STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255117	A. BUILDING _____ B. WING _____	04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF EUPORA	156 E WALNUT AVE EUPORA, MS 39744

(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 4/25/23-4/27/23. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation related to F550 for resident's rights, F578 related to not updating an Advanced Directive, F585 related to an unresolved grievance, F656 related to not developing a person centered care plan, F677 related to activities of daily living, F689 related to accidents and hazards, and F880 related to infection control. The census at the time of the survey was 111 and the facility is licensed for 119 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		6/2/23

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

Electronically Signed | 05/09/2023

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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review and facility policy review the facility failed to honor a resident's privacy as evidenced by a sign posted over the resident's bed that read two (2) stool samples needed with the resident's name and date, for one (1) of 111 residents reviewed for dignity. Resident #99 Findings include: Review of the facility policy titled, "Resident's Rights and Quality of Life" with a revision date 5/1/12 revealed under, "Policy Statement ... It is the policy of (Proper Name) that all residents have the right to a dignified existence, self-determination, and communication with	F 550	The center took immediate action by removing the sign above the resident #99□s bed on 4/25/23. The Director of Education (DCE) began education on 4/25/23 and continued until 5/12/23 to ensure 100% of staff understood to avoid putting signs up regarding sensitive resident information and remove any signs if identified. All residents and patients are potentially affected by this practice. The Director of Nursing conducted 100% audit 4/25/23 of all resident rooms to check for personal health information. No additional variances were located. Immediate interventions on 4/25/23 to assure	

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F 550	Continued From page 2 access to people and services inside and outside the facility." This review revealed "A resident has the right...To personal privacy and confidentiality of personal and clinical records." An interview and observation on 04/25/23 at 10:35 AM, with Resident #99 revealed a handwritten sign posted on the wall above the resident's bed that read, Resident #99's name and the need to collect two (2) stool samples. On interview Resident # 99 revealed he was not aware the sign had been posted on his wall. An interview and observation on 4/26/23 at 10:55 AM, with Registered Nurse (RN) #1 confirmed that there was a sign posted on Resident #99's wall dated 4/4/23, which listed the residents name and the need to collect 2 stool samples. She immediately removed the sign and stated, "I wouldn't like that posted on my wall for others to see; it's a privacy thing." An interview with the Director of Nursing (DON) on 4/26/23 at 3:50 PM, confirmed that posting the sign on Resident #99's room wall with his name and the need for stool samples was a dignity issue and should not have been placed there. Record review of Resident #99's Admission Record revealed the resident was admitted to the facility on 12/19/2022 with diagnoses that included Other Seizures, Non-Traumatic Intracerebral Hemorrhage in Hemisphere, Subcortical, and Dysphagia, unspecified. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/24/23 revealed under section C a Brief Interview for Mental Status (BIMS) score of 7,	F 550	interventions were carried forward included assigning department heads rooms to check on an ongoing basis for posting of signs. System changes to avoid a reoccurrence event included implementation of Environmental Rounds on 4/28/23 to include no personal or clinical information hanging in rooms The Administrator initiated an in-service on 4/28/23 with team members regarding updated Environmental Rounds check list . To assure continued compliance, on 5/1/23 the Administrator and or Director of nurses began auditing 6 resident□s rooms weekly x 4 weeks then monthly x2 months. Any variance discovered will be corrected immediately, followed by education. This performance improvement plan will be reviewed monthly in Quality Assurance Performance Improvement (QAPI) x 3 months with first QAPI scheduled for 5/24/23, or longer if needed.	

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F 550	Continued From page 3 which indicated Resident #99 is severely cognitively impaired.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.	F 578		6/2/23

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F 578	Continued From page 4 (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to reevaluate the Advance Directive information for a resident and to provide the information to the resident directly once she was able to cognitively receive the information for one (1) of 32 residents' Advance Directives reviewed. Resident #65 Findings include: Record review of the facility policy titled, "Advance Directives", dated 11/1/16, revealed, "(Proper name of facility) recognizes the dignity and value of each Resident's right to make health care decisions and to be fully informed of his or her complete health status. Furthermore, (Proper name of facility) recognizes the right of each Resident to issue Advance Directives regarding his or her health care." The policy also revealed, "The center will provide residents with information regarding Advance Directives at admission... If a resident is incapacitated at the time of admission so that he/she is unable to receive information about Advance Directives or articulate whether he/she has an Advance Directive, the center will provide information regarding Advance Directives to the resident's family or Resident Representative. Once the resident is no longer incapacitated, the center will provide information to the resident regarding Advance Directives and/or inquire whether the resident has an	F 578	Immediate action initiated on 4/28/23 by Director of Nursing Services (DNS) to correct the issue with #65 included reviewing the advance directives with the resident. A new advanced directive was signed by the resident. Immediate action taken included 100% review of all resident's advanced directive paper work on 5/1/23 by the Interdisciplinary team (IDT) to identify any other residents that might have been effected by this practice. All residents were at risk for this issue. Any resident that was able to make their own decision was then provided education on the Physician Orders Sustaining Treatment (POST) form and given the opportunity to sign the POST form. If the resident's chose not to sign the form and preferred the Responsible Party (RP) to sign, documentation of such was added to the medical record. Going forward to assure this issue does not occur again, any new admit is encouraged to sign their own advanced directive. Any new admit with a Power of Attorney (POA) will be encouraged to sign their own advanced directive (AD) paperwork unless the POA specifically states another person is legally responsible at the time of admission. If	

