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	255154	A. BUILDING _____ B. WING _____	05/25/2023

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CRYSTAL REHABILITATION AND HEALTHCARE CENTER	902 SGT JOHN A PITTMAN DRIVE GREENWOOD, MS 38930

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 5/22/23-5/25/23. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation and cited deficiencies at F585, F656, F658, F677, F693 and F812. The census at the time of the survey was 86 and the facility is licensed for 100.	F 000		
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. §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	F 585		6/21/23

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

Electronically Signed | 06/14/2023

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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 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,

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F 585	Continued From page 2 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 decision. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, facility policy review and record review the facility failed to resolve grievances in a manner that would prevent them from reoccurring as evidenced by ongoing resident complaints regarding not receiving ice water for four (4) of 86 residents reviewed during survey. Resident 32, 33, 45 and 62 Findings Include:	F 585	1.Resident #32, 33, #45, and #62 were interviewed by Social Services Director (SSD) on 05/25/2023 regarding their grievance from residents 'council of not receiving ice water three times a day. Resident #32, #33, #45, and #62 received water at 05/23/2023. 2. All residents have the potential to be affected by this practice.	

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F 585	Continued From page 3 Record review revealed a typed statement on facility letterhead dated 5/24/23 that revealed the facility did not have a policy regarding unresolved grievances and was signed by the Administrator. Record review of the facility policy titled, "Hydration Management" with a revision date of January 2023 revealed, "...Procedure...Hydration passes three times a day (approximately 10 AM, 2 PM and 7 PM) whereby all residents will be offered beverage. The total volume of fluids offered at each hydration pass will be approximately 4 oz's". During the resident council meeting on 5/23/23 at 2:30 PM, Residents #32, #33, #45 and #62 revealed that they have complained about not getting ice water like they are supposed to, and it is not getting any better. Resident #33 revealed that the staff are supposed to pass ice water at the beginning of their shift, but do not always do that. Resident #45 revealed that it depends on who is working to whether they pass the ice water or not. Resident #62 revealed that weekends seem to be worse, but you never know if you are going to get ice water or not. They revealed that in the past when they have complained about the ice water situation, it would get better for a while and then they slack off again. An interview on 5/24/23 at 10:45 AM, with Certified Nurse Assistant (CNA) #1 revealed it is the responsibility of the CNAs to pass water to the residents at the beginning of their shifts. She revealed she cannot recall a time or reason why they would not have been able to pass ice water. An interview on 5/24/23 at 10:50 AM, with	F 585	3. On 05/25/2023, a Public posting with Grievance Official contact information was posted on residents bulletin board across from east wing nurses station. Beginning 05/31/2023, Nursing Home Administrator (NHA) and Social Services Director (SSD) will perform an audit of grievances from November 2022 to present to determine if grievances had been investigated and resolved. Beginning 05/31/2023, Nursing staff, housekeeping staff, dietary staff, maintenance and administrations staff was educated by Social Services Director (SSD) regarding grievance policy. Beginning 05/25/2023, grievances are reviewed in the morning meeting, Monday-Friday. Grievances that cannot be resolved within a week will have documented reason it could not be resolved and when resolution can be expected. 4. Beginning on 05/30/2023, Social Services will interview 2 residents and 2 family members weekly times 2 months to discuss resolution of grievances. Grievance trends with resolutions will be discussed weekly x 12 beginning 05/30/2023 between Social Services and Administrator. Findings will be submitted to the Quality Assurance and Performance Improvement Committee monthly starting 06/21/2023 times 3 months.	

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Licensed Practical Nurse (LPN) #1 confirmed it is the responsibility of the CNAs to pass ice water to the residents at the beginning of their shift.

An interview on 5/24/23 at 11:00 AM, with the Assistant Director of Nurses (ADON)-Infection Preventionist revealed they have had these issues with resident's complaining about not getting ice water for a while. She revealed the facilities ice machines have been torn up a few times and they had to get ice from the store. She revealed that they have done several in-services with the staff regarding the importance of passing ice water.

An interview on 5/24/23 at 11:10 AM, with the Corporate Nurse confirmed the residents complaining about not receiving ice has been an ongoing issue. She revealed the ice machines in the hall broke and they had to use the kitchen ice maker; then they fixed those, and the kitchen went out. She confirmed they had done several in-services regarding this and cannot believe it is still an issue.

