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	255300	A. BUILDING _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK RETIREMENT CENTER	49 WILLOW CREEK LANE BYRAM, MS 39272

(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 2/21/23 through 2/23/23. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F561, F565, F677, F690, F758, and F812. The census a the time of the survey was 85, and the facility held a license for 88 beds.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to	F 561		3/29/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/13/2023

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 561	Continued From page 1 participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility policy review, the facility failed to honor the resident's right to make choices, as evidenced by residents having to remain out of bed during mealtimes for two (2) of four (4) residents reviewed for choices. Resident #15 and #24 Findings include: Review of the facility policy titled, "Residents Rights," with the date reviewed/revised of 4/18/18, revealed " ... 6. Self-determination. The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: ... b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident." A record review of a signed letter provided by the Administrator, on the facility's letterhead, dated 2/23/23, revealed "There is no written policy that care is not to be given during mealtimes." During an interview on 2/21/23 at 11:03 AM, Resident #24, revealed she preferred to lay down at lunch time, as this is something she has done in the past. However, she revealed staff have told her that no one is allowed to go back to bed during lunch time, so she is required to stay up. An interview and observation on 2/21/23 at 12:40 PM, revealed Resident #15 was tired of sitting up,	F 561	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #15 and Resident #24 were assessed by the Director of Nursing. No negative outcome from this alleged deficient practice was identified. Both Residents were assured that in the future a staff member would be to provide assistance to Residents during mealtime. 2. Steps taken to identify other residents having the potential to be affected by the same alleged practice. Residents in the facility as identified by the Minimum Data Set that require assistance being put in bed have the potential to be affected by the alleged deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On February 21, 2023, an in-service was completed by the Administrator and Director of Nursing for licensed nurses and certified nurse assistants that assistance must be provided during mealtime to residents requesting assistance. Beginning February 22, 2023,	

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F 561	Continued From page 2 but could not get help to get in bed until all the lunch trays were picked up. Although the resident was observed to have completed her lunch, and her tray had been removed from her room, she revealed there was a rule that no one could ask to get back in bed during mealtime. An interview on 2/21/23 at 12:44 PM, Certified Nurse Aide (CNA) #4, revealed she had been told no resident can get back in bed until all the trays for a meal are passed out, all residents that need to be fed are fed, and all trays are picked up after the mealtime was over. She commented she did observe Resident #15 and asking to get in bed, but the resident had to wait until the trays were picked up before she could go to bed. CNA #4 revealed she was not aware of a past request from Resident #24 to go to bed during a mealtime. During an interview on 2/21/23 at 12:48 PM, with Licensed Practical Nurse (LPN)#2, and the Registered Nurse (RN)/Wound Care Nurse, they both revealed that residents are not to be put to bed during mealtimes. They reported that the meal trays must be passed out, the CNAs must feed the residents that require assistance with their meals, and the CNAs must then pick up all the trays prior to assisting residents to bed. They noted they were unaware of past requests from Resident #24 to go to bed during mealtime. Both nurses revealed that they were not aware if this was facility policy or if is information that had been passed on to them by other staff in their training. An interview on 2/21/23 at 2:00 PM with the Director of Nursing (DON), revealed residents are aware, during mealtimes, the CNAs pass out	F 561	staff were assigned daily to provide assistance to Residents and answer call lights during mealtime. 4. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur. Daily assignment sheets are reviewed, daily in morning Clinical Meeting, to ensure compliance. Daily review will continue for the one. Any negative findings will be acted on and reported to the Quality Assurance Committee beginning on March 24th. Beginning March 6, 2023, Activities will interview five (5) residents, twice a week for two (2) months and then five (5) residents weekly for three (3) months to ensure that assistance is being provided to residents during mealtime. These findings will be reported weekly, to the Director of Nursing and Administrator in the morning Stand-Up Meeting, so that any problems can be addressed immediately. The results of the monitoring will be brought to the Quality Assurance committee for five (5) months beginning on March 24th.	

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F 561	Continued From page 3	F 561		

meal trays, feed the residents that require assistance, and must pick up the meal trays before residents are placed back in bed. The DON also revealed she could not recall if this practice was based on facility policy. However, confirmed that residents have the right to choose when they want to go to bed, and that preferences were not being honored for Resident #15 and Resident #24.