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F 578	Continued From page 5 Advance Directive." An interview with the Administrator on 4/26/23 at 4:00 PM, revealed Resident #65 was admitted to the facility after a major stroke and she was unable to sign the Advance Directive on admission and there was no Power of Attorney authorizing a designated person to make medical care decisions for the resident. She revealed that the Resident's Representative was present on admission, and she signed the Advanced Directive with the resident present. An interview with the Director of Nursing (DON) on 4/26/23 at 4:01 PM, revealed that on admission, Resident #65 was physically unable to sign the Advance Directive and the Brief Interview for Mental Status (BIMS) had not been done, therefore, Resident #65's cognitive status was unknown. An interview with the Administrator on 4/27/23 at 10:10 AM, revealed each resident had the right for their Advance Directive preference to be honored. She confirmed that on admission, Resident #65 was unable to sign her Advance Directive and the information was not provided directly to the individual as her condition improved. She confirmed the Advanced Directive for Resident #65 had not been verified or signed by the resident. Record review of Physician Orders for Sustaining Treatment form signed by the Resident's Representative and dated 3/6/21, revealed a Do Not Attempt Resuscitation status with comfort measures only. Record review of Order Summarey Report	F 578	the resident waives the decision to sign their own paperwork/Advanced Directive (AD) it will be documented as such in the medical record. An in-service was provided to the IDT on 5/1/23 by the Administrator to review updated process of resident's signing their own advanced directive paperwork. On 5/1/23 The administrator began auditing 5 residents POST form weekly x4 weeks, then monthly x2 months to assure new process is being followed. Any variance to the plan of correction will be corrected immediately and carried to Quality Assurance Performance Improvement (QAPI) x 3 months with first QAPI scheduled for 5/24/23, or longer if needed.	

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F 578	Continued From page 6 revealed an order dated 10/5/2018 for "Do Not Resuscitate". Record review of Resident #65's Care Plan revealed a care plan that the resident had an Advance Directive for "Do Not Resuscitate" with the goal listed as "patient's wishes will be honored". Record review of the Admission Record revealed Resident #65 was admitted to the facility on 10/4/2018. Diagnoses included Cerebral Infarction due to Thrombosis of left middle cerebral artery, Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side, Hypertension, and Acute on Chronic Diastolic (Congestive) Heart Failure. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 3/15/23, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact.	F 578		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.	F 585		6/2/23

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§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all

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information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance

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F 585	Continued From page 9 decision. This REQUIREMENT is not met as evidenced by: Based on resident representative and staff interview, record review and facility policy review the facility failed to resolve a grievance as evidenced by the resident representative not being reimbursed for missing clothing for one (1) of 23 residents sampled. Resident # 62 Findings include: Record review of the facility policy titled, "Customer Concern (Grievance) Policy" with a revision date of "July 2018" revealed under "Purpose ...Support each customer's (patient's/resident's) right to voice concerns (grievances) and to ensure after receiving a concern, the center actively seeks a resolution and keeps the customer appropriately apprised of its progress toward resolution. The goal is to encourage open communication of customer concerns in an environment free from reprisal, retaliation, or discrimination. We have a commitment to customer service and have systems in place to address concerns, Our Grievance Official is the center Administrator. The Grievance Official's contact information, including phone number and email address, will be readily available to any resident or family member who requests it". This review revealed under "Process ...The team member will determine what the customer wants corrected or done differently. If within the team member's authority to do so, he/she will immediately correct the problem. If the concern is not within their authority to immediately address, team members will advise the customer (patient/resident) the proper authority will be	F 585	On 4/28/23, the administrator reimbursed resident #62 for missing clothing. On 4/27/23, an in service was provided by the Administrator to the social worker regarding the reimbursement process. 100% of all grievances received over the past 3 months were audited on 4/27/23 by the Administrator to assure resolution had been executed. No additional unresolved resolution noted. All residents have the possibility of being effected. Going forward, systemic changes include that all grievances will be logged to track for timely resolution. On 4/28/23 the Administrator conducted and in-service to our leadership team on the new process of tracking grievances. On 5/1/23, the administrator will conduct an audit of grievance log for resolution weekly x 4 weeks and monthly x 2 months. This issue will be addressed in to Quality Assurance Performance Improvement (QAPI) for a minimum of 3 months beginning with QAPI on 5/24/23 to assure continued compliance. Any variance will be addressed immediately.	

