STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25E115	A. BUILDING _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE RETIREMENT HOME	209 OAK CIRCLE DUNCAN, MS 38740

(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 re-certification survey at the facility from 4/10/2023 to 4/13/2023. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA identified non-compliance and cited F 584, F 604, F 644, F 656, F 678, F 757, F 812, and F 880 . The census at the time of the survey was 60 and the facility is licensed for 60 beds.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		5/25/23

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

Electronically Signed | 05/09/2023

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F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review and facility policy review the facility failed to replace a broken overbed table for one (1) of 60 residents reviewed. Resident #40 Findings Include: Record review of the facility policy, "Preventive Maintenance or Resident Equipment Policy and Procedure", without a date, revealed, "Purpose: To provide a safe environment for residents and to meet safety guidelines. Policy: It is the job of all staff to identify areas of concern regarding the maintenance of resident equipment and the building. Procedure: 1. Preventative maintenance will occur throughout the year...4. Any concerns with resident equipment or maintenance of the facility will be reported to the Maintenance Supervisor or Administrator to address in a timely manner.."	F 584	F 584. Safe/Clean/Comfortable/Homelike Environment. 1. On 4/11/2023, the damaged overbed table was removed from the resident□s room and replaced with a new overbed table by Maintenance. On 4/11/2023, Administrator inserviced all staff on removal and notifying Maintenance on any broken or damaged equipment. On 4/11/2023, Maintenance was in-service on daily rounds with documentation in the maintenance log booklet, removal of damaged equipment, and notification of Administrator on items that need to be replaced. 2. All residents have potential to be affected by this deficient practice. 3. Measure put in place to ensure the alleged deficient practice does not reoccur. a) On 4/11/2023, Administrator provided	

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F 584	Continued From page 2 An observation on 04/10/23 at 6:50 PM, revealed that Resident #40's bedside table was in disrepair. The tabletop was leaning downward, to the right approximately 15 degrees. Resident #40 had his personal items and water cup pushed to left side of the table in attempt to prevent the items from sliding off of the table. An observation on 4/11/23 at 9:15 AM, revealed that the Resident #40's overbed table continued to lean downward, to the right approximately 15 degrees. During an interview on 4/11/23 at 9:15 AM, Resident #40 revealed he thought someone put something heavy on his table and it had been leaning for a couple of days. During an interview and observation with Licensed Practical Nurse (LPN) #2 on 4/12/23 at 9:20 AM, she revealed that if she notices or receives notification of a piece of equipment that is broken or in disrepair, she would remove it from the room and notify maintenance. LPN #2 verified that the overbed table in Resident #40's room was broken and should have been removed from the room and replaced. She confirmed that the resident's belongings and meal tray could fall off the table. In an interview with CNA #2 at on 4/12/23 at 9:21 AM, he revealed that he put Resident #40's meal tray on the table and did not even notice that the table was leaning, he stated it should be removed because the resident's belongings or meal tray could fall onto the floor. In an interview with the Maintenance staff on 4/12/23 at 9:30 AM, he confirmed that the table	F 584	an in-service with all staff including Maintenance on the Maintenance log booklet, located at the nurse□s station, where staff will document any equipment or issues with equipment b) On 4/14/2023 Maintenance begin using the book and will review and sign off the log booklet daily. c) On 4/14/2023, Administrator will review the maintenance log booklet weekly 4. On 4/11/2023, The Maintenance Director will be responsible and ensure the deficient practice On 4/14/2023 The Administrator will monitor the book weekly x 8 weeks or until compliance is met to ensure maintenance needs are being completed. Any negative findings will be reported 5/10/2023 to Administrator for Quality Assurance monthly and quarterly for 6 months basis to review findings and make recommendations for changes and/or revisions as needed	

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F 584	Continued From page 3 should have been replaced. During an interview with the Administrator on 4/12/23 at 9:50 AM, she stated that maintenance makes monthly rounds on rooms to check call lights and beds and that if anything is noted they should add it to their list and make sure it is fixed. During an interview with the Administrator on 4/13/2023 at 12:00 PM, she confirmed that staff should have noticed Resident #40's table was broken and replaced it immediately. A record review of Resident #40's Admission Record revealed he was admitted to the facility on 12/31/2019 with diagnosis of Unspecified Psychosis not due to substance or known psychological condition and Paranoid Schizophrenia. The record review of Resident #40's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/21/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicates no issues with cognitive status.	F 584		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 604		5/25/23

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F 604	Continued From page 4 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record and policy review the facility failed to ensure residents were free from physical restraints for one (1) of 60 residents reviewed. Resident #26. Findings Include: Record Review of the facility policy titled, "Restraint Devices, Physical Policy and Procedure" without a date, revealed, "Purpose: ... 3. Restraints of any type will not be used as punishment or as a substitute for more effective medical and nursing care or for the convenience of the facility staff... Policy: Restraints are to be used as ordered by the physician. Procedure: 1. Assess the resident's need for least restrictive restraint/safety device use... 2. Obtain informed	F 604	F 604. Right to be Free from Physical Restraints. 1. Correction action accomplished for alleged deficient practice: On 4/11/2023, resident #26 was assessed by Director of Nursing and the long bedrail was removed, no negative findings noted. a) On 4/11/2023,Director of Nursing completed a 100% audit was completed and all siderails were removed from beds that were not ordered by Director of Nursing and Maintenance. On 4/11/2023, the medical director was notified of the need to have a 1/4 inch rail to allow the resident to assist in turning in the bed to help staff with care. A new physician order was obtained, consent	