An interview on 5/24/23 at 11:20 AM, with the Administrator confirmed that the residents had been complaining about not getting ice water for a while. She revealed she has the nurse managers in each hall making rounds and completing a questionnaire on each resident and getting it to her before 9:00 AM so it can be discussed in the standup meeting. She confirmed that according to these questionnaires there are still some random complaints from residents regarding not receiving their ice water.

An interview on 5/25/23 at 9:40 AM, with the Activities Director confirmed that residents'

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complaints about not receiving ice and water have been ongoing. She revealed that it would get better and then it would pop back up again. She revealed she completes a grievance form when the residents have a complaint, and this particular grievance went to the Director of Nurses (DON).

Record review of the resident council meeting minutes from 12/14/22 through 5/10/23 revealed that the complaint of ice water not getting passed had been brought up four times with the most recent being from the meeting held on 5/10/23.

Record review of the facility in-services regarding ice being passed to residents revealed there had been 4 in-services with nursing staff in the last 12 months.

Resident #32

Record review of Resident #32's Admission Record revealed the resident was admitted to the facility on 01/26/19 with medical diagnoses that included Barrett's Esophagus without Dysplasia.

Record review of Resident #32's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/17/23 revealed in Section C a Brief Interview for Mental Status (BIMS) of 15, which indicated the resident was cognitively intact.

Resident #33

Record review of Resident #33's Admission Record revealed the resident was admitted to the facility on 06/18/17 with medical diagnoses that included Anxiety Disorder Unspecified.

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F 585	Continued From page 6 Record review of Resident #33's MDS with and ARD of 3/6/23 revealed in Section C a BIMS of 15, which indicated the resident was cognitively intact. Resident #45 Record review of Resident #45's Admission Record revealed the resident was admitted to the facility on 12/16/20 with medical diagnoses that included Major Depressive Disorder Recurrent, Unspecified. Record review of Resident #45' MDS with an ARD of 5/3/23 revealed in Section C a BIMS of 13, which indicated the resident was cognitively intact. Resident #62 Record review of Resident #62's Admission Record revealed the resident was admitted to the facility on 09/02/21 with medical diagnoses of Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side. Record review of Resident #62's MDS with an ARD of 5/18/23 revealed in Section C a BIMS of 15, which indicated the resident was cognitively intact.	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	F 656		6/21/23

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F 656	Continued From page 7 §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 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-	F 656		

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F 656	Continued From page 8 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, record review, and facility policy review the facility failed to Implement a care plan for Activities of Daily Living (ADL) care Resident #3 , PEG (percutaneous endoscopic gastrostomy) tube medication administration (Resident # 77) and tube feeding (Resident #238) for three (3) of 18 residents reviewed. Resident #3, #77 and #238. Findings include: Record review of the facility policy titled "Care Plans, Comprehensive Person-Centered" dated 10/22 and revised on 1/23 revealed, "Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. ... 8. The comprehensive, person-centered care plan will: ...b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; ..." Resident #3 Review of Resident #3's care plan titled, "Bathing" revealed ADL-I prefer whirlpool (T, Th, Sat) on 7-3. Resident will require supervision during showers. Check facial hair and nails. Under "Bathing and Showering": Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse.	F 656	1. The care plan for resident #03 was implemented on 05/23/2023. CNA #04 provided resident #03 with nail care, shave, foot care and shower provided on 05/23/2023. The care plan for resident #77 was implemented on 05/26/2023. On 05/26/2023, LPN assigned to resident #77 care flushed PEG tube medication as described in care plan. The care plan for resident #238 was implemented on 05/23/2023. Director of Nursing corrected resident #238 tube feeding pump to the correct setting on 05/23/2023. 2. All residents have the potential to be affected for not implementing care plans 3. On 05/29/2023, Director of Nursing, Assistant Director of Nursing, and Staff Development Coordinator provided education to licensed nursing staff and certified nursing assistants on schedule for Activities of Daily Living (ADL). On 05/24/2023, Assistant Director of Nursing provided education to LPN #03 on following the care plan for flushing during Percutaneous Endoscopic Gastrostomy. On 05/24/2023 Staff Development Coordinator provided education to licensed nurses on ensuring feeding administration and feeding pump rate match physician order and care plan. 4. Beginning 05/26/2023, Director of Nursing, Assistant Director of Nursing, and Staff Development Coordinator will perform visual audits to ensure care plan implementation daily x2 weeks, weekly x2, biweekly x 2, and monthly x 2 for 2	