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notified. The customer will be assured the concern will be investigated fully and follow-up communication will occur within 48 hours".

An interview on 4/25/23 at 11:30 AM, with Resident # 62's representative revealed that the resident has had clothes missing in the past and that she had spoken with the social worker on two occasions, and nothing was ever done. She revealed she later brought in the tags of the missing clothes and turned into the administrator about 2-3 weeks ago and is still waiting. She stated that the missing clothes added up to about 100 dollars.

An interview on 4/26/23 at 2:36 PM, with Social Services #1 confirmed a grievance was filed in 11/1/22 for Resident #62 regarding some missing clothes, but the family never brought a receipt. She revealed that she spoke with the resident's daughter again on 3/9/23 regarding some missing gowns and she brought the receipt for the gowns to the Administrator on 3/14/23. She revealed that a new grievance should have been completed for the 3/9/23 conversation, but it never was. She revealed that the Administrator informed her to reimburse Resident #62's family for the gowns, but it has not been done yet, because a formal grievance has not been completed and passed up to the staff member responsible for the reimbursement.

An interview on 4/26/23 at 4:20 PM with the Administrator confirmed that Resident #62's family had brought her a receipt on 3/14/23 for 2 gowns and she told her that was fine since it was near summer now, she did not need the sweater and stuff that she lost and had filed a grievance for on 11/1/22. She confirmed that the family had

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F 585	Continued From page 11 not been reimbursed yet, because the social worker thought I had done it, and I thought she had but it will be done today. She confirmed that it was a miscommunication between staff, and it should have already been resolved. Record review of the facility Customer Concern/Grievance Communication Log revealed that Resident #62's daughter filed a grievance 11/1/2022 regarding some missing clothing with no resolution noted. This review revealed a receipt was given to the facility on 3/14/23 regarding 2 gowns at $48.00 a piece for a total of $96.00 with no formal grievance form completed and no resolution noted. Record review of Resident #62's Admission Record revealed she was admitted to the facility on 08/08/2019 with medical diagnoses that included Unspecified Dementia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/31/23 revealed in Section C a Brief Interview for Mental Status of 05, which indicated the resident is severely cognitively impaired.	F 585		
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	F 656		6/2/23

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F 656	Continued From page 12 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged 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	F 656	On 4/26/23 the Director of Nurses (DNS) assessed resident #58 smoking habits	

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F 656	Continued From page 13 to develop a person-centered care plan for a resident who smokes for one (1) of 23 resident care plans reviewed. Resident #58 Findings include: Review of the facility policy titled, "Comprehensive Care Plan" revealed under, "Practice Guidelines: #1. The interdisciplinary care plan is implemented to guide health care center staff in the provision of necessary care and services to obtain and maintain the highest practicable physical, mental, and psychosocial well-being of the resident and promotion of the resident and family in planning care...#3. Interdisciplinary team communicates mental and psychosocial problems, needs, and concerns to the care planning team for inclusion in the overall plan of care." Resident #58 Record review of the facilities list of smokers confirmed that Resident # 58 was a smoker. Record review of Resident #58's care plans revealed that there was no care plan related to smoking. An interview with Registered Nurse (RN) #1 on 4/26/23 at 3:35 PM, revealed that she did not recall when Resident # 58 started smoking again. An interview with Minimum Data Set (MDS) Nurse # 1 and MDS Nurse # 2 on 4/26/23 at 3:39 PM, revealed that the floor Registered Nurse (RN) should have initiated a smoking care plan when the resident began smoking. They also revealed that because the Safe Smoking	F 656	and determined no negative consequences of resident smoking. The person centered care plan was updated along with the smoking assessment on 4/27/23 by the Minimum Data Set nurse. On 4/27/23 the DNS performed a 100% audit of all smokers to assure that each smoker had a smoking assessment and person centered care plan. On 4/27/23, the DNS completed a 100% audit of all Smoking Evaluations to determine if any other residents flagged for smoking and then compared this with the care plan. No additional variances were found. Any resident with the desire to smoke may be affected by this practice. The Administrator determined the Activities Department to be the process owner for smoking beginning 5/1/23. Going forward, the Activities Director will ensure completion of smoking assessment and care plan at the time of admission or when there is a change in smoking desire. The Minimum Data Set nurse will assure that care plans will be developed based on smoking assessment On 4/28/23, the Director of Clinical Education (DCE) completed education with nurses on accuracy of completing the clinical health assessment and as needed smoking evaluation. Beginning 4/28/23, the DNS will review all new admissions or readmissions in Clinical Start up to determine that their	