An interview on 2/21/23 at 09:20 AM, with the Administrator, revealed the CNAs are to complete the mealtimes, breakfast, lunch, and dinner, before assisting resident, to avoid cross contamination. She added that the nurses are available and should have assisted with putting Resident #15 back to bed. She noted Resident #15's and Resident #24's rights were not being honored, if they requested to be put in bed. The Administrator revealed the facility did not have a policy preventing residents from going to bed during mealtimes. She stated this was a directive from lead staff.

Record review of the "Face Sheet" for Resident #15, revealed the facility admitted the resident to the facility on 4/8/22. Current diagnoses include Hemiplegia and Dementia.

Record review of Section C of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 1/9/23, for Resident #15, revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating the resident had moderate cognitive impairment.

Record review of the" Face Sheet" for Resident #24, revealed the facility admitted the resident to the facility on 11/15/21. Current diagnoses include

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F 561	Continued From page 4 Type 2 Diabetes Mellitus and Acute Transverse Myelitis. Record review of Section C of the Annual MDS Assessment, with an ARD of 11/14/22, for Resident #24, revealed a BIMS score of 15, indicating Resident #24 is cognitively intact.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 565		3/29/23

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F 565	Continued From page 5 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record reviews, and facility policy review, the facility failed to document and act promptly to resolve grievances and recommendations from Resident Council Meetings for six (6) of 6 months of resident council meeting minutes reviewed. Findings include: A review of the facility policy titled, "Resident and Family Grievances," with a date reviewed of 2/3/23, revealed, "Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. ... 2. The Grievance Official, Administrator or Director of Nursing is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion; leading any necessary investigations by the facility ... Policy Explanation and Compliance Guidelines: ...8. Grievances may be voiced in the following forums ... d. Verbal complaint during resident or family council meetings ....10. Procedure: ... b. The staff member receiving the grievance will record the nature and specifics of the grievance on the designated grievance form or assist the resident or family member to complete the form. ... d. The Grievance Official will take steps to resolve the grievance, and record information about the	F 565	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? The Social Services Director reviewed the last six (6) months of Resident Council Minutes for any concerns having been reported to Resident Council and ensured that the concerns had been addressed. There were no negative outcomes from this alleged deficient practice. 2. Steps taken to identify other residents having the potential to be affected by the same alleged practice. All residents who have grievances have the potential to be affected by the alleged deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? In-service for staff in all departments was completed on March 1st by the Administrator regarding the grievance process and the need to utilize that system for all concerns/complaints expressed by residents and/or their	

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F 565	Continued From page 6 grievance, and those actions, on the grievance form. ... e. The Grievance Official, or designee, will keep the resident appropriately apprised of progress towards resolution of the grievances. ... 12. The facility will make prompt efforts to resolve grievances." A record review of the Resident Council Meeting Minutes for 9/28/22, 10/19/22, 11/23/22, 12/7/22, 1/25/23, and 2/15/23, revealed there were no documented grievances or review from concerns voiced during the previous month's meeting. During the Resident Council Meeting held on 2/22/23, at 2:30 PM, Resident #36 revealed that she became the Resident Council President six (6) months ago. In an interview with the President, she revealed she did not remember seeing the staff member present at the meetings writing down any of the resident complaints made during the meetings or reporting feedback to the group on responses or actions taken regarding the previous month's complaints. During the meeting, at 2:40 PM, Resident #68 was interviewed regarding her Resident Council Meeting attendance. Resident #68 revealed she used to regularly attend the meetings but stopped due to there being no resolution to any issues brought up in the meetings. She confirmed complaints were discussed, but nothing was ever done. An interview, during the meeting at 2:56 PM, with Resident #1, revealed she too had once regularly attended the Resident Council Meetings, but had grown tired of going to the meetings to discuss her complaints, listen to the complaints of other residents, and returning to the meeting the next	F 565	families. The Social Worker and the Activities Director will begin taking minutes and attending the Resident Council Meetings, at the request of the Resident Council, beginning March 1, 2023. Any concerns brought before the council will follow the grievance process. The Social Services Director and Activities Director are responsible for responding to all concerns/grievances and reporting back to both the individual Resident making the complaint as well as to the Resident Council at the next meeting. 4. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur. Resident Council Minutes and any grievances associated with those minutes will be reviewed by the Administrator following each meeting beginning March 1, 2023. Any negative findings will be brought to the Quality Assurance Committee beginning March 24th. Monitoring of monthly Resident Council Minutes by the Quality Assurance Committee will continue for two (2) months. The administrator will continue to review monthly minutes and grievances, identifying issues that need to be referred to the Quality Assurance Committee for interventions and monitoring.	