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F 656	Continued From page 9 An observation and interview on 05/22/23 at 10:40 AM, revealed Resident #3 to have long fingernails on both hands with dirty brownish material under the nails. The nails are past the tips of the fingers. The bottom of both feet had black colored material on them. The resident had a beard that was scraggly. The resident stated that he usually has a beard but does not want it this long. An observation on 5/23/23 at 9:10 AM, revealed Resident #3 continues to have brownish material under the fingernails on both hands and black material on the bottom of his feet. An observation and interview, on 5/23/23 at 2:10 PM, with Certified Nursing Assistant (CNA) #4 revealed that the resident goes to the shower on Tuesday, Thursday, and Saturday. She stated that she took over from his assigned CNA who left early. She stated the CNA told her the resident had his morning care before she left. She stated that his feet do not look like they were washed, and his fingernails are dirty. She stated that she was going to redo his care. An interview, on 05/25/23 at 10:43 AM with the Director of Nursing (DON) confirmed Resident #3 had a care plan in place but was not being followed. Review of the facility Admission Record for Resident #3 revealed an admission date of 5/26/20 with diagnoses that included Atherosclerotic Heart Disease, Epilepsy, and Bipolar Disorder. Review of Section C of the Minimum Data Set (MDS) for Resident #3 with an Assessment	F 656	months. Director of Nursing, Assistant Director of Nursing, and Staff Development Coordinator will discuss trends from daily rounds and visual audits weekly x 4 weeks and monthly x 2 in Clinical Standards meetings beginning 06/14/2023. Finding will be submitted to the Quality Assurance and Performance Improvement Committee monthly beginning 06/21/2023 times 2 months.	

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Reference Date (ARD) of 3/6/23 revealed a Brief Interview for Mental (BIMS) score of 10 which indicated Resident #3 had moderately impaired cognition.

Resident #77

Record review of the care plan for Resident #77 with a focus titled, "I require feeding tube for nutrition and hydration r/t (related to) DYSPHAGIA FOLLOWING CEREBRAL INFARCTION". The interventions included: Enteral Feed Order every shift Provide 60 cc (cubic centimeters) H2O (water) ac (before) meds, 30 cc H2O between meds.

An observation on 05/24/23 at 10:00 AM, during administration of PEG medications for Resident #77 revealed Licensed Practical Nurse (LPN) #3 drew up approximately 15 ml (milliliters) of water into a 60 ml syringe and placed the syringe into the PEG tube and flushed the water into the tube while listening to the left upper abdomen with a stethoscope. Following this clear fluid and then tan-colored fluid backed up in the tube. She then flushed the tube with approximately 30 cc water and before the water cleared the syringe, she poured the first crushed, undiluted medication into the syringe, then added more water. When the water with the first medication in it was about halfway down the syringe, LPN #3 added more water and then poured in the next undiluted medication and poured in more water, then the next medication. She administered a total of five (5) medications. LPN #3 did not measure water for any of the flushes.

An interview on 05/25/23 at 10:18 AM, with the DON revealed LPN #3 did not follow the care plan

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for flushing during PEG tube medication administration.

Review of the facility Admission Record for Resident #77 revealed an admission date of 3/3/23 with diagnoses that included Cerebral Infarction, Systolic (Congestive) Heart Failure, Aphasia, and Dysphagia.

Resident #238

A review of Resident #238's care plan titled,"I require tube feeding as my primary nutrition r/t (related to) Dysphagia," revealed Interventions: "Enteral Feed order every shift Tube Feeding Continuous: Formula-Jevity 1.5 at 50 cc/hr (cubic centimeters/hour) x 22 hours to allow for ADL care..."

An observation on 5/22/23 at 11:10 AM, revealed Resident #238 had Jevity 1.5 formula running at 40 cc/hr via PEG tube pump.