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F 656	Continued From page 14 Assessment was not completed there was no way for them to know that the resident needed a smoking care plan. An interview with the Director of Nurses (DON) on 4/26/23 at 3:50PM, confirmed that Resident #58 should have had a care plan for smoking needs and that the failure to care plan put Resident # 58 at risk for possible injury. Record review of Resident # 58's Admission Record revealed that the resident was admitted to the facility on 12/22/22, with diagnoses that include Acute on Chronic Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure, and Peripheral Vascular Disease, Unspecified.	F 656	desire to smoke has been evaluated. The Interdisciplinary Team (IDT)began meeting 5/2/23 every Tuesday and Thursday to review assessments and care plans for accuracy. To assure continued compliance, on 5/1/23, the Administrator began auditing smoking assessments and care plans are completed for all new admissions weekly x 4 and then monthly x 2 to assure that residents with the desire to smoke are identified and have person centered care plans for smoking. Any variance will be corrected immediately. This process improvement plan will be addressed in Quality Assurance Performance Improvement (QAPI) for a minimum of 3 months beginning with QAPI on 5/24/23 to assure continued compliance.	
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, staff interview, record review and facility policy review the facility failed to provide services to maintain hygiene for a resident who was dependent on the staff as evidenced by long nails with a brown substance under each nail and 1/4-inch-long gray hair on the resident's chin for one (1) of 111 resident's reviewed. Resident #1	F 677	The unit manager assessed resident # 1 on 4/25/23 and immediately assured the nails were trimmed and clean and the facial hair was removed. Education was initiated on 4/26/23 by the Director of Nurses (DNS) and Director of Clinical Education (DCE) to the Certified Nurse Aides (CNA) regarding care of nails and facial hair. This resident's care plan was	6/2/23

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F 677	Continued From page 15 Findings include: Review of the facility policy titled, "Nail Care" with no revision date revealed under, "Policy ...The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health." Also revealed under, "Policy Explanation and Compliance Guidelines:.. #3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. #4. Routine nail care, to include trimming and filing, will be provided on a regular schedule (such as weekly on Wednesday 3-11 shift). Nail care will be provided between scheduled occasions as the need arises..." Review of the facility policy titled, "Grooming a Resident's Facial Hair" with no revision date revealed under, "Policy ...It is the practice of this facility to assist residents with grooming facial hair to help maintain proper hygiene as per current standards of practice..." An observation on 4/25/23 at 10:56 AM, revealed Resident #1 had long, gray chin hairs extending approximately one-fourth (1/4) inch from the chin. Further observation revealed long, jagged fingernails on both hands extending approximately three-eight (3/8) inches from the tips of fingers with a brown substance underneath each nail. An interview and observation on 4/26/23 at 10:45 AM, with Certified Nurse Aide (CNA) #1 confirmed that Resident # 1 did have long chin hair, and that it should have been shaved. She also confirmed that Resident # 1's nails were long and did not look clean. She stated, "No, her nails haven't been cut or cleaned," and confirmed that	F 677	reviewed and updated by the DNS on 4/26/23. All residents are potentially affected by this practice The DNS assured that the nursing staff conducted a 100% audit on 4/26/23 of all residents to assess for facial hair and jagged nails Any residents identified with either unwanted facial hair or long/jagged nails immediately corrected. Going forward, systemic changes implemented on 4/28/23 to avoid this issue included implementing an environmental rounds check list to include observation of nails and facial hair. Any resident with log nails or facial hair should be evaluated immediately and corrected based on the resident's preferences. An in-service was conducted by the Administrator (ADM) on 4/28/23 with team members regarding updated environmental rounds along with implementation. CNAs education was initiated by the DCE on 4/26/23 regarding checking nails and facial hair as part of their daily care of residents. On 4/28/23, the Administrator began an audit of a minimum of 5 residents weekly then monthly x 2 months of residents to assure that facial hair is removed and nails are trimmed in accordance with the resident's wishes. This process improvement plan will be reviewed in Quality Assurance Performance	