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F 604	Continued From page 5 consent for restraint device use... 3. Obtain physician's order for safety device..." An observation on 4/10/23 at 7:15 PM, revealed Resident #26 was in the bed with his eyes closed. The right side of bed against the wall with a side rail the length of the bed raised on the left side of the bed. An observation and interview on 4/11/23 at 8: 20 AM, with Resident #26 revealed, he was sitting up in bed eating breakfast, right side of bed was against the wall, with a side rail the length of the bed, raised on the left side of the bed. When Resident #26 was asked if he knew why he had the side rail up he stated, " I don't know, thank you." An observation on 4/12/23 at 10:00 AM, revealed sitting up in bed with the right side of bed against wall, and a side rail the length of the bed, remained raised on the left side of the bed. During an interview and observation with Licensed Practical Nurse (LPN) #1 on 4/12/23 at 10:45 AM, she verified that Resident # 26's bed was against the wall on the right side and that a full side rail, the length of the bed, was in use on the left side of the bed. She revealed that she did not know why the side rail was up. LPN #1 stated that with the bed against the wall on one side, and a full side rail up on the other side, it could be considered a restraint. She stated that the resident could get wedged between the mattress and injure an arm or leg. During an interview on 4/12/23 at 10:50 AM, with Certified Nursing Assistant #1 (CNA) he stated that Resident #26 should not have had the side	F 604	was obtained, assessment completed, care plan was completed, and a new 1/4 inch rail was placed on the left side of the bed. On 4/11/2023, a 100% audit was completed for restraints, siderails, orders, consents, assessments. On 4/11/2023, Director of Nursing provided nursing staff in-service on restraints, residents who have restraints and the type of restraints. 2. All residents have potential to be affected by this deficient practice. 3. Measure put in place to ensure the alleged deficient practice does not reoccur. a)On 4/11/2023, Administrator/Director of Nursing in-service to all nursing staff and maintenance on side rail vs assistance bar procedure. On 4/11/2023, Maintenance instructed by Administrator siderails will only be placed on beds with an ordered. In the event of a room change, beds will be assessed to ensure rails remain as indicated by orders. 4.On 4/11/2023, Director of Nursing will make weekly rounds to assess siderail use within the facility weekly x 8 wks or until compliance is met. 5. Any negative findings will be reported to Administrator for Quality Assurance 5/10/2023 monthly and quarterly for 6 months review findings and make recommendations for corrections.	

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F 604	Continued From page 6	F 604		

rail up. He stated that he put the side rail down this morning and did not know who put it up.

During an interview with the Director of Nursing (DON) on 4/12/23 at 10:54 AM, she stated Resident #26 was using the side rail for bed mobility and that he could help staff turn him by pulling on the side rail. She stated he had a full side rail on the bed because that was probably the only rail they had.

An interview with the Minimum Data Set (MDS) nurse on 4/13/23 at 8:25 AM, revealed that she uses the Physician's orders to determine if a side rail assessment and care plan are needed. She confirmed that Resident #26 did not have a physician's order for side rails.

During an interview with the DON on 4/13/23 at 8:27 AM she verified that Resident #26 should have had a consent, physician's order, side rail assessment and care plan for the full side rail on his bed prior to 4/12/23.

During an interview with the Administrator on 4/13/23 at 12:20 PM, she confirmed that with the bed against the wall on one side and a full side rail on the other side of the bed, it could be considered a restraint, especially with no consent, physician's order, or care plan. She stated that the bed rail was 78 inches long.

Record review revealed no consent for side rail use, no physician's order for side rail use, no side rail assessment, and no care plan was developed for the full side rail until 4/12/23.

Record review of Resident #26's Admission Record revealed he was admitted to the facility on

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F 604	Continued From page 7 6/16/2017 with diagnoses that included Cerebral Infarct, Unspecified Dementia, and Hemiplegia and Hemiparesis after Cerebral Infarct Affecting Left Non-Dominant Side. Record review of Resident #26's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/7/23, Section C, Brief Interview for Mental Status (BIMS) score is 11, indicating moderately impaired cognition. Section G, Physical Function, Bed Mobility is extensive assistance of two (2) staff members.	F 604		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review the facility failed to submit a	F 644	F 644. Coordination of PASARR and Assessments.	5/25/23