An observation on 5/23/23 at 10:30 AM, revealed Resident #238 had Jevity 1.5 infusing at 40 cc/hr , directions on the Jevity formula bottle read rate: 50cc/hr.

An observation of Resident #238's tube feeding pump and Jevity 1.5 formula bottle hanging on 5/23/23 at 10:35 AM, with the Director of Nursing (DON) confirmed the feeding tube pump read 40 cc/hr infusing and the label on the Jevity bottle read 50 cc/hr.

An interview with the DON on 05/23/23 at 11:47 AM, confirmed the staff were not following the care plan and revealed the purpose of the comprehensive care plan is to direct person

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CRYSTAL REHABILITATION AND HEALTHCARE CENTER	902 SGT JOHN A PITTMAN DRIVE GREENWOOD, MS 38930

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F 656	Continued From page 12 centered care. Record review of the Admission Record revealed that the facility admitted Resident #238 to the facility on 5/18/23 with diagnoses of Nontraumatic Intracranial Hemorrhage, Dysphasia following Nontraumatic Intracranial Hemorrhage, and Encounter for Attention to Gastrostomy.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review and facility policy review, the facility failed to properly administer Percutaneous Enteral Gastrostomy (PEG) flushes during medication administration to a resident, failed to assess the pulse rate before administration of a medication, and failed to have resident rinse the mouth after the administration of an inhaler for two (2) of eight (8) resident medication administrations reviewed. Resident #30 and Resident #77 Findings Include Review of the facility policy titled, "Administering Medications", revised April 2019, revealed, "Policy heading Medications are administered in a safe and timely manner, and as prescribed ...Policy Interpretation and Implementation...2. The	F 658	1. Resident #77 pulse was not checked prior to administration of digoxin. Labs (Digoxin level, Comprehensive metabolic panel, and Comprehensive blood count) ordered by Medical Director on 05/30/2023. Licensed practical nurse (LPN) administering medication did not flush with water after medication administration. LPN #03 was educated on medication administration prior to her return to work by Staff Development Coordinator on 05/24/2023. Medical Director (MD) visited will resident #77 on 05/31/2023 and provided no new orders . Resident #30 was administered an inhaler. 2. Residents requiring medication administration have the potential to be negatively affected.	6/21/23

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F 658	Continued From page 13 director of nursing services supervises and directs all personnel who administer medications and /or have related functions ...11. The following information is checked /verified for each resident prior to administering medications:.. b. Vital signs, if necessary ..." Review of the facility policy titled, "Administering Medication through an Enteral Tube" with a revision date of January 2023 revealed, "Purpose The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube ...General Guidelines ...3. Administer each medication separately and flush between medications ...6. Use warm purified water for diluting medications and for flushing ...Steps in the procedure...6. Verify placement of feeding tube...9. Dilute medication: ...b. Dilute crushed (powered medication with at least 30 mL purified water (or prescribed amount) ...10. Administer each medication separately ...12 ...c. Begin flush before the tubing drains completely. 13. If administering more than one medication, flush with 15 mL warm purified water (or prescribed amount) between medications. 14. When the last of the medication begins to drain from the tubing, flush the tubing with 15 mL of warm purified water (or prescribed amount) ..." Review of the facility policy titled, "Administering Medications through a Metered Dose Inhaler" with a revision date of October 2010 revealed, "Purpose The purpose of this procedure is to provide guidelines for the safe administration of inhaled medications ...Equipment and Supplies The following equipment and supplies will be necessary when performing this procedure ...5. gargling solution;.."	F 658	3. On 05/24/23, Staff Development Coordinator provided education to licensed and registered nurses regarding professional standards of medication administration. Beginning 05/24/2023, licensed and registered nurses were observed performing medication administration by Director of Nursing, Assistant Director of Nursing, and Staff Development Coordinator. 4. Beginning 05/26/2023, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, and Registered nurse supervisors will perform visual audits across different shifts including Saturdays and Sundays, 5 x a week for 1 month, 3 x week for 3 months, and 1 x a week for 2 months. Issues and trends will be discussed weekly in Clinical Standards meeting beginning 06/14/2023. Findings will be submitted to the Quality Assurance and Performance Improvement Committee monthly starting 06/21/2023 times 3 months.	