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month realizing that nothing was being done about their complaints. She voiced she could not remember if anyone wrote down what was being said in the meetings, but none of the staff followed up with her about any of the complaints she had made.

An interview on 2/22/23, at 3:30 PM, with the facility's Social Services Director, revealed she was responsible for monitoring the Resident Council Meetings. She revealed, at the beginning of the meetings, the residents are informed that she was aware they may have a lot of complaints, but they should keep them to a minimum and concentrate on what can be done to make things better. She stated that she sat in the back at the meetings, allowed the Resident Council President to conduct the meeting and keep the Resident Council Meeting minutes, and had no further input. She also noted there had been complaints by the residents in the meetings, but she did not write formal grievances for the complaints. Instead, she stated she would call the departments involved and allow them to handle the complaints.

An interview on 2/22/23 at 03:55 PM, with the Administrator, revealed the residents have the option to report grievances to Social Services at times other than in Resident Council Meetings. She noted that Social Services have a Grievance Log and residents were aware they could file a Grievance with Social Services. The Administrator did not confirm that Social Services should have documented and followed up for resolution of grievances from the Resident Council Meetings.

An interview on 2/23/23 at 11:40 AM, with the

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Assistant Activities Director, revealed she was present in the January and February 2023, Resident Council Meetings, and the mediator for the residents. She noted the Resident Council President conducted, as well as documented the meetings. She confirmed she did not write down the resident grievances from the meeting, as it was the responsibility of the Resident Council President to document the grievances.

A record review of the Grievance Log for September 2022, through February 2023, did not reveal grievances from any of the Resident Council Meetings.

A record review of the "Face Sheet "for Resident #1, revealed the facility admitted the resident on 5/14/21.

A record review of Section C of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 2/9/23, for Resident #1, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #1 is cognitively intact.

A record review of the "Face Sheet" for Resident #36, revealed the facility admitted the resident on 8/5/16.

A record review of Section C of the Quarterly MDS Assessment, with an ARD of 2/1/23, for Resident #36, revealed a BIMS score of 15, indicating Resident #36 is cognitively intact.

A record review of the "Face Sheet" for Resident #68, revealed the facility admitted the resident on 11/23/22.

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F 565	Continued From page 9 A record review of Section C of the Quarterly MDS Assessment, with an ARD of 2/21/23, for Resident #68, revealed a BIMS score of 15, indicating Resident #68 is cognitively intact.	F 565		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and facility policy review, the facility failed to shave a resident that required assistance with shaving for one (1) of 18 residents reviewed for Activities of Daily Living. Resident #48 Findings include: Review of the facility policy titled, "A.M. Care" revealed, "A.M. care will be given to residents daily ... Responsibility: All Nursing Assistants. Equipment: ... 7. Razor, shaving cream ..." An observation on 2/21/23 at 9:01 AM, revealed Resident #48 unshaven with facial hair about ½ inch long. He stated he hasn't been shaved in a month, but when he was able to do it for himself, he shaved daily. An observation on 2/21/23 at 10:00 AM, revealed Resident #48 receiving a bed bath. In an interview on 2/21/23 at 3:15 PM, Certified Nursing Assistant (CNA) #1 confirmed she had given Resident #48 a bath this morning. She	F 677	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident #48 was shaved on 2-21-23 at 4 pm. There were no negative outcomes from this alleged deficient practice. 2. Steps taken to identify other residents having the potential to be affected by the same alleged practice. Residents in the facility as identified by the Minimum Data Set as needing help with Activities of Daily Living have the potential to be affected by the alleged deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On February 21, 2023, the Director of Nurses and licensed nurses completed an	3/29/23

