission date were late.	F 640	*Residents #6,15,31,39,58,79,92 and 93 were assessed on 3/23/2023 by the director of Nursing (DON) with no adverse findings noted. Residents # 20,24,32,36,49,60,88 and 104 were assessed on 3/23/2023 by the Assistant Director of Nursing (ADON) with no adverse findings noted. *All residents of the facility have the potential to be affected. *The Minimal Data set (MDS) office was in-serviced by the Staff Development Coordinator (SDC) on 3/23/2023 regarding □Resident Assessment.□ The facility Medical Director reviewed the policy □Resident Assessment□ with no recommended changes to the policy on 3/23/2023. The Director of Nursing (DON) reviewed the assessment summary on 3/24/2023 to ensure MDS were completed timely. The facility Quality Assessment and Assurance Committee met on 3/24/2023 to review the plan of correction for F Tag 640. *Beginning 3/24/2023, the Director of Nursing (DON) will review the assessment summary weekly for 12 weeks to ensure Minimum Data Set assessments are completed timely according to the Resident Assessment Instrument (RAI) guidelines to ensure ongoing compliance with F tag 640 and will report to the Quality Assessment and Assurance committee for 3 months. The first facility	

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F 640	Continued From page 23 Record review of Resident #15's Face Sheet revealed the resident was admitted to the facility on 03/19/15 with medical diagnoses that included Major Depressive Disorder. Resident #20 Record review of Resident #20's MDS with an ARD of 01/20/23 revealed the assessment was closed on 02/22/23 and transmitted on 03/03/23, which indicated the assessment closure and the transmission were late. Record review of Resident #20 ' s Face Sheet revealed the resident was admitted to the facility on 11/06/20 with medical diagnoses that included Old Myocardial Infarction and Anxiety Disorder. Resident #24 Record review of Resident #24's MDS with an ARD of 01/20/23 revealed the assessment was closed on 02/27/23 and transmitted on 03/03/23, which indicated the assessment closure and the transmission were late. Record review of Resident #24's Face Sheet revealed the resident was admitted to the facility on 11/05/20. Resident #31 Record review of Resident 31's Quarterly MDS with an ARD of 01/24/23, revealed the assessment was transmitted on 3/8/23, which indicated the assessment transmission date was more than 14 days after the ARD. Review of Resident # 31's Face Sheet with an admission date of 5/21/20. Resident # 32	F 640	Quality Assessment and Assurance Committee meeting will be held on 4/28/2023.	

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Record review of Resident #32's MDS with an ARD of 01/20/23 revealed the assessment was closed on 02/27/23 and transmitted on 03/03/23, which indicated the assessment closure and the transmission were late.

Record review of Resident #32's Face Sheet revealed the resident was admitted to the facility on 09/05/18.

Resident # 36
Record review of Resident #36's MDS with an ARD of 01/23/23 revealed the assessment was closed on 03/02/23 and transmitted on 03/03/23, which indicated the assessment closure and the transmission were late.

Record review of Resident #36's Face Sheet revealed the resident was admitted to the facility on 05/06/21.

Resident #39
Record review of Resident #39's Quarterly MDS with an ARD of 01/25/23, revealed the assessment was transmitted on 3/03/23, which indicated the assessment transmission date was than 14 days after the ARD. .

Review of Resident # 39's Face Sheet revealed an admission date of 11/16/17.

Resident # 49
Record review of Resident # 49's Quarterly MDS with an ARD of 01/24/23, revealed the assessment was transmitted on 3/03/23, which indicated the assessment completion date was more than 14 days after the ARD.

Review of Resident # 49's Face Sheet revealed

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an admission date of 11/3/20.

Resident #58
Record review of Resident #58's MDS with an ARD of 01/18/23 revealed the assessment was closed on 02/22/23 and transmitted on 3/3/23, which indicated the assessment closure and transmission were late.

Record review of Resident #58's Face Sheet revealed the resident was admitted to the facility on 04/21/22.

Resident #60
Record review of Resident # 60 's Quarterly Minimum Data Set with an ARD of 01/25/23, revealed the assessment was transmitted on 3/03/23 , which indicated the assessment completion date was more than 14 days after the ARD.

Review of Resident # 60's Face Sheet revealed an admit date of 12/02/19.

Resident #79
Record review of Resident #79's Annual MDS with an ARD of 01/24/23 and as of 3/08/23 had not been transmitted, which indicated the assessment assessment was more than 14 days after the ARD.