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Resident #77

An observation on 05/24/23 at 10:00 AM, during administration of PEG medications for Resident #77 revealed Licensed Practical Nurse (LPN) #3 drew up approximately 15 ml (milliliters) of water into a 60 ml syringe and placed the syringe into the PEG tube and flushed the water into the tube while listening to the left upper abdomen with a stethoscope. Following this clear fluid flush a tan-colored fluid backed up in the tube. She then flushed the tube with approximately 30 cc water and before the water cleared the syringe, she poured the first crushed, undiluted medication into the tube, then added more water. When the water with the first medication in it was about halfway down the syringe, LPN #3 added more water and then poured in the next undiluted medication and poured in more water, then the next medication. She administered a total of five (5) medications. LPN #3 did not measure water for any of the flushes and did not wait for one (1) medication to clear the syringe before adding the next undiluted medication. During the 10:00 AM medication pass, also revealed LPN #3 did not obtain Resident #77's pulse rate prior to the administration of Digoxin 125 micrograms (mcg).

An interview on 5/24/23 at 1:10 PM, with LPN #3 revealed she was not sure how much water to use for flush or between medications. She stated that she didn't know why she did not dilute medications prior to administering them. She stated that's usually how I do it. LPN #3 stated that checking tube placement should be with air because water could cause aspiration or could go into the abdomen. LPN #3 stated that she gave the medications how she has always given PEG

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medications. She confirmed that this way, basically can get the medications mixed together. LPN #3 stated she had a medication in-service on hire. She stated that she should mix each of the medications with water, but she is not sure how much but thinks 10 cc and flush should be 10 to 15 cc.

During an interview on 5/24/23 at 1:15 PM with LPN #3, she stated that she doesn't know why she did not count the pulse. She stated that Digoxin can slow the heart rate and should not be given if the pulse rate is below 60. LPN #3 stated "she just forgot".

An interview, on 05/25/23 at 10:40 AM, with the Director of Nurses (DON) revealed she did not know what to think about how LPN #3 administered the PEG medications. She stated LPN #3 does not need to be giving meds and will be taken off the schedule, in-serviced and worked with one on one. She stated that Resident #77's pulse should have been taken to make sure it was not too low before giving the medication (Digoxin).

Review of the Order Summary Report with active orders as of 06/27/2023 for Resident #77, revealed an order dated 3/8/23, Enteral Feed Order every shift Provide 60 cc H2O ac (before) meds, 30 cc H2O between meds.

Review of the Order Summary Report with active orders as of 06/27/2023 for Resident #77, dated an order dated 2/13/23, for Digoxin 125 mcg Give 1 tablet by mouth one time a day for heart failure.

Review of the PDR.Net Digoxin-drug summary revealed a nurse should assess the apical pulse

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for one full minute before administering Digoxin.

Review of the facility Admission Record for Resident #77 revealed an admission date of 3/3/23, (original admission date of 2/13/23) with diagnoses that included Cerebral Infarction, Systolic (Congestive) Heart Failure, Aphasia, and Dysphagia.

Review of Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ADR) of 3/10/23, revealed a Brief Interview for Mental Status (BIMS) score of 3 which indicated Resident #77 had severely impaired cognitive skills and never/rarely made decisions.

Resident #30

An observation on 5/24/23 at 8:15 AM, revealed LPN #2 administered a Symbicort 160 mg (milligram) /4.5 mg inhaler to Resident #30, and she failed to have the resident rinse her mouth after the resident finished her inhalations.

An interview with LPN #2 on 5/24/23 at 8:25 AM, confirmed she did not have Resident #30 rinse her mouth after the inhaler. She stated she guessed she was just nervous. LPN #2 stated not having the resident rinse their mouth could cause irritation.

An interview 5/25/23 at 8:20 AM with Resident #30 revealed that she used inhalers when she was at home, and she knows that she is supposed to rinse her mouth. She stated that none of the nurses here get her to rinse her mouth. She denied having any soreness in her mouth.