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F 677	Continued From page 10 confirmed that she had washed his face but didn't offer him a shave, because she didn't think he needed it. However, after looking at the resident again, she stated he had needed to be shaved. During an interview on 2/22/23 at 4:00 PM, the Director of Nursing (DON) revealed Resident #48 did need to be shaved. She confirmed the hair on the face of Resident #48 was about approximately ½ inch long and he should have been offered a shave. An interview on 2/23/23 at 12:23 PM, CNA #5 revealed the residents are assigned shower days on a schedule at the nurse's desk. She confirmed that shaving is part of that care. An interview with the DON on 2/23/23, at 10:45 AM, revealed CNA's have a list of residents scheduled for showers and that care includes all care required by the residents, including shaving. A record review of the "Face Sheet," for Resident #48, revealed the facility admitted the resident on 11/1/22. The diagnoses of Resident #48 included Type 2 Diabetes Mellitus with Diabetic Neuropathy, Peripheral Vascular Disease, Muscle Weakness, and Lack of Coordination. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/20/23, revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact.	F 677	audit of all residents to see which residents needed to be shaved and ensure if the resident needed to be shaved the task was completed All certified nurse assistants were in-serviced on March 1, 2023, by the Director of Nurses on the importance of ensuring dependent resident□s receive assistance in completing Activities of Daily Living. 4. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur. The Director of Nursing or Registered Nurse Supervisor will monitor five residents twice a week for three (3) months and weekly for three (3) months to ensure that residents are being shaven beginning February 28, 2023. Any negative findings will be addressed immediately. Results of the monitoring will be submitted to the Quality Assurance committee beginning March 24th for six (6) months.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		3/29/23

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(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 690	Continued From page 11 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to provide appropriate catheter care of for one (1) of	F 690	1. What corrective action will be accomplished for those residents found to have been affected by the alleged	

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F 690	Continued From page 12 three (3) residents reviewed for a catheter care. Resident #29 Finding's include: Review of the facility policy titled, "Catheterization Policy," with no revision date, revealed, ... "Reminders -Tubing and bag should be properly positioned below hip level ..." An observation on 2/21/23 at 8:45 AM, revealed Resident #29 lying in bed with a nephrostomy bag attached to the head of the bed on her right side. The head of the bed that was elevated to approximately 30 degrees. An interview on 2/22/23 at 8:40 AM, with Certified Nurse Assistant (CNA) #2, revealed that Resident #29 gets turned every two hours. The CNA stated the urine catheter bag does not affect her turning, because it always stays at the head of the bed. An observation on 2/22/23 at 9:22 AM, revealed, Resident #29 was lying in bed with her nephrostomy bag at the head of the bed, that was elevated approximately 30 degrees. An observation and interview on 2/22/23 at 1:41 PM, with the Registered Nurse (RN)/Wound Care Nurse and CNA #3, confirmed that Resident #29's nephrostomy bag was laying at the head of her bed, that was elevated to approximately 30 degrees. An interview with the Wound Care Nurse revealed that a urine catheter bag needs to be kept below the kidneys to help with flow, but Resident #29's has always been kept at the head of the bed, but she is not sure why. CNA #3 confirmed that the resident's nephrostomy bag is always at the head of her bed, but she is also not	F 690	deficient practice? Resident # 29 nephrostomy bag was moved to proper placement below the level of bladder by Director of Nursing on February 21, 2023. There was no negative outcome from this alleged deficient practice. 2. Steps taken to identify other residents having the potential to be affected by the same alleged practice. Residents with a urinary appliance as identified by the Minimum Date Set have the potential to be affected by the alleged deficient. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? In-service for nursing staff (Registered Nurses, Licensed Practical Nurses and Certified Nursing Assistants) was completed regarding the placement of urinary appliances occurred on February 24th by Director of Nursing. On February 22, 2023, residents with urinary appliances were assessed to make sure that all appliances were in the proper position by the Director of Nurses and the Registered Nurse Supervisor. All Appliances were found to be in appropriate placement. 4. Monitoring the corrective actions (Quality Assurance Program) to ensure	