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F 677	Continued From page 16 the resident could scratch her skin and cause an infection. She stated that the CNAs were responsible for cutting the resident's nails if the resident did not have diabetes and they are responsible for cleaning the residents' nails and should clean them during showers or whenever the nails become dirty. An interview and observation on 04/26/23 at 11:00 AM, with Registered Nurse (RN) #1 confirmed that the resident had long nails with a brown substance underneath and confirmed that the resident had long gray hair on her chin. She confirmed that Resident # 1 is not a diabetic, and the CNAs were responsible for trimming and cleaning the nails of a non-diabetic resident. She stated that the nurses usually follow up at the end of the day to ensure the nail care was performed. She revealed long dirty nails could cause infection and be a safety hazard to the resident. Record review of Resident #1's Admission Record revealed the resident was admitted to the facility on 09/27/2017 with medical diagnoses that included Unspecified Psychosis Not Due to a Substance or Known Physiological Condition and Anxiety Disorder. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/16/23 revealed under section C a Brief Interview for Mental Status (BIMS) score of 11, which indicated Resident #1 is moderately impaired and under section G, the resident requires one (1) person physical assistance with personal hygiene.	F 677	Improvement (QAPI) for a minimum of 3 months beginning with QAPI on 5/24/23 to assure continued compliance.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		6/2/23

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F 689	Continued From page 17 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review and facility policy review the facility failed to perform a safe smoking assessment for one (1) of five (5) residents reviewed for smoking. Resident #58 Findings include: Review of the facility policy titled, "Smoking Policy", with an effective date of May 1, 2021, revealed under "Purpose 1. To maximize our ability to provide a safe environment for all residents, visitors, and staff. 2. To perform assessments, which determine a resident's ability to smoke safely and determine what, if any, additional measures are needed to protect residents from possible self-inflicted injury due to smoking habits...Procedure 1. Upon admission, quarterly, and with any change in condition, it is to be determined by the nurse if the resident requires supervision while smoking. Utilize the "Safe Smoking Assessment..." An interview with Resident #58 on 4/26/23 at 3:00 PM, verified that she was a smoker but was unsure when she began smoking again.	F 689	On 4/26/23 the Director of Nurses (DNS) assessed resident #58 smoking habits and determined no negative consequences of resident smoking. The person centered care plan was updated along with the smoking assessment on 4/27/23 by the Minimum Data Set nurse. On 4/27/23 the DNS performed a 100% audit of all smokers to assure that each smoker had a smoking assessment and person centered care plan. On 4/27/23, the DNS completed a 100% audit of all Smoking Evaluations to determine if any other residents flagged for smoking and then compared this with the care plan. No additional variances were found. Any resident with the desire to smoke may be affected by this practice. The Administrator determined the Activities Department to be the process owner for smoking beginning 5/1/23. Going forward, the Activities Director will ensure completion of smoking assessment and care plan at the time of admission or when there is a change in	

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F 689	Continued From page 18 An interview with the Director of Nurses (DON) on 4/26/23 at 3:20 PM, revealed that the floor nurse should have completed a safe smoking assessment for Resident #58. An interview with Registered Nurse (RN) #1 on 4/26/23 at 3:35 PM, revealed that she completed the Clinical Health Status Evaluations if they were due when she was on duty. She revealed that it contained a question about smoking and if the resident smokes the Safe Smoking Assessment should be completed. She does not recall when Resident # 58 started smoking. An interview with the Minimum Data Set (MDS) Nurse # 1 and MDS Nurse # 2 on 4/26/23 at 3:39 PM, revealed that the Clinical Health Status Evaluation is completed on admission and quarterly in conjunction with the MDS, by the floor RN. They both revealed that if a resident smokes it should be indicated on the evaluation. They revealed that when Resident # 58 was admitted to the facility on 12/22/22 she was too sick to smoke, and they knew that she was not smoking at that time but were not aware that Resident # 58 had begun smoking and did not know when she started smoking. They also revealed that when Resident # 58 started smoking the floor RN should have completed a safe smoking assessment. An interview with the DON on 4/26/23 at 3:50 PM, confirmed that Resident #58 should have been assessed for safe smoking and that failure to assess Resident # 58 for safe smoking could have put Resident # 58 at risk for injury. A record review of Resident #58's Clinical Health Status Evaluation, completed on 3/29/23 in	F 689	smoking desire. The Minimum Data Set nurse will assure that care plans will be developed based on smoking assessment On 4/28/23, the Director of Clinical Education (DCE) completed education with nurses on accuracy of completing the clinical health assessment and as needed smoking evaluation. Beginning 4/28/23, the DNS will review all new admissions or readmissions in Clinical Start up to determine that their desire to smoke has been evaluated. The Interdisciplinary Team (IDT)began meeting 5/2/23 every Tuesday and Thursday to review assessments and care plans for accuracy. To assure continued compliance, on 5/1/23, the Administrator began auditing smoking assessments and care plans are completed for all new admissions weekly x 4 and then monthly x 2 to assure that residents with the desire to smoke are identified and have person centered care plans for smoking. Any variance will be corrected immediately. This process improvement plan will be addressed in Quality Assurance Performance Improvement (QAPI) for a minimum of 3 months beginning with QAPI on 5/24/23 to assure continued compliance.	