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F 644	Continued From page 8 change in status referral for a Level II resident review related to a new diagnosis of Hallucinations and Mood Disorder with Major Depressive like episode for one (1) of six (6) residents reviewed. Resident #44 Findings include: Review of the facility's policy titled "Pre-Admission Screening and Resident Review (PASRR) Policy and Procedure", undated, revealed, "Purpose :To ensure completion of Pre-Admission Screening and Resident Review (PASRR) level two evaluations to assess the need for facility placement and service, including planning and facilitation of behavioral health services...Policy: The facility is to review resident diagnosis and medications upon admission and throughout the resident stay to determine if a level two request for resident review is to be completed ...Procedure: ...2. Referring all level II residents and all residents with a newly evident or possibly serious mental disorder, intellectual disability, or a related condition for a level II resident review upon a significant change in status assessment ...5. A Resident Review for level II evaluation should be considered for the following residents: a. Residents with Tier one diagnosis (Schizophrenia, Bi-Polar d/o (disorder), Major depressive d/o, Schizoaffective or other Psychotic d/o) or Tier two diagnosis (Depression , Anxiety/Panic d/o ,Obsessive compulsive d/o, Delusional d/o, Trauma related disorder/PTSD (Post traumatic stress disorder) , Somatoform or Personality d/o) is to have a completed resident review form according to OBH (Office of Behavioral Health) guidance ...c. The resident has a new mental diagnosis, which will not normally resolve itself once the condition	F 644	1. Correction action accomplished for alleged deficient practice: On 4/11/2023, Director of Nursing assessed Resident # 44 with no further negative findings. . On 4/11/2023, Director of Nursing completed reviewed all of charts of deficit residents was reviewed, the Mississippi Division of Medicaid was contacted for education related to Preadmission Screening and Resident Review and level II trainings; training scheduled for 6/12/2023 for administrator, social director. 2. All residents have potential to be affected by the deficient practice. 3. Measures put in place to ensure the alleged deficient practice does not reoccur. a) On All residents with a behavior change, diagnosis change, or conditions changes related hospital admissions to psychotic conditions will have a Level II completed., starting on 4/14/2023 by Director of Nursing and Social Service. b) Social Director will make daily visits x6 weeks and discuss and findings in morning standup for directions on addressing, beginning 4/14/2023 4. Social Director will make daily visits with residents and discuss and findings in morning standup for directions on addressing, beginning 4/14/2023 The Administrator will report findings to the Quality Assurance Committee Quality Assurance 5/10/2023 monthly and quarterly for 6 months will review findings and make recommendations for changes and/or revisions as needed.	

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F 644	Continued From page 9	F 644		

stabilizes ..."

A record review of Resident #44's diagnosis list revealed a new diagnosis after admission to the facility on 10/6/2020 of Mood Disorder with Major Depressive like episode with an onset date of 1/29/21 and Hallucinations with an onset date of 6/3/21.

An interview with the Administrator on 4/12/23 at 8:20 AM, revealed she or the social worker were responsible for doing the PASRR on admission and revealed she was unaware that with a change in mental diagnosis or new diagnosis that she was required to submit a new change of status form for a Level II resident review. The Administrator confirmed that she had not been doing that.

An interview with the Administrator on 4/12/23 at 3:30 PM confirmed there are no other PASRR' s for Resident #44 other than the initial one completed on 10/07/2020 and confirmed there should have been a change in status request for a Level II when the resident received the new mental disorder diagnoses after admission.

An interview with the Social Worker on 4/13/23 at 9:00 AM revealed a change in status request for a Level II review should be completed if a new mental diagnosis or psychotropic medication is received. She revealed the purpose of a level II PASRR is it can provide extra instruction and services for the resident with specific individualized care and if the PASRR or change in status request is not completed the resident may miss services offered and recommended.

An interview with the Administrator on 4/13/23 at

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11:25 AM revealed the facility has a standup meeting every morning during the week, discuss all new orders including new diagnosis, and after the Psych Nurse Practitioner makes rounds all of her notes and recommendations are reviewed.

A record review of psychiatric evaluation dated 1/29/23 revealed a new diagnosis of Mood Disorder due to unknown physiological condition with depressive features, and a new order for Zoloft 25 milligram (mg) every morning for depression and anxiety with the Rationale: patient experiencing depression and anxiety.

A record review of the psychiatric evaluation dated 6/3/21 revealed a diagnosis of Mood Disorder due to unknown physiological condition with depressive features, Anxiety due to known physiological condition, and rule out unspecified psychosis of unknown physiological condition. Summary of the visit revealed Resident #44 saw a "Neuro" (Neurologist) on 5/21/21 and was started on Seroquel 25 mg at bedtime for suspected AVH (Auditory Visual Hallucinations).

Record review of the Admission Record revealed the facility admitted Resident #44 to the facility on 10/06/20 with diagnoses of Vascular Dementia with behavioral disturbance, Cerebral Vascular Disease, and Ataxia following Cerebral Vascular Disease.

Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 3/23/23, revealed that Resident # 44 had a Brief Interview of Mental Status (BIMS) score of 02 which indicated that he was severely cognitively impaired. Section E coded 0-Behaviors not exhibited.