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F 658	Continued From page 17 An interview on 5/25/24 at 10:40 AM, with the DON revealed not having a resident rinse their mouth after an inhaler could have negative after side effects occur, like oral cavity problems. Review of the Medication Review Report dated 5/24/2023, for Resident #30 revealed an order dated 4/26/23, for Symbicort Inhalation Aerosol 160-4.5 mcg(micrograms)/act(actuate) two (2) puff inhale orally, two times a day for shortness of breath, related to other Asthma. Review of the "Quick Guide to Using Your Symbicort Inhaler" revealed after using the Symbicort Inhaler, rinse your mouth with water. Spit out the water. Do not swallow it. Review of the facility Admission Record for Resident #30 revealed an admission date of 4/26/23 with diagnoses that include Asthma, Morbid Obesity, and Anxiety Disorder. Review of Section C of the MDS with an ADR of 5/3/23 revealed a BIMS score of 12 which indicated Resident #30 had moderately impaired cognition.	F 658		
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 observation, staff and resident interview, record review and facility policy review, the facility failed to provide nail care, shaving and	F 677	1. Resident #3 had not received nail care or shave as planned. Nail care and shave was performed by Certified nursing	6/21/23

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F 677	Continued From page 18 appropriate bathing to a resident requiring assistance with Activities of Daily Living (ADL's) for one (1) of 86 residents reviewed. Resident #3 Findings Include Review of the facility policy titled, "Activities of Daily Living (ADL), Supporting", revised March 2018, revealed residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and oral hygiene. The policy interpretation and implementation revealed under #2. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care). During an observation and interview on 05/22/23 at 10:40 AM, revealed Resident #3 to have long fingernails on both hands with dirty brownish material under the nails. The nails were past the tips of the fingers. The bottom of both feet had black colored material on them. The resident had a beard that was scraggly. Resident #3 stated that he usually has a beard but does not want it this long. An observation of Resident #3 on 5/23/23 at 9:10 AM revealed he continues to have brownish material under the fingernails on both hands.	F 677	assistant (C.N.A) #04 on 05/24/2023. 2. All residents have the potential to be affected by this practice. 3. Director of Nursing (DON), Assistant Director of Nursing (ADON), and Staff Development Coordinator (SDC) completed an audit to determine residents in need of nail care and shave on 05/26/2023. Residents identified had care performed on 05/26/2023. Activities of Daily Living (ADL) care were added to the Kardex of 5 residents a day beginning 05/25/2023 by MDS Coordinators. Director of Nursing will make rounds daily beginning 05/25/2023 to monitor for ADL care completion. Licensed nurses will work with C.N.A.s to complete ADL care. Licensed nurses and C.N.A.s were educated by SDC how to perform ADL care on 05/29/2023. 4. Beginning 05/26/2023, Director of Nursing, Assistant Director of Nursing, and Staff Development Coordinator will perform visual audits for care daily x 2 weeks, weekly x 2, biweekly x 2, and monthly x 2. Director of Nursing, Assistant Director of Nursing, and Staff Development Coordinator will discuss trends from daily rounds and visual audits weekly x 4 weeks and monthly x 2 for 2 months in Clinical Standards meeting. Findings will be submitted to the Quality Assurance and Performance Improvement Committee monthly starting 06/21/2023 times 2 months.	

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In an observation and interview on 5/23 23 at 2:10 PM, with Certified Nursing Assistant (CNA) #4 revealed that the resident goes to the shower on Tuesday, Thursday, and Saturday. She stated that she took over from his assigned CNA who left early and the CNA told her the resident had his morning care before she left. She stated that his feet do not look like they were washed, and his fingernails are dirty. She stated that she was going to redo his care.

An interview, on 5/23/23 at 2:15 PM, with Resident #3 confirmed he went to the shower this morning.

An interview on 5/23/23 at 2:20 PM, with Registered Nurse (RN) #1 confirmed Resident #3's fingernails were long and dirty.

An interview on 5/23/23 at 3:45 PM, with the Director of Nursing (DON) revealed that the residents should get better care. She stated that they do not take care of residents like that in this facility. Residents are to be clean and neat and Resident #3 was not taken care of as expected.

Review of the facility Admission Record for Resident #3 revealed an admission date of 5/26/20 with diagnoses that included Atherosclerotic Heart Disease, Epilepsy, and Bipolar Disorder.