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F 689	Continued From page 19 conjunction with the Quarterly MDS, revealed under Respiratory/Cardiovascular section, question number three (3)." Does resident smoke" was left unanswered. A record review of the list of smokers in the facility confirmed that Resident # 58 was a smoker. A record review of Resident # 58's medical record revealed there was no assessment by a qualified professional to determine if Resident #58 could safely smoke. A record review of Resident # 58's Admission Record revealed that the resident was admitted to the facility 12/22/22, with diagnoses that include Acute on Chronic Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure and Peripheral Vascular Disease, Unspecified. A record review of Resident # 58's Minimum Data Set with an Assessment Reference Date (ARD) of 3/29/2023, revealed in Section C a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident had moderate cognitive impairment.	F 689		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or	F 742		6/2/23

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F 742	Continued From page 20 post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, the facility failed to develop a person centered care plan for Post Traumatic Stress Disorder (PTSD) for one (1) of 23 care plans reviewed, Resident # 66. Findings include: Review of the facility policy titled, "Comprehensive Care Plan" revealed under, "Practice Guidelines: #1. The interdisciplinary care plan is implemented to guide health care center staff in the provision of necessary care and services to obtain and maintain the highest practicable physical, mental, and psychosocial well-being of the resident and promotion of the resident and family in planning care...#3. Interdisciplinary team communicates mental and psychosocial problems, needs, and concerns to the care planning team for inclusion in the overall plan of care." Resident #66 Review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/24/23 revealed in section I a diagnoses of Post-Traumatic Stress Disorder (PTSD) and in section C a Brief Interview for Mental Status (BIMS) score of 15, which indicates Resident # 66 is cognitively intact. An interview with Resident # 66 on 4/26/23 at 10:20 AM, revealed that she requested to see her	F 742	On 4/26/23 The Director of Nurses (DNS) immediately assessed resident #58 and determined no negative effects of lacking a careplan for her Post Traumatic Stress Disorder (PTSD). On 4/26/23, the Minimum Data Set (MDS) nurse developed a care plan for PTSD for this resident. Education was provided to the MDS nurses by the DNS on 4/26/23 regarding the need to complete care plans on admission for any resident admitted with a PTSD or other traumatic diagnosis. Immediate actions to identify others that may have been potentially affected by this practice included a 100% audit of all residents by the DNS on 4/26/23 with a diagnosis of PTSD or who experienced other reported traumatic event. Any resident has the potential to be effected by this practice. Systemic approaches to avoid this practice from occurring again includes reviewing the diagnosis and clinical health status of any new resident to identify those residents with a prior PTSD diagnosis or other history of a traumatic event. The admission nurse will review each referral beginning on 4/28/23, for any evidence of documented trauma and alert	

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F 742	Continued From page 21 personal (out of the facility) psychiatrist for counseling and medication management. She stated," I think I'm doing okay right now." An interview with Social Services (SS) #1 on 4/26/23 at 2:20 PM, revealed that Resident #66 does receive psychiatric services but cannot recall if the resident had a diagnosis of Post Traumatic Stress Disorder (PTSD) without reviewing the chart. She revealed she addresses PTSD on the social history evaluation she does on admission. She revealed she identifies the history/symptoms of trauma and potential triggers by speaking with the resident and family. She revealed she does not do the care plans related to PTSD and is unsure who in the facility does. An interview with the Director of Nursing (DON) on 4/26/23 at 2:45 PM, confirmed that Resident #66 does have a diagnosis of PTSD and does not have a care plan for PTSD. She revealed that it was important for the resident to have a care plan for PTSD so that staff can be aware of the symptoms and potential triggers and help determine possible coping mechanisms. She revealed social services should have initiated the care plan, and the MDS nurse should ensure the care plan was complete and accurate. She revealed that they all work together as a team to get a complete comprehensive care plan. She revealed that Resident # 66 does see a personal psychiatric doctor routinely. An interview on 4/26/23 at 4:30 PM, with the Director of Nurses (DON) revealed she spoke with Resident #66's daughter and discovered that the residents PTSD came from a childhood experience and domestic violence. She revealed that the daughter informed her that the triggers	F 742	the nursing staff. The social worker will report any identified trauma obtained during her social work history. The interdisciplinary team were educated on 4/28/23 by the Administrator and DNS regarding identification of a PTSD diagnosis and other reported trauma. The IDT began meeting every Tuesday and Thursday on 5/2/23 to review assessments and care plans for the week based on the MDS schedule To assure continued compliance, on 5/1/23, the Administrator will assure an audit is completed weekly x 4 weeks and then monthly x 2 of new residents to assure we care plan any PTSD and other traumatic event. Any negative variance will be addressed immediately. This process improvement plan will be addressed in Quality Assurance Performance Improvement (QAPI) for a minimum of 3 months beginning with QAPI on 5/24/23 to assure continued compliance	