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F 690	Continued From page 13 sure why. An interview on 2/22/23 at 1:54 PM, with Licensed Practical Nurse (LPN) #2, confirmed that urine drainage bags should be kept below the bladder, but Resident #29's nephrostomy bag was always kept on the resident's right side at the head of the bed. She revealed she usually moves the bag lower, but it gets moved back up. An interview on 2/22/23 at 2:00 PM, with the Director of Nurses (DON), confirmed that Resident #29's nephrostomy bag should be kept lateral or below the kidneys to prevent back flow, which could lead to kidney stones or bacteria flowing back into her kidneys. An observation on 2/23/23 at 7:50 AM, revealed Resident #29's nephrostomy bag was laying above the resident's pillow at the head of the bed, with the head of the bed elevated to approximately 30 degrees. Record review of Resident #29's "Face Sheet," revealed the facility admitted the resident to the facility on 3/22/19, with medical diagnoses that included Unspecified Dementia, personal history of Urinary Tract Infections and Calculus of Kidney. Record review of then Minimum Data Set (MDS) for Resident #29, with an Assessment Reference Date (ARD) of 11/02/22, revealed in Section C a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident was severely cognitively impaired and Section H revealed the resident had an indwelling catheter.	F 690	that the alleged deficient practice does not recur. The Director of Nursing or Registered Nurse Supervisor will check placement of all urinary appliances daily for one (1) month and then weekly for three (3) month beginning February 27th. Any negative findings will be addressed immediately and one on one counseling/in-servicing will occur. The results of monitoring will be brought to the Quality Assurance committee for four (4) months beginning on March 24th.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use	F 758		3/29/23

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F 758	Continued From page 14 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 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	F 758		

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F 758	Continued From page 15 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 interviews, record reviews and facility policy review, the facility failed to ensure as-needed (PRN) psychotropic medications were discontinued after 14 days, for one (1) of six (6) residents reviewed for unnecessary medications. Resident # 9 Findings include: Review of the facility policy titled, "Psychotropic Medication Policy and Procedure" with a revision date of 3/21/17, revealed "Policy: Physicians//providers will use psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring. Standards: 1. The facility will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications in the facility to include regular review for continued need, appropriate dosage, side effects, risks and or benefits ... 9. Orders for PRN psychotropic medications will be time limited (i.e., times 2 weeks) and only for specific clearly documented circumstances. PRN orders for anti-psychotic drugs are limited to 14 days unless the prescriber evaluates the resident for the appropriateness of	F 758	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? A stop date of February 23, 2023 was given for Resident #9□s Ativan 0.5 milligrams, one tablet by mouth every eight (8) hours as needed for anxiety. A new order was given on February 23, 2023, to continue Ativan 0.5 milligrams, one tablet by mouth every eight (8) hours as needed for anxiety for six (6) months. The order was given order was given by the Nurse Practitioner. There were no negative outcomes from this alleged deficient practice. 2. Steps taken to identify other residents having the potential to be affected by the same alleged practice. Residents with as needed orders for psychotropic drugs have the potential to be affected by this alleged deficient practice.	

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F 758	Continued From page 16 that medication ..." A record review of the February 2023, "Physician Orders," for Resident #9 revealed, "... Lorazepam (Ativan) 0.5 mg (milligram) tablet give one tablet by mouth every eight hours as needed for anxiety ...Order Date 4/21/22 and Start Date 4/21/22 ..." the order did not include a stop date. A record review of the past ten (10) months of Resident #9's Electronic Medication Administration Record (EMAR) revealed that the resident has continued to receive the PRN medication beyond the required 14 day limit, for the past ten (10 months. This PRN order was continuous, without the required reassessment, documentation of rationale for continued use, and new orders. Resident #9's EMAR documentation revealed since the order was written on 4/21/22, the resident has received Lorazepam 0.5 mg tablets seven (7) times in April 2022, 20 times in May 2022, 16 times in June 2022, ten (10) times in July 2022, four (4) times in August 2022, three (3) times in September 2022, two (2) times in October 2022, two (2) times in November 2022, four (4) times in December 2022, ten (10) times in January 2023, and 11 times thus far in February 2023. A record review of the "Face Sheet," revealed the facility admitted Resident #9 on 07/30/19. The resident's current diagnoses include Major Depressive Disorder and Anxiety Disorder. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/2/23, revealed in Section C a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident's cognition was moderately	F 758	3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? An audit of as needed Psychotropics orders was initiated by the Medical Records Nurse on February 28th. Upon completion, results were reviewed in Clinical Meeting to ensure stop dates are in place. There were no additional instances identified by the audit. An in-service was conducted on March 3rd by the Director of Nursing regarding the need for a stop date on all as needed Psychotropic medication orders. 4. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur. The Medical Records Nurse will conduct weekly audits of all as needed psychotropics orders beginning March 6, 2023. Any as needed orders without stop dates will be brought to daily Clinical Meeting for immediate action. All findings will be reported for four (4) months. to the Quality Assurance Committee begin March 24th	