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for 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	F 656		5/25/23

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F 656	Continued From page 12 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and policy review the facility failed to develop and implement care plans for behavior and side effect monitoring for a residents with mental disorders and received psychotropic medications and for a resident with side rails for three (3) of 26 residents care plans reviewed. Resident #4, #26, #44 Resident #4 Findings include: A record review of the facility policy, titled, "Care Plan Policy and Procedure", with no date, revealed Purpose: To provide a comprehensive person-centered plan of care addressing resident's needs, strengths, goals, and approaches. Policy: Each resident's care plan will remain current and inform staff of resident's needs, strengths, goals, and approaches. Procedure: ...2 a. It is the policy of this facility to utilize an advanced care planning approach to review and determine patient centered care plans based on the following areas... v. ADL Needs... XI. Services furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being... A record review of the Order Summary dated	F 656	F656. Develop/Implement Comprehensive Care Plan 1. Correction action accomplished for alleged deficient practice: On 4/11/2023, residents #4,#26, #44 charts were reviewed by Minimum Data Set Nurse and Director of Nursing, and care plan developed for siderails, behavior, and side effect monitoring in place. a) On 4/11/2023, Director of Nursing correction made to medical director orders and Kardex for certified nursing assistant related to side rail use. 2. All residents have potential to be affected by this deficient practice. 3. Measure put in place to ensure the alleged deficient practice does not reoccur. a)Minimum Data Nurse Nurse will update care plans and individualized according to residents with all changes and during each MDS quarterly, annual, admission, or significant change reviews, beginning 4/14/2023 b)Weekly Interdisciplinary Team meetings to include psychotropic medicines with behavior and side effect monitoring and restraints will be completed with care plans updated at	

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F 656	Continued From page 13 4/12/23 and the Electronic Medication Administration Record (EMAR) for Resident #4 revealed Klonopin Tablet 0.5 MG at bedtime related to anxiety disorder unspecified ...Seroquel 150 mg by mouth at bedtime related to Unspecified psychosis ... Zoloft 125 mg one time daily for anxiety disorder. State Agency (SA) found no monitoring for side effects of the Psychotropic medications or behaviors related to Resident #4's mental illness diagnoses. An interview with Licensed Practical Nurse (LPN) #2 on 4/12/23 at 2:56 PM, revealed that if staff are not documenting the targeted behaviors or monitoring of side effects the staff are not following the plan of care. A record review of the Comprehensive Care plans for Resident #4 revealed no care plan was developed to address the monitoring of specific targeted behaviors related to the resident's diagnosis of Psychosis, Anxiety, Schizophrenia Delirium and Delusional Disorder. A record review of the care plan titled, "The resident uses ANTI-ANXIETY medications," with a revision date of 1/23/23, revealed "Goal: The resident will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review date...Interventions: Administer Anti-Anxiety medications as ordered by physician. Monitor for side effects and effectiveness Q -SHIFT (every shift)... Monitor/document/report PRN(as needed) any adverse reactions to ANTI-ANXIETY therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea,	F 656	each meeting beginning 4/17/2023 4. 4/14/2023,The Minimum Data Set nurse will monitor weekly x 8 weeks or until compliance is met and ensure the deficient practice does not reoccur by completing care plans with updates from new physician orders, findings during morning standup, weekly IDT meetings, daily clinical meetings. On 4/14/2023 Director of Nursing will follow up daily with clinical care plan logs pulled each morning for review in standup. The Administrator will report findings to the Quality Assurance Committee 5/10/2023 monhtly and quarterly for 6 months Quality Assurance will review findings and make recommendations for changes and/or revisions as needed	

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stomach upset, blurred or double vision. UNEXPECTED SIDE EFFECTS: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations"...

A record review of the care plan titled, "The resident uses antidepressant medication," with a revision date of 1/23/23, revealed "Goal: "The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date ...Interventions: Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT...Monitor/document/report PRN adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL(activities of daily living) ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, (weight)wt. loss, n/v(nausea/Vomiting), dry mouth, dry eyes'...
A record review of the care plan titled, "The resident uses psychotropic medications," with a revision date of 1/23/23, revealed "Goal: The resident will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date...Interventions: Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Monitor/document/report PRN any adverse reactions of PSYCHOTROPIC medications:

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unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person" ...

Record review of the Admission Record revealed that the facility admitted Resident #4 to the facility on 8/06/20 with diagnoses of Psychosis unspecified, Anxiety disorder, Schizophrenia Delirium, and Delusional Disorder.

Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 1/26/23, revealed that Resident #4 was rarely/never understood. Section E revealed verbal behavioral symptoms directed toward others one to three days during the reference period.

Resident #26

An observation on 4/10/23 at 7:15 PM, revealed Resident #26 was in bed, with his eyes closed, the right side of the bed against the wall with a side rail the length of the bed raised and in use on the left side of the bed.

A record review of Resident #26's care plan revealed Focus: The resident has an activities of daily living (ADL) self-care performance deficit related to (r/t) impaired...revised on 3/16/2023. Goal: The resident will... Interventions: ...MAY HAVE 1/4 SIDE RAIL FOR POSITIONING AND ASSISTANCE WITH TURNING EVERY SHIFT FOR POSITIONING AND TURNING...with an

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initiation date of 4/11/2023.

An interview with the Minimum Data Set (MDS) nurse on 4/13/23 at 8:25 AM revealed that she is responsible for updating resident care plans and uses the Physician's orders to determine if a side rail assessment and care plan are needed. She stated Resident #26 did not have a care plan regarding side rail use because he did not have an order for the side rail.

During an interview with the Director of Nursing (DON) on 4/13/23 at 8:27 AM, she verified that Resident #15 did not have a care plan for the use of a side rail on his bed prior to 4/11/23, but that he should have.