Review of Resident # 79's Face Sheet revealed an admission date of 2/20/20.

Resident #88
Record review of Resident 88's Annual MDS with an ARD of 01/25/23, revealed the assessment was transmitted on 3/3/23, which indicated the assessment transmission date was more than 14

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days after the ARD.

Review of Resident # 88's Face Sheet revealed an admission date of 2/01/22.

Resident #92
Record review of Resident #92's MDS with an ARD of 01/20/23 revealed the assessment was closed on 02/22/23 and transmitted on 03/03/23, which indicated that the assessment closure and transmission were late.

Record review of Resident #92's Face Sheet revealed the resident was admitted to the facility on 02/05/21.

Resident #93
Record review of Resident #93's MDS with an ARD of 01/27/23 revealed the assessment was closed on 03/01/23 and transmitted on 3/3/23, which indicated the assessment closure and transmission were late.

Record review of Resident #93's Face Sheet revealed the resident was admitted to the facility on 07/28/22.

Resident #104
Record review of Resident #104's MDS with an ARD of 01/24/23 revealed the assessment was closed on 3/7/23 and transmitted on 03/08/23, which indicated the assessment closure and the transmission were late.

Record review of Resident #104's Face Sheet revealed the resident was admitted to the facility on 02/01/22.

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An interview on 3/9/23 at 11:15 AM with the Minimum Data Set (MDS) Coordinator, MDS Assessment Nurse #1 and MDS Nurse #2 confirmed they were behind on their MDS assessments and transmissions. The MDS coordinator reviewed the MDS validation reports with State Agents (SA) present and confirmed that according to the dates of the assessment completion and transmission that they were late. The MDS Coordinator revealed that at one point they had five staff members, went down to four staff members and about two months ago one of their staff members went out on medical leave which left them with three staff members. The MDS Coordinator revealed that they have 6 or 7 admissions a day and have to do those assessments along with completing Medicare charting on all skilled residents daily with the facility currently having 40.. The MDS Coordinator revealed that she had not told anyone that they were behind on their MDS assessments or transmissions but should have. She revealed that the purpose of the MDS assessment was to capture all of the information on the resident's that help indicate what care is needed for the residents and payment for the facility. She revealed that if the MDS was not completed timely then the resident might not get proper care. MDS Nurse #2 revealed that she had a conversation on Monday 3/6/23 with the Director of Nurse (DON) regarding getting some overtime so she can come in and get caught up on some work. MDS Nurse #2 revealed that the DON ask what they could do to help and that they would need to be looking for someone to help them get caught up.

An interview on 3/9/23 at 11:45 AM with the DON and the Administrator revealed that the DON

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F 640	Continued From page 28 denied having a conversation with MDS Nurse #2 regarding the MDS department being behind and needing help. The DON revealed no one had ever mentioned being late with their assessments. The DON revealed that she had conversations in passing with MDS Nurse #2 regarding MDS being busy but had no idea they were that bad behind and if she had known she would have got them some help. The DON confirmed that the MDS nurses also do daily Medicare charting on all skilled residents, which is time consuming. The Administrator revealed that the MDS coordinator attends the morning stand up meetings and had never mentioned that they were behind. The Administrator stated, "I can't deny they are short staffed in the MDS department". The Administrator confirmed they had 4 staff members in MDS until about 2 months ago, but stated, "I've never done MDS and Medicare charting so I do not know how long it would take to get it done". The DON stated, "I am no MDS guru" and confirmed they were short staffed in the MDS department. The DON revealed that MDS assessments are how the facility gets reimbursed.	F 640		
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	F 656		4/28/23

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F 656	Continued From page 29 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 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 resident and staff interview, record review and facility policy review the facility failed to develop a person centered comprehensive	F 656	*Resident #7 was assessed on 3/23/2023 by the Director or Nursing (DON) with no adverse findings noted. Residents #24	