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F 758	Continued From page 17 impaired. An interview on 2/22/23 at 2:35 PM, with the Pharmacy Consultant revealed that Ativan would need a 14 day stop date, unless the physician documents the indications for use, why it needs to be extended and the time for when to review again. An interview on 2/22/23 at 2:45 PM, with the Administrator revealed that a resident taking a psychotropic medication, without a stop date, could have an increase in their potential for falling, changes in behavior, and many other complications. An interview on 2/22/23 at 3:00 PM, with the Director of Nurses (DON), confirmed that Resident #9 did not have a stop date for Ativan. She revealed that she is aware that most psychotropic medications should have a stop date.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		3/29/23

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F 812	Continued From page 18 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review, the facility failed to maintain a clean ice machine for the residents as evidenced by white, red, and black residue build up on the inside and outside of the ice machine, observed on one (1) of five (5) kitchen tours. Findings include: Review of the facility policy titled, "Cleaning Instructions Ice Maker and Dispenser," dated 9/04, revealed, "Policy: Equipment shall be maintained in a clean and sanitary condition ... Procedure: ... The ice making system can be cleaned in place without disassembling the water system. The cleaning process should be performed at least every 6 months or more often if local water conditions dictate ..." An observation and interview on 2/21/23, at 8:08 AM with the Dietary Cook, revealed the ice machine to have streaks of white residue running down from the door covering the ice machine and down the left outer side of the ice machine. There were also observations of the following: 1. Streaks of faded white residue on the inside of the door covering the ice machine. 2. Red residue on the inside ledge, under the door covering the ice machine. 3. Buildup of red residue that extended across the full length of the bottom edge of a white	F 812	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? On February 21, 2023 the ice machine was immediately cleaned both inside and outside by the Dietary Manager. On February 22nd cleaning logs were placed on all ice machines to record the dates the machine was cleaned and who cleaned that machine. There were no negative outcomes from this alleged deficient practice. 2. Steps taken to identify other residents having the potential to be affected by the same alleged practice. Residents in the facility who receive ice from the ice machine have the potential to be affected by the alleged deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On February 24, 2023, the Administrator completed an audit of all ice machines to ensure cleanliness, all were found to be clean, and cleaning schedule logs were	

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F 812	Continued From page 19 plastic guard, located inside the ice machine, which hung over the ice. 4. Condensation dripping off the white plastic guard and running through the red residue onto the ice located below it. 5. Buildup of red residue inside the machine, on the metal hinges on the right side of the door, located above the ice. 6. Buildup of red residue on a black, outward curved, rubber flap that hung on the right inside area of the ice machine, located under the right-side metal hinge. 7. Thick black build up on a black, outward curved rubber flap that hung inside the machine The Dietary Cook used a wet, white, towel and wiped away the red residue on the inside ledge of the ice machine, located under the door and the red residue on the white plastic guard, that had condensation dripping through it onto the ice. The Dietary Cook confirmed that the ice machine was not clean, but the Dietary Manager is responsible for keeping it clean. An observation and interview on 2/21/23, at 8:30 AM with the Dietary Manager, revealed he was responsible for cleaning the ice machine. He stated that it was last cleaned in January 2023, however, he does not keep a cleaning log for the ice machine, but he makes sure it is cleaned every month. He confirmed that he observed the white streaks, as well as the red and black buildup located inside the machine. He too was observed using a wet, white, towel to wipe more of the red and black residue off the rubber flap. The Dietary Manager confirmed the ice machine was not clean. He revealed that an unclean ice machine could contaminate the ice and cause the residents to become sick.	F 812	posted and completed. Dietary and Maintenance staff were in-serviced on the importance of monthly cleaning of the ice machine on February 22,2023 by the Administrator. 4. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur. The Administrator will monitor condition of icemakers weekly for three (3) months and bi-weekly for three (3) months. This began on February 24, 2023. Any negative findings will be addressed immediately and reported in Quality Assurance Committee for beginning March 24th for six (6) months.	

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F 812	Continued From page 20 An interview on 2/22/23, at 4:00 PM with the Administrator, revealed the ice machine should have been clean, as it could contaminate the ice that was being served to the residents. He confirmed that contaminated ice had the potential to cause illness.	F 812		