Review of Section C of the Minimum Data Set (MDS) for Resident #3 with an Assessment Reference Date (ARD) of 3/6/23 revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated Resident #3 had moderately impaired cognition.

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F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review the facility failed to meet a resident's nutritional needs as evidenced by not administering feeding formula at the rate ordered to meet the residents EEN (Exclusive Enteral Needs) for one (1) of seven (7) Percutaneous Endoscopic Gastrostomy (PEG) tube fed residents reviewed. Resident #238 Findings include: Review of the facility policy titled, "Enteral Nutrition" revised January 2023, revealed "Policy	F 693	1. Resident #238 feeding rate on pump did not match physician's order to feeding and setting on pump. The setting on pump was changed to match order by Director of Nursing (DON) on 05/23/2023. DON educated Licensed Practical Nurse (LPN) on duty immediately following correction. Resident assessed by Director of Nursing (DON). Labs (Comprehensive metabolic panel, and Comprehensive blood count) ordered on 05/30/2023 by Medical Director. Medical Director (MD) visited on 05/31/2023 with	6/21/23

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F 693	Continued From page 21 Statement Adequate nutritional support through enteral nutrition is provided to residents as ordered. Policy Interpretation and Implementation ... 4. Enteral nutrition is ordered by the provider based on the recommendations of the dietitian..." An observation of Resident #238 on 5/22/23 at 11:10 AM, revealed Jevity 1.5 formula running at 40 cc/hr. (cubic centimeters/hour) via PEG tube pump. An observation of Resident #238's tube feeding on 5/23/23 at 10:30 AM, revealed Jevity 1.5 running at 40 cc/hr. Directions on the Jevity formula bottle read rate: 50 cc/hr. An observation and interview of Resident #238's tube feeding pump settings and Jevity 1.5 formula bottle label on 5/23/23 at 10:35 AM, with the Director of Nursing (DON), she confirmed the feeding tube pump was infusing at 40 cc/hr. and the label on the Jevity bottle read 50 cc/hr. A record review of the Order Summary Report with active orders as of 5/23/23 for Resident #238 with the Director of Nursing (DON) on 5/23/23 at 10:37 AM, revealed an order for " ...Tube Feeding Continuous_ Jevity 1.5 at 50 cc/hr. x (times) 22 hours to allow for ADL (activities of daily living) care. Nutritional information: (1650 kcals (kilocalories), 70g (grams) protein, 836 cc free water, 900 cc H2O (water) flush, 200 cc H2O Med Flush)". The DON confirmed Resident #238 was not receiving the correct rate of tube feeding and revealed possible complications from not receiving the correct amount of feeding is weight loss and dehydration. An interview with the Assistant Director of Nursing	F 693	no new orders. 2. All residents with enteral feedings have the potential to be affected by this practice. 3. Staff Development Coordinator, Director of Nursing, and Assistant Director of Nursing reviewed orders for residents with feeding tubes comparing feeding pump rates and feedings administered to physician order on 05/26/2023. Licensed nurses were educated by Staff Development Coordinator, Director of Nursing, and Assistant Director of Nursing on feeding pump settings. Education with return demonstration for pump usage was also completed by Staff Development Coordinator, Director of Nursing, and Assistant Director of Nursing. New nurses will be educated during orientation. On 05/26/2023, Director of Nursing, Staff Development Coordinator, and Assistant Director of Nursing began verifying that Licensed nurses are following physician orders for administering correct ordered amount of tube feeding by making visual rounds. In-services began on 05/26/2023. 4. Beginning 05/25/2023, audits will be daily x 2 weeks, weekly x 2 weeks, biweekly x 2months, and monthly x 1 month. Results of audits will be reviewed weekly x 4weeks in Clinical Standards meeting, monthly x 2 Clinical Standards meeting to ensure compliance beginning 06/14/2023 for 2 months. Findings will be submitted to the Quality Assurance and Performance Improvement Committee monthly starting 06/21/2023 times 2 months.	