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F 656	Continued From page 30 care plan for residents with a language deficit and respiratory care for three (3) of 34 resident care plans reviewed. Residents #7, #24, and #98. Findings include: A record review of the facility's policy titled "Care Plan Process", revised 08/17, Step# 9: "The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs, including culturally-competent and trauma-informed as well as, these items or services that would be required but are not due to the exercise of resident rights (refusal)." Resident #7 An observation on 3/06/23 at 10:12 AM, revealed a nebulizer machine with mask and tubing laying on bedside table not in storage bag. A record review of the comprehensive care plans for Resident # 7, revealed there was no care plan addressing nebulizer therapy needs. A record review of Resident #7's physician's orders revealed an order dated 11/30/22, "IPRATALBUTEROL 0.5-3(2.5) MG (milligrams) ML (milliliter) INHALATION VIA NEBULIZER DAILY IN THE MORNING AND AT BEDTIME SOB (shortness of breath)/WHEEZING" and an order dated 10/14/22 "IPRAT-ALBUTEROL 0.5-3(2.5) MG ML INHALATION VIA NEBULIZER EVERY 6 HOURS AS NEEDED SOB/WHEEZING."	F 656	and 98 were assessed by the facility Assistant Director of Nursing (ADON) with no adverse findings noted on 3/23/2023. *Resident #7□s care plan was developed on 3/24/223 by Minimum Data Set (MDS) Licensed Practical Nurse (LPN). Resident #24□s care plan was developed on 3/8/2023 by MDS LPN. Facility Staff Development Coordinator received a new order on 3/13/2023 to d/c resident #98 nebulizer order due to non-usage per the resident□s physician. *All residents with language deficit and respiratory care needs have the potential to be affected. Residents receiving respiratory care had their care plans reviewed and will be updated as needed by 04/07/2023 by the facility Director of Nursing (DON) and the Assistant Director of Nursing (ADON). Residents with language deficits had their care plans reviewed and will be updated as needed by 04/07/2023 by the facility DON and ADON. The facility nursing department was in-serviced by the Staff Development Coordinator (SDC) on 3/23/2023 regarding □Care Plan Process.□ The facility Medical Director reviewed the policy, □Care Plan Process□ with no recommended changes to the policy on 3/23/2023. The facility Quality Assessment and Assurance Committee met on 3/24/2023 to review the plan of correction for F Tag 656. *Beginning 3/24/2023, the Director of Nursing (DON) will review Care Plans of	

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F 656	Continued From page 31 A record review of the March 2023 Electronic Medication Record (E-MAR), revealed Resident # 7 received scheduled IPRAT-ALBUTEROL 0.5-3(2.5)MG ml Inhalation Nebulizer daily in the morning and at bedtime for SOB/Wheezing from the 1st through the 7th of March. An interview with Minimum Data Set (MDS) RN Assessment Nurse on 03/08/23 at 01:41 PM, revealed Resident #7 should have a care plan addressing any respiratory therapy and she is unsure why it was not care planned. Record review of Resident #7's Face Sheet revealed he was admitted on 6/09/22 with diagnoses of Cerebral Infarction, Heart Failure, and Chronic Obstructive Pulmonary Disease. Record review of the MDS Section C with an Assessment Reference Date (ARD) of 3/08/23 revealed Resident # 7 had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact. Resident #24 An observation and interview on 3/6/23 at 12:00 PM, revealed that Resident #24 was sitting up in a wheelchair in her room watching TV. On interview the resident answered with a single repetitive word, used inflection in her voice, hand gestures and nodding of her head to answer simple yes and no questions. Record review of Resident #24's care plans revealed the resident did not have language deficit care plan. An interview on 3/7/23 at 2:30 PM, with Certified	F 656	residents receiving respiratory care and language deficits weekly for 12 weeks to ensure a comprehensive care plan and will report to the Quality Assessment and Assurance committee for 3 months. The first facility Quality Assessment and Assurance Committee meeting will be held on 4/28/2023.	

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Nurse Assistant (CNA) #1 and CNA #2 revealed that until you get use to Resident #24 it is sometimes difficult to understand her, but she makes her wants and needs known by pointing.

An interview on 3/8/23 at 2:00 PM with the Director of Nurses (DON) revealed that Resident #24 has a diagnosis of a language deficit She confirmed the resident is hard to communicate with, but if you give her time, you can usually understand her. She revealed that the resident should have a communication care plan but did not. She revealed the purpose of the care plan would be to provide education to the staff on how to care for the resident since she has the communication deficit. She revealed that MDS is responsible for putting in the care plans.

An interview on 3/9/23 at 10:32 AM, with the MDS Coordinator confirmed that Resident #24 has a language deficit diagnosis but does not have a language deficit care plan. She confirmed that the resident should have a language deficit care plan and that MDS would have been responsible for putting that care plan in. She confirmed that the purpose of the care plan was for the staff to know how to communicate with the resident and with the care plan not being completed then the staff may not know how to communicate with her.

Record review of Resident #24's Face Sheet revealed the resident was admitted to the facility on 11/05/20 with medical diagnoses that included Other Speech/Language Deficit following Unspecified Cerebral Vascular Disease.