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F 742	Continued From page 22 for the resident included, that it was important to the resident that staff always knock on her door, the resident prefers female staff and loud noises and crowds are also triggers. The DON confirmed the importance of the resident needing a PTSD care plan to include these triggers so that staff would be aware while supplying care. Review of Admission Record revealed Resident #66 was admitted to the facility on 12/22/20 with diagnoses that included Unspecified Dementia, unspecified severity, with other behavioral disturbance, Post-Traumatic Stress Disorder, unspecified, Major Depressive Disorder, recurrent, unspecified, Schizoaffective Disorder, bipolar type, Bipolar Disorder, current episode depressed, mild or moderate severity, unspecified.	F 742		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		6/2/23

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F 880	Continued From page 23 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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	255117	A. BUILDING _____ B. WING _____	04/27/2023

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F 880	Continued From page 24 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review the facility failed to prevent the possible spread of infection as evidenced by staff failed to sanitize a multi-use resident blood pressure cuff after each use, sanitize a multi-use stethoscope prior to use, to sanitize hands after administering eye drops and prior to administering percutaneous endoscopic gastrostomy (PEG) medication, and failed to rinse and dry a PEG tube syringe after use to prevent the growth of bacteria for two (2) of five (5) residents reviewed during medication and treatment administration. Resident #65 and Resident #91. Findings include: Review of the facility's policy titled, "Infection Control," with an effective date of 11/1/2017, revealed under "Policy Statement ... This Center's infection control policies and practices are intended to facilitate maintaining a safe sanitary environment and to help prevent and manage transmission of diseases and infections...Interpretation and Implementation:... 2.) Objectives: a.) Establish guidelines for implementing Isolation precautions, including standard precautions...Standard Precaution: All residents ... Hand Hygiene before and after every	F 880	Immediate interventions involved the Director of Nurses (DNS) assessing both residents #65 and #91 and no negative consequences were noted related to infection control. The nurse(s) failing to maintain infection control guidelines were educated on a 1:1 basis by the DNS on 4/27/23. All residents in the Center are potentially affected by this break in practice. The DNS, Assistant DNS (ADNS) and the Director of Clinical Education completed competency evaluations on nurses to determine who needed additional training due to a breach in infection control guidelines beginning 4/27/23 and continuing to 5/19/23 until 100% of nurses educated on infection control procedures during med-pass, 100% of nurses educated on hand hygiene, 100% updated competencies for all nurses for med-pass and peg syringe care and storage, as well as 100% 1:1 in-servicing provided with nurses On 4/27/23 nurses received education by DNS and DCE on infection control guidelines to include, medication pass,	

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F 880	Continued From page 25 resident contact ...Safe disposal or cleaning of instruments..." Review of the facility's policy titled, "Cleaning and Disinfection of Resident-Care Equipment," with no revision date revealed, "Policy: Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC (Centers for Disease Control) recommendations in order to break the chain of infection...Definitions: Reusable single-resident items are items that may be used multiple times, but for one resident only ...Reusable multiple-resident items are items that may be used multiple times for multiple residents. Examples include stethoscopes and blood pressure cuffs ...Policy Explanation and Compliance Guidelines:..3 d.) Multi-resident use equipment shall be cleaned and disinfected after each use..." A review of the manufacturer guidelines provided by the facility of the peg tube syringe used by the facility revealed, "The-Pole-Syringe Irrigation Syringe," Instructions: 5.) Rinse syringe thoroughly with hot water after use..." A review of the facility's performance checklist titled, "Administering Enteral Nutrition: Gastrostomy," revealed Implementation:..2.) Performed hand hygiene, applied clean gloves ... A review of the facility's performance checklist titled, "Instilling Eye Medications," revealed Implementation:... 7.) Instilled eye medications:.. b). removed gloves and performed hand hygiene ...	F 880	handy hygiene, cleaning of equipment and storage of percutaneous syringes. Return demonstration of collected to assure competency. Beginning 5/1/23, the DCE will conduct competency evaluation on all newly hired nurses and other nurses on a minimum of an annual basis. To assure continued compliance of corrective action, on 4/28/23, the DNS began weekly audits of at least 2 nurses per week x 4 weeks and then monthly x 2 months. Any break in infection control will result in immediate education of staff. Beginning 5/1/23, the Administrator (ADM) will assure that the DCE is competing competency evaluations of nursing staff on hire and then at a minimum annually thereafter. The corrective action process will be addressed in Quality Assurance Performance Improvement (QAPI) for a minimum of 3 months beginning with QAPI on 5/24/23 to assure continued compliance	