Record review of Resident #26's Admission Record revealed he was admitted to the facility on 6/16/2017 with diagnoses that included: Cerebral Infarct, Unspecified Dementia, and Hemiplegia and Hemiparesis after Cerebral Infarct Affecting Left Non-Dominant Side.

Record review of the MDS with and an Assessment Reference Date (ARD) of 2/7/23, Section C, Brief Interview for Mental Status (BIMS) score was 11, indicating moderately impaired cognition. Section G, Physical Function, Bed Mobility is extensive assistance of two (2) staff members.

Resident #44

A record review of the Order Summary Report dated for Resident #44 revealed, Seroquel 37.5 mg by mouth at bedtime related to unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance,

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Mood Disorder, and Anxiety ... Seroquel 12.5 mg every morning related to Hallucinations ...Zoloft 125 mg daily for Major Depressive Disorder. The SA found no monitoring for side effects or monitoring for targeted behaviors in the Order Summary or in the MAR.

A record review of the Comprehensive care plans for Resident # 44 revealed no care plan was developed to address Resident #44's specific targeted behaviors related to the use of antipsychotic medications.

A record review of the care plan titled, "The resident uses antidepressant medication," with a revision date of 12/27/22, revealed "Goal: The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date...Interventions: Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT...Monitor/document/report PRN adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt. loss, n/v, dry mouth, dry eyes"...

A record review of the care plan titled, "The resident uses psychotropic medications," with a revision date of 12/27/22, revealed "Goal: The resident will be/remain free of psychotropic drug related complications, including movement

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disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date...Interventions: Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT...Monitor/document/report PRN any adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person"...

An interview with the Director of Nursing (DON) 4/13/23 at 9:00 AM, revealed the monitoring of side effects and targeted behaviors should be on the care plan and verbalized the targeted behaviors will be added to the care plan for Resident's #4 and #44.

An interview with the Administrator on 4/13/23 at 10:09 AM revealed the monitoring for side effects and targeted behaviors should be on the resident's care plan and the E-MAR and confirmed the care plans for Resident's #4 and #44 were not being followed for monitoring.

Record review of the Admission Record revealed that the facility admitted Resident #44 to the facility on 10/06/20 with diagnoses of Vascular Dementia with behavioral disturbance, Hallucinations and Mood Disorder with Major Depressive like episode.

Record review of the MDS with an ARD of

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F 656	Continued From page 19 3/23/23, and section C revealed that Resident #44 had a Brief Interview of Mental Status (BIMS) score of two (2) which indicated that she was severely cognitively impaired. Section E coded 0-Behaviors not exhibited.	F 656		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review the facility failed to ensure a residents' code status was documented consistently throughout the medical record, as evidenced by Full Code and Do Not Resuscitate status documented for one (1) of twenty-six residents observed. Resident #18 Resident #18 Review of the facility's, "Advance Directives Policy and Procedure", undated, revealed: "Policy The facility will adhere to the state and federal regulations regarding advance directives. The facility will honor the wishes of the resident per their advance directive..." Record review of the Admission Record revealed Resident #18 was admitted to the facility on 3/14/23. Diagnosis Information listed "Do Not Resuscitate (DNR)". The Advance Directive section of the Admission Record indicated	F 678	F678 Cardio-Pulmonary Resuscitation (CPR) Bullet 1. Correction action accomplished for alleged deficient practice: On 4/13/2023, Res #18, resident record was completed and the correct code status of Do Not Ressucitate was placed in all areas of the electronic medical record,by Director of Nursing. No further negative findings noted. On 4/13/2023, Director of Nursing, a 100% audit was completed on all residents residing within the facility of proper code status. On 4/13/2023, Director of Nursing provided in-service was done with the nursing staff and Social Service Director on admission and the signing of code status of all residents beginning 4/14/2023. 2. All residents have potential to be affected by this deficient practice.	5/25/23

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F 678	Continued From page 20 "Cardiopulmonary Resuscitation (CPR) Full Code." Record Review of Resident #18's Order Summary Report revealed "Diagnoses ...Do Not Resuscitate (DNR). An order dated 4/10/23 revealed "CPR Full Code..." On 04/13/23 at 9:40 AM, an observation of the nameplate outside Resident #18's room revealed a red dot by the resident's name. An interview on 04/13/23 at 9:45 AM, with Certified Nurse Aide (CNA) #4 revealed the way we know if the resident is a full code or DNR is we look it up on the Kiosk or on their face sheet in the chart. She revealed a red dot by their name on the doorplate means they are a DNR. An interview on 04/13/23 at 10:03 AM, with Licensed Practical Nurse (LPN) #2 revealed the way we know the code status of the resident is we pull their name up on the computer and look at the order. She confirmed that Resident #18 is a full code and showed State Agent (SA) where the information was found at the top of Resident #18's Electronic Medication Record (EMAR). She revealed that Residents with a red dot by their name on their doorplate means they are DNR. LPN #2 confirmed that on the door plate of Resident #18's room that she is a DNR according to the red dot. She revealed this is wrong, Resident #18 is a full code in the computer. LPN #2 stated " I will have to let the Social Worker know that it's wrong. This could be bad if we didn't know the proper code status for the resident." An interview on 04/13/23 at 10:30 AM, with the	F 678	Bullet 3. Measures put in place to ensure the alleged deficient practice does not reoccur. a)Upon admission all residents will have the code status completed and signed by the Medical Director at the time of admission. b)Director of Nursing in-service nursing on 4/13/2023 regarding code status of Do Not Ressucitate and Full Code. c) Director of Nursing in-service nursing on 4/13/2023 regarding proper documentation of code status and location in the system of Point Click Care. Bullet 4. Beginning 4/14/2023, The Director of Nursing will review new admission for accuracy to be completed with 24 hours. Weekly x 8 weeks. The Administrator will report findings to the Quality Assurance Committee on 5/10/2023 monthly and quarterly for 6 months basis in person/telephone. Quality Assurance will review findings and make recommendations for changes and/or revisions as needed.	