Record review of Resident #24's MDS with an ARD of 01/20/23 revealed in Section B that the resident had speech that was unclear and was

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sometimes understood, with ability being limited to making concrete request and in Section C a BIMS score of 14, which indicates the resident is cognitively intact.

Resident #98

An observation on 03/07/23 at 8:19 AM, revealed a nebulizer mask lying inside the opening of the nebulizer machine.

A record review of the comprehensive care plans for Resident #98, revealed no care plan addressing nebulizer therapy needs.

A record review of the physician's orders, revealed an order dated 10/14/22 "IPRAT ALBUTEROL 0.5-3(2.5) MG ML INHALATION VIA NEBULIZER EVERY 4 HOURS AS NEEDED SOB/WHEEZING."

An interview with MDS Registered Nurse/Assessment Nurse on 03/08/23 at 01:41 PM, revealed Resident #7 should have a care plan addressing any respiratory therapy and she is unsure as to why it was not care planned.

An interview with the DON on 03/08/23 11:50 AM, she revealed she was unable to find a care plan for respiratory treatments.

Record review of Resident # 98's Face Sheet revealed he was admitted on 3/21/22 with diagnoses of Cerebral Infarction, Hyperlipidemia, and Hypertensive Crisis.

Record review of the MDS Section C with an ARD of 1/8/23 revealed Resident # 98 had a BIMS score of 6, indicating he was severely cognitively

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F 656	Continued From page 34 impaired. An interview with the MDS Coordinator on 03/08/23 at 1:48 PM, revealed the purpose of the comprehensive care plan was to form care specific to each resident's needs, and confirmed that possible concerns from not developing a care plan is lack of appropriate resident centered care and not meeting the resident's needs. An interview with the Corporate Quality Improvement Nurse on 03/08/23 at 02:13 PM, revealed the purpose of the care plan is to direct staff of the person centered care and needs of the resident and concerns of not developing the care plan is residents may not receive the specific individualized care necessary they need to meet their needs.	F 656		
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, resident and staff interview, record review and facility policy review the facility failed to properly store nebulizer mask and tubing in a storage bag for two (2) of nine (9) residents reviewed for respiratory care. Residents # 7 and #98.	F 695	*Resident #7 was assessed on 3/23/2023 by the Director or Nursing (DON) with no adverse findings noted. Resident #98 was assessed by the facility Assistant Director of Nursing (ADON) with no adverse findings noted on 3/23/2023.	4/28/23

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F 695	Continued From page 35 Findings include: A record review of the facility's policy titled "Nebulizer", revised 10/17, Revealed" Purpose: 1.) To administer bronchial medications and humidifying agents into the lungs. 2.) To assist in loosening secretions ...Cleaning Equipment: 4.) Store in a clean plastic bag ..." Resident #7 An observation on 3/06/23 at 10:12 AM, revealed nebulizer mask and tubing laying on the bedside table and was not in a storage bag. An observation and interview with Resident #7 on 3/7/23 at 11:00 AM, revealed the nebulizer mask was sitting on a box on bedside table. Resident #7 revealed she had her nebulizer in a bag before but not in a good while. An observation with Licensed Practical Nurse (LPN) #2 on 3/7/23 at 1:10 PM, she confirmed Resident #7's nebulizer mask was lying on the nebulizer machine and confirmed it should be in a storage bag when not in use. LPN #2 removed the nebulizer mask from the room. LPN # 2 also revealed possible complications of improper storage is respiratory infections. A record review of Resident#7's Physician Orders dated 11/30/22, revealed "IPRAT-ALBUTEROL 0.5-3(2.5)MG ML INHALATION VIA NEBULIZER DAILY IN THE MORNING AND AT BEDTIME SOB/WHEEZING" and an order dated 10/14/22 "IPRAT-ALBUTEROL 0.5-3(2.5)MG ML INHALATION VIA NEBULIZER EVERY 6 HOURS AS NEEDED SOB/WHEEZING."	F 695	Resident #7□s nebulizer mask and tubing was replaced on 3/23/2023 by the facility Staff Development Coordinator (SDC). Resident #98 no longer uses a nebulizer mask or tubing as of 3/13/2023 per physicians order. *Residents receiving respiratory care have the potential to be affected. *Residents receiving respiratory care had their nebulizer mask and tubing inspected by the facility SDC on 3/24/2023 to ensure proper storage. Facility Nursing staff were in-serviced by the SDC on 3/23/2023 related to the facilities policy □Nebulizer.□ The facility Medical Director reviewed the policy, □Nebulizer□ with no recommended changes to the policy on 3/23/2023. The facility Quality Assessment and Assurance Committee met on 3/24/2023 to review the plan of correction for F Tag 695. *Beginning 3/24/2023, the SDC will inspect nebulizer masks and tubing of residents receiving respiratory care 3 times weekly for 4 weeks and then weekly for 2 months. The SDC will report to the Quality Assessment and Assurance committee for 3 months. The first facility Quality Assessment and Assurance Committee meeting will be held on 4/28/2023.	