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An observation of medication administration with Licensed Practical Nurse (LPN) #1 on 4/26/23 at 7:30 AM, revealed LPN #1 took a blood pressure for Resident #65 using a multi-resident use machine and then pushed the device back out in the hallway. LPN #1 then administered eye drops to Resident #65, then stepped in the hallway and asked the Maintenance Director to get her a stethoscope. The Maintenance Director returned and gave the stethoscope to LPN #1 who then began to check PEG tube placement and administer medications via PEG wearing the same gloves she wore when administering eye drops. Observation by the State Agent (SA) revealed LPN #1 failed to sanitize the multi-use blood pressure cuff after use, sanitize her hands after administering the eye drops, disinfect the multi-use stethoscope before use, sanitize hands prior to administering peg tube medications, and failed to rinse and dry tube feeding syringe after use to prevent growth of bacteria from wet nesting.

An observation of medication administration with LPN #2 on 4/26/23 at 8:40 AM, revealed LPN #2 obtained the blood pressure of Resident # 91 using a multi-resident use machine, LPN #2 then sanitized her hands and pushed the multi-resident use machine back to the desk and plugged it in. The SA observed no disinfection of the blood pressure machine after use.

An interview with LPN #1 on 4/26/23 at 8:00 AM, she confirmed she did not disinfect the multi-resident use blood pressure cuff after use, she also confirmed she failed to sanitize her hands after administering the eye drops and prior to administering PEG medications. LPN #1 went

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on to confirm she should have sanitized the stethoscope prior to checking peg placement because she could not verify that it was already cleaned before use and confirmed she should have rinsed and dried the PEG tube syringe to prevent growth of bacteria from being in a wet moist place. LPN #1 went on to reveal failing to disinfect multi-use equipment puts the staff and other residents at risk for cross contamination and increased risk of infections.

An interview with the Maintenance Director on 4/26/23 at 8:20 AM, confirmed he got a stethoscope that was lying on top of the nurse's desk for LPN #1 but verified he did not know if it had been sanitized or not.

An interview with LPN #2 on 4/26/23 at 8:50 AM, confirmed she failed to sanitize the multi-use blood pressure machine after using it, and revealed concerns of failing to sanitize multi-use equipment could cause cross contamination of bacteria to other residents and staff which could cause infections.

An interview with the Infection Control (IC)/Clinical Instructor on 4/26/23 at 10:57 AM, revealed all multi-use equipment is to be cleaned before and after each use to prevent transmission of infections between residents and confirmed the PEG tube syringes should be rinsed with water and dried before storing to prevent wet nesting setting up bacteria. IC/Clinical instructor also confirmed hand sanitation should have been performed between medication administration to different routes and revealed a concern from not sanitizing hands between different routes is transfer of bacteria from one area of the body to another causing infection.

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F 880	Continued From page 28 An interview with the Director of Nursing (DON) on 4/26/23 at 1:10 PM, confirmed a PEG tube syringe would be considered a reusable single-resident item and should be rinsed, dried, and stored in a bag after every use. She also confirmed the facility did not have a policy that states to clean and dry PEG syringe, but they will be updating the policy and revealed a concern of improper cleaning of equipment and hand washing increases the risk of infection. Record review of Resident #65's Admission Record revealed the resident was admitted to the facility on 3/20/22 with diagnoses of Acute or Chronic diastolic congestive heart failure, Atrial Fibrillation, and Hemiplegia following a cerebral Infarction. Record review of Resident #91's Admission Record revealed that the resident was admitted to the facility on 2/17/23 with diagnoses of Heart Failure, Type 2 Diabetes, and Schizophrenia.	F 880		