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F 678	Continued From page 21 Director of Nurses (DON) confirmed that the code status on the Admission Record did not match the orders and that could be a mixed communication to the staff. She revealed everyone in the building is a Full code until the DNR order is signed by the Physician and revealed she just got the signed DNR Physician order back today. She revealed that having both DNR and Full code for Resident #18 should not be in place. An interview and observation on 04/13/23 at 10:57 AM, with the Administrator revealed when a resident is admitted to the facility, they are all full code status until we get the paperwork back from the Doctor. She confirmed that the Admission Record revealed a diagnosis of Do Not Resuscitate and below the order under Advance Directive reveals CPR full code. She confirmed that two different code statuses should not be on the Admission Record. The Administrator confirmed it could give inconsistent information for the staff to use in an emergency. A review of the Minimum Data Set (MDS), Section C, with an Assessment Reference Date (ARD) of Mar 20, 2023, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident is cognitively intact.	F 678		
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		5/25/23

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F 757	Continued From page 22 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record and policy review the facility failed to ensure residents were free from unnecessary drug use as evidenced by no behavior or side effects monitoring for psychotropic drugs use for two (2) of four (4) residents reviewed. Resident's #4 and #44 Findings include: Review of the facility's policy tiled, "Behavior and Side Effect Monitoring of Psychotropic Medications", with no date, revealed "Purpose: To monitor effectiveness of the psychoactive medication and supportive diagnosis, to ensure resident receives highest quality of care. Policy: Resident's with psychoactive medications ordered shall have behavior and side effects monitoring completed daily and as needed. Procedure: 1.) The nurse shall monitor resident each shift for effectiveness and side effects of psychoactive medication ...2.)The nurse will document behavior and/or side effects on the eMAR (Electronic	F 757	F 757 Drug Regimen is Free from Unnecessary Drugs 1. Correction action accomplished for alleged deficient practice: On 4/11/2023, a chart audit was completed by Director of Nursing on resident #4 and #44 with updated oreders, to assess for physician orders and documentation of behaviors and side effects of psychotropic medicines. a)On 4/11/2023 and 4/12/2023 a 100% chart audit was completed, by Director of Nursing and new orders placed in system on all residents on psychotropics medicines for behaviors and side effects. a) Director of Nursing, On 4/11/2023 and 4/12/2023 a 100% audit was completed for gradual dose reduction and collaboration with psychiatric nurse practitioner 2. All residents have potential to be affected by this deficient practice.	

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F 757	Continued From page 23 Medication Record) or in the nurses notes ..." Resident #4 An observation and interview on 4/11/23 at 10:00 AM, revealed Resident #4 was sitting in his room with no behaviors noted. He was watching television and stated he was feeling good. A record review of the Order Summary Report revealed an order date of 3/14/23 for Klonopin Tablet 0.5 milligram (mg) at bedtime related to anxiety disorder unspecified ...Seroquel 150 mg by mouth at bedtime related to Unspecified psychosis ... Zoloft 125 mg one time daily for anxiety disorder. The SA found no physician's order for monitoring for side effects or monitoring for targeted behaviors with psychotropic medication use for Resident #4. A record review of the Electronic Medication Administration Record (E-MAR) for Resident #4 revealed there was no monitoring in place for side effects or targeted behaviors of psychotropic medications April 1st through April. 12th, 2023. Record review of Resident #4's of Progress Notes for March and April 2023 revealed only three (3) episodes of behaviors documented and no documentation of monitoring for side effects found. Record review of the Admission Record revealed that the facility admitted Resident #4 to the facility on 8/06/20 with diagnoses of Psychosis unspecified, Anxiety Disorder, Schizophrenia Delirium, and Delusional Disorder. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date	F 757	3. Measure put in place to ensure the alleged deficient practice does not reoccur. On 4/11/2023 in-service by Director of Nursing with nurisng staff on admission of new residents on psychotropic medicine must have orders to address behavior and side effects On 4/11/2023 in-service by Director of Nursing with Minimum Data Set nurse on care plan of all residents on psychotropic medicines to ensure care plans are individualized with targeted behaviors and side effects. 4. On 4/12/2023, The Director of Nursing will ensure this deficiency does not occur by daily review of new medicine orders weekly x 8 weeks or until compliance is met. The Administrator will report findings to the Quality Assurance Committee monthly and quarterly basis in person/telephone. Quality Assurance 5/10/2023 monthly and quarterly for 6 months will review findings and make recommendations for changes and/or revisions as needed.	