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A record review of the March 2023 Electronic Medication Record(E-MAR), revealed Resident # 7 received scheduled IPRAT-ALBUTEROL 0.5-3(2.5)MG ml Inhalation Nebulizer daily in the morning and at bedtime for SOB/Wheezing from the 1st through the 7th of March 2023.

Record review of Resident #7's Face Sheet revealed he was admitted on 6/09/22 with diagnoses of Cerebral Infarction, Heart Failure, and Chronic obstructive pulmonary disease.

Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 3/08/23 revealed Resident # 7 had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact.

Resident #98

An observation on 03/06/23 at 10:30 AM, revealed a nebulizer mask was laying on the bedside table and not in a storage bag.

An observation on 03/07/23 at 8:19 AM, revealed the nebulizer mask was laying inside the opening of the nebulizer machine and was not in a storage bag.

An observation with LPN #2 on 03/07/23 at 1:00 PM, confirmed Resident # 98's nebulizer mask was laying on the nebulizer machine and it should be in a storage bag when not in use. LPN #2 removed the nebulizer mask from the room. LPN # 2 also revealed possible complications of improper storage is respiratory infections.

A record review of the Physician Orders, revealed

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	255274	A. BUILDING _____ B. WING _____	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOME	638 HIGHLAND COLONY PARKWAY RIDGELAND, MS 39157

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an order dated 10/14/22 "IPRAT-ALBUTEROL 0.5-3(2.5) MG ML INHALATION VIA NEBULIZER EVERY 4 HOURS AS NEEDED SOB/WHEEZING."

A record review of the March 2023 E-MAR revealed Resident # 98 receives did not receive any nebulizer treatments from the 1st through the 7th of March 2023.

An interview with the Director of Nursing (DON) on 3/7/23 at 1:30 PM, revealed that oxygen and nebulizer masks and tubing should be stored in a storage bag when not in use for infection control concerns and confirmed possible complications of improper storage is Respiratory infection.

An interview with the Corporate Quality Improvement Nurse on 03/07/23 at 1:35 PM, revealed oxygen and nebulizer tubing and masks should be stored in a storage bag and a possible complication of improper storage is infections and accidents.

An interview with LPN #1 on 03/08/23 at 11:00 AM, revealed the oxygen and nebulizer tubing should be changed out weekly, labeled and dated and stored in a storage bag.

An interview with the Administrator on 03/08/23 11:55 AM, she revealed she is not medical, but a possible concern of improper nebulizer storage and tubing change is infections.

An interview with the Infection Control Nurse (ICN) on 03/09/23 08:10 AM, revealed nebulizer tubing and masks should be stored in a bag when not in use and if it was not stored in a bag staff are not following the policy. The ICN confirmed

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F 695	Continued From page 38 possible concerns from not storing the nebulizers appropriately is bacterial infections. Record review of Resident #98's Face Sheet revealed he was admitted on 3/21/22 with diagnoses of Cerebral Infarction, Hyperlipidemia, and Hypertensive Crisis. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 1/8/23 revealed Resident # 98 had a Brief Interview for Mental Status (BIMS) score of 6, indicating he was severely cognitively impaired.	F 695		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		4/28/23

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F 758	Continued From page 39 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review and facility policy review the facility failed to provide documentation or a diagnosis supporting the use of an anti-psychotic medication for one (1) of three (3) residents reviewed for unnecessary psychotropic medications. Resident #42 Findings include: Record review of the facility policy "Psychotropic Medications" with a revision date of 10/22, revealed, " A psychotropic drug is any drug that	F 758	* Resident #42 was assessed on 3/23/2023 by the Director of Nursing (DON) with no adverse findings noted. Resident #42 was seen by behavioral health consultant on 3/24/2023 with the recommendation of a gradual dose reduction until safe for medication to be discontinued. *Residents receiving psychotropic medications have the potential to be affected.	

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F 758	Continued From page 40 affects brain activities associated with mental processes and behavior ...Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record ..." An observation on 3/6/23 at 12:20 PM, revealed Resident #42 sitting in her wheelchair in her room with her daughter present, no behaviors noted. An observation on 3/7/23 at 9:15 AM, revealed Resident #42 sitting in her room with her daughter present, no behaviors noted. An interview on 3/7/23 at 2:15 PM, with Certified Nurse Assistant (CNA) #1 revealed she has not known Resident #42 to have any behaviors. She revealed she is usually a pleasant lady and is up out of her room a lot. She revealed the resident allows her to provide care without any issues. An interview on 3/8/23 at 11:45 AM, with Social Services #1 revealed she has never known Resident #42 to have any sort of behaviors. An interview on 3/8/23 at 2:40 PM, with the Director of Nurses (DON) confirmed that Resident #42 does not have behaviors. She revealed the resident gets aggravated with her family when they come and stay too long, but besides that she has no real behaviors. She confirmed that Resident #42 had an order for Seroquel due to the family requesting that she be put on Seroquel. She revealed the family asked the Nurse Practitioner (NP) in 01/2023 to increase the Seroquel from 25 milligrams (mg) to 50 mg because they said the resident was getting more agitated. She revealed that there was no	F 758	*Residents receiving psychotropic medications were reviewed by facility DON and Assistant Director of Nursing on 3/24/2023 to ensure proper diagnosis. Facility Nursing staff were in-serviced by the Staff Development Coordinator on 3/23/2023 related to □Psychotropic Medication.□ The facility Medical Director reviewed the policy, □Psychotropic Medications□ with no recommended changes to the policy on 3/23/2023. The facility Quality Assessment and Assurance Committee met on 3/24/2023 to review the plan of correction for F Tag 758. * Beginning 3/24/2023, the facility DON will audit physician orders related to Psychotropic medications to ensure proper diagnosis 3 times weekly for 4 weeks and then weekly for 2 months. The DON will report to the Quality Assessment and Assurance committee for 3 months. The first facility Quality Assessment and Assurance Committee meeting will be held on 04/28/2023	

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progress note indicating that was the reason for the increase in Seroquel in 01/2023. She confirmed the resident did not have a diagnosis of psychosis and her dementia diagnosis was with no behaviors. She also confirmed that on the residents most recent Minimum Data Set (MDS) Section D and E revealed the resident had no mood or behavior issues. She revealed that the resident receiving an anti-psychotic without having a diagnosis or behavior needs could cause the resident to be lethargic.

An interview on 3/8/23 at 3:00 PM, with the NP confirmed she wrote the order to increase Resident #42's Seroquel from 25 mg to 50 mg in 01/23 because the family informed her on her rounds that the resident had increased agitation with the staff and was refusing care such as having her vital signs taken. She revealed that no staff member informed her that the resident was having behaviors or was agitated and she never addressed it with them. She revealed the resident did not have psychotic behaviors. She confirmed that she had not written a progress note when she increased the resident's Seroquel at the family's request in 01/2023. When the State Agent (SA) asked if there would have been a different medication she could have tried instead of Seroquel, she stated "possibly." She revealed that if the resident received Seroquel and did not need it then she could be overly sedated and it could lower her blood pressure and change her vital signs.

Record review of Resident #42's Physician Orders with an order date of 2/3/2023 revealed"Seroquel 50 mg 1 tablet by mouth twice daily psychosis, monitor for target behaviors, psychotic episodes."

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Record review of Resident #42's Electronic Medication Administration Record for 02/2023 and 03/2023 revealed the resident was receiving Seroquel 50 mg 1 tablet by mouth twice daily/psychosis at 9:00 AM and 7:00 PM.

Record review of the facilities Interdisciplinary Team Psychotropic Dashboard for December 2022, January 2023 and February 2023 indicated the resident needed a diagnosis code for Seroquel.

Record review of Resident #42's Face Sheet revealed the resident was admitted to the facility on 06/18/2021 with medical diagnosis that included Unspecified dementia, unspecified severity without behaviors/psychosis/mood/anxiety. The current diagnosis list did not include a diagnosis of Psychosis.

Record review of Resident #42's Minimum Data Set with an Assessment Reference Date of 12/09/22 revealed in Section D that the resident had no mood issues, in Section E that the resident had no behaviors and in Section C a Brief Interview for Mental Status score of 4, which indicates that the resident has severe cognitive impairment.