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(ARD) of 1/26/23 revealed that Resident #4 was coded rarely/never understood. Section E revealed verbal behavioral symptoms directed toward others one (1) to 3 days during the reference period.

Resident #44

An observation on 4/11/23 at 10:30 AM, revealed Resident #44 lying in bed watching television with no verbal responses when spoken to.

A record review of the Order Summary Report revealed an order dated 2/22/23 Seroquel 37.5 mg by mouth at bedtime related to unspecified Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disorder, and anxiety... Seroquel 12.5 mg every morning related to Hallucinations with an order date 8/20/22 ...Zoloft 25 mg daily for Major Depressive disorder with an order date 11/22/22...The State Agency (SA) found no physician's order for monitoring for side effects or monitoring for targeted behaviors with psychotropic medication use for Resident #44

Record review of the E-MAR for Resident #44 revealed no monitoring for side effects or targeted behaviors of psychotropic medications April 1st through April 12th, 2023.

Record review of Resident #44's Progress Notes for March and April 2023 revealed no documentation of monitoring for side effects or behaviors found.

Record review of the Admission Record revealed that the facility admitted Resident #44 to the facility on 10/06/20 with diagnoses of Vascular

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Dementia with behavioral disturbance, Cerebral Vascular Disease, and Ataxia following Cerebral Vascular Disease, Hallucinations and Mood Disorder with Major Depressive like episode.

Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 3/23/23, revealed that Resident #44 had a Brief Interview of Mental Status (BIMS) score of 02 which indicated that he was severely cognitively impaired. Section E coded 0-Behaviors not exhibited.

An interview with the Administrator on 4/12/23 at 2:50 PM, revealed Residents #4 and #44 did not have a physician's order for monitoring for side effects or targeted behaviors of psychotropic drugs and confirmed it was not on the Electronic Medication Record (E-MAR), but it should be.

An interview with Licensed Practical Nurse (LPN) #2 on 4/12/23 at 2:56 PM, revealed the nurses monitor for side effects of all psychotropic medications and targeted behaviors and it is documented on the E-MAR. She also revealed that they monitor for side effects and behaviors to identify any concerns like over sedation or toxicity and increased agitation and notify the doctor. She revealed that if staff are not documenting the targeted behaviors on the E-MAR or documenting monitoring of side effects on the E-MAR staff cannot prove that the resident is being monitored at all.

An interview with the Director of Nursing (DON) on 4/12/23 at 3:21 PM, revealed that the monitoring for targeted behaviors and side effects of psychotropic drugs should be on the E-MAR and documented every shift and to notify the

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F 757	Continued From page 26 doctor of any concerns. She confirmed if there was no monitoring for side effects for Resident #4 and #44 and confirmed the resident was at risk for staff missing signs of side effects from med use. An interview with the Administrator on 4/13/23 at 10:09 AM, she confirmed for resident #4 and #44 the standard of practice for monitoring the use of psychotropic drugs was not being followed.	F 757		
F 812 SS=D	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. (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, record review and facility policy review the facility failed to prevent the possible spread of infection by storing an ice scoop on the ice in the ice machine	F 812	F 812 Food, Procurement, Store/Prepare/Serve-Sanitary 1. Correction action accomplished for alleged deficient practice:	5/25/23

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F 812	Continued From page 27 during one (1) of three (3) kitchen observations. Findings include: Record review of the Facility policy titled, "Cleaning Instructions: Ice Machine and Equipment Policy and Procedure" without date revealed staff should store the ice scoop beside or on top of the machine in a clean non-porous container that allows the water to drain off and not pool around the scoop. On 04/10/23 at 7:00 PM, during the initial tour of the kitchen revealed the ice scoop was stored and resting on top of the ice in the ice machine in the kitchen. The plastic scoop holder was empty and sitting on top of the ice machine. On 4/10/23 at 7:25 PM, an interview with Dietary Staff #1 confirmed the ice scoop was resting on top of the ice in the ice machine located in the kitchen and confirmed the scoop should not be in the ice machine but should be kept in the scoop holder on top of the ice machine. Dietary Staff #1 revealed that he knew the scoop should not be kept in the ice machine and thought the reason the scoop should not be left on the ice in the ice machine was because it could get lost. Dietary Staff #1 revealed he was not sure who left the scoop in the machine. On 4/10/23 at 7:30 PM, an interview with Dietary Staff #2 confirmed that the scoop being left in the ice machine would have germs on it and should be kept in the scoop holder on top of the ice machine. She revealed she has attended training that instructed staff they should not lay or leave the scoop in the ice machine because it could spread germs.	F 812	On 4/10/2023, Dietary manager was notified of survey findings and the ice machine was disconnected and all ice removed, Dietary Manager sanitized and disinfection of the ice machine was done. On 4/11/2023, Dietary Manager in-service 100% of dietary staff on proper ice scoop storage, which is on top of the machine. 2. All residents have potential to be affected by this deficient practice. 3. Measures put in place to ensure the alleged deficient practice does not reoccur. On 4/11/2023, and in-service by the Dietary manager was completed with 100% of dietary staff on storage of ice scoop, infection control, and prevention of illness to the residents. Both shifts will ensure the ice scoop is placed in the dishwasher for disinfecting and stored properly. On 4/21/23 Dietary Manager, secured Scoop holder to the top of the ice box 4. On 4/11/2023 The dietary staff will document the daily placement and disinfecting of the ice scoop. 4/12/2023 The DM will report in daily morning meeting x 8 week or until compliance is met. any concerns or potential issues related to the proper storage of the ice scoop. The Administrator will report findings to the Quality Assurance Committee 5/10/2023 monthly and quarterly basis x 6 months in person/telephone. Quality Assurance will review findings and make recommendations for changes and/or revisions as needed.	

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F 812	Continued From page 28 On 4/10/23 at 7:35 PM, an interview with the Dietary Manager (DM) confirmed the ice scoop should not be inside the ice maker on the ice. The DM revealed the scoop would be contaminated and could cause the spread of infection and all the staff know they should not leave the scoop in the ice machine and they know why. On 4/12/23 at 3:15 PM, an interview with the Administrator revealed she was aware the scoop was left in the ice machine and was aware of the in-service training addressing the proper storage of the ice scoop. The Administrator revealed that leaving the scoop in the ice machine could cause the spread of infection. Record review of the in-service training provided to the dietary staff dated 3/1/23 revealed cleaning duties which included a handout addressing the proper storage of ice scoops. Signatures of those that attended the training include the dietary staff.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		5/25/23

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F 880	Continued From page 29 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable 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.	F 880		

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F 880	Continued From page 30 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to prevent the possible spread of infection when a nurse placed gloves in her pocket and then wore them during a finger stick on a resident. Resident # 1 Findings include: Record review of a statement on facility letterhead dated 4/13/2023 and signed by the Administrator revealed "(Proper Name of Facility) does not have a policy regarding employees placing gloves inside of their pockets." On 4/12/23 at 11:15 AM, an observation of Licensed Practical Nurse (LPN) #2 perform a finger stick for Resident #1 revealed LPN #2 standing at her medication cart in the hall, and gathering her supplies. LPN #2 placed clean gloves in her pocket before entering Resident #1's room, proceeded to prepare for the finger stick, removed the contaminated gloves from her pocket, put them on her hands and performed the finger stick with the contaminated gloves on her	F 880	F 880. Infection Prevention & Control 1. Correction action accomplished for alleged deficient practice: On 4/12/2023, Director of Nursing assessed Res #1 with no negative findings noted. On 4/12/2023, Gloves were removed by the staff and placed in the trash container, and her hands were washed. On 4/12/2023, the DON in serviced all staff on proper carry of gloves and the dispose of used gloves, infection control, and transmission of communicable diseases and infection. 2. All residents have potential to be affected by this deficient practice. 3. Measures put in place to ensure this alleged deficient practice does not reoccur. a)On 4/12/2023, the Director of Nursing in serviced all staff on proper carry of gloves and the dispose of used gloves, infection control, and transmission of communicable diseases and infection.	

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F 880	Continued From page 31 hands. LPN #2 completed the finger stick, returned to her med cart, removed the gloves, and placed them in the trash in the med room. On 4/12/23 at 11:30 AM, an interview with LPN #2 confirmed she placed the gloves in her pocket and used the contaminated gloves to perform the finger stick on Resident #1. LPN #2 revealed she knew she should not put the gloves in her pocket because of cross contamination. She stated she was nervous about performing the finger stick on Resident #1 because at times he "acts out" during the procedure. LPN #2 revealed she has not attended an in-service training that addressed that nurses should not place gloves in their pocket. On 4/12/23 at 3:35 PM, an interview with the Administrator revealed LPN #2 reported to her after the finger stick that she messed up and put the gloves in her pocket. The Administrator revealed staff should not put gloves in their pocket due to contamination of gloves and possible spread of infection. On 4/13/23 at 8:25 AM an interview with the Director of Nursing (DON) revealed she has not had any in services that directly addressed not putting gloves into your pocket, she stated that the in services she has provided for infection control or finger stick covered the standard procedures. The DON stated she did not think they had a policy that addressed placing clean gloves in nurses pockets. Record review of Resident #1's Physician's orders revealed an order for Accuchecks before meals and at bedtime with orders for the sliding scale insulin.	F 880	4. Director of Nursing/Infection Preventist Nurse to make unannounced rotating rounds beginning 4/13/2023 x 8 days on all shifts. IP nurse to make rounds weekly rotating shifts x4 weeks for observation of infection control concerns. IP nurse to provide monthly education on infection control to all staff beginning 4/13/2023. The DON/IP will report in daily morning meeting beginning 4/13/2023 any concerns or potential issues related to infection control issues. The Administrator will report findings to the Quality Assurance Committee monthly and quarterly starting 5/10/2023 Quality Assurance will review findings and make recommendations for changes and/or revisions as needed.	

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F 880	Continued From page 32 Record review of Resident #1's Admission Record revealed he was admitted to the facility on 4/6/06 with diagnoses that included Type II Diabetes Mellitus, Dementia and Malignant Neoplasm of Prostate. Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/16/23 revealed a Brief Interview of Mental Status (BIMS) score of nine (9) which indicates the resident's cognitive status is moderately impaired.	F 880		