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F 693	Continued From page 22 (ADON) on 5/23/23 at 11:40 AM revealed that not receiving the correct amount of tube feeding could result in weight loss and dehydration. A record review of the Nutritional Therapy Evaluation completed on 5/19/23 for Resident #238 revealed, " ...E. Assessment: ...Current tube feeding not meeting EEN (Exclusive Enteral Needs) ... F. Nutrition Plan: Recs(Recommendation) 1) Discontinue Jevity 1.5 @ (at) 40 cc/hr. x 22 hrs 2) Provide Jevity 1.5 @ 50 cc/hr. x 22 hours... 3) Continue flushes (Tube feeding will provide 1650 kcals, 70g protein, 836cc free water, 900cc H2O flush, 200 cc H20 Med Flush)." A record review of the Medication Administration Record (MAR) for Resident #238 for May 2023, revealed, " ...Jevity 1.5 at 50 cc/hr." with a start date of 5/19/23 being signed off as administered as ordered. Record review of the Admission Record revealed that the facility admitted Resident #238 to the facility on 5/18/23 with diagnoses of other Nontraumatic Intracranial Hemorrhage, Dysphasia following Nontraumatic Intracranial Hemorrhage, and encounter for Attention to Gastrostomy. Record review of the Brief Interview for Mental Status (BIMS) dated 5/23/23, revealed that Resident #238 was coded severe cognitive impairment.	F 693		
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 -	F 812		6/21/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 23 §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 observations, staff, and resident interviews the facility failed to prevent the possibility of a foodborne illness as evidenced by out-of-date turkey sandwiches left on a residents overbed table for one (1) of 86 residents reviewed during survey. Resident #60 Findings Include: Record review of the typed statement on facility letterhead revealed the facility did not have a policy regarding food storage in the resident's rooms and was signed by the Administrator. An observation and interview on 05/22/23 at 10:44 AM, with Resident #60 in the resident's room revealed there were three meat and cheese sandwiches wrapped in plastic wrap on top of the resident's overbed table. This observation revealed that each sandwich had a different date,	F 812	1. Sandwiches were removed from resident #60 room by Director of Nursing on 05/25/2023. 2. All residents who receive snacks have the potential to be affected by this practice. 3. On 05/25/2023, Nurses and Certified Nursing Assistant made rounds in residents' rooms ensuring no other residents were affected. Residents were educated in residents' council about throwing snacks away after 2 days. On 05/24/2023, nursing staff was educated by Staff Development Coordinator regarding throwing expired snacks away from residents' rooms. Beginning 05/25/2023, Licensed nurses will make rounds daily to look for expired snacks in rooms and assist with correcting issues. 4. Beginning 05/26/2023, Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255154	A. BUILDING _____ B. WING _____	05/25/2023

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F 812	Continued From page 24 and the dates were 5/15/23, 5/19/23 and 5/21/23. The resident stated, "Sometimes I eat them and sometimes I do not." An observation and interview on 5/23/23 at 3:28 PM, with Certified Nurse Assistant (CNA) #2 and CNA #3 confirmed that Resident #60 had three turkey and cheese sandwiches wrapped in plastic wrap laying on her overbed table. CNA #2 confirmed that each sandwich had a different labeled date on it and the dates were 5/15/23, 5/19/23 and 5/21/23. CNA #2 revealed that these sandwiches were ruined and needed to be thrown away. CNA #2 and CNA #3 revealed it is the responsibility of all staff to throw outdated perishable food away that is found in the resident's room. CNA #2 revealed that she would consider Resident #60 to sometimes be able to know to throw away expired food and sometimes she would not. CNA #2 revealed that if the resident had eaten the sandwiches, then she could have got food poisoning. An interview on 5/23/23 at 4:00 PM, with the Assistant Director of Nurses (ADON)-Infection Control Nurse confirmed that if Resident #60 had eaten any of the turkey and cheese sandwiches that had dates of 5/15/23, 5/19/23 and 5/21/23 that had been left on her overbed table then it could have made her sick. An interview on 5/24/23 at 2:00 PM, with the Administrator revealed that the staff always like to ask the residents before we remove something from their room, but we will need to educate the resident if we find out of date food that would need to be removed. An interview on 5/25/23 at 8:30 AM, with the	F 812	Nursing, Assistant Director of Nursing, and Staff Development Coordinator will perform visual audits for expired snacks daily x 2 weeks, weekly x 2, biweekly x 2, and monthly x 2 for 2 months. Director of Nursing, Assistant Director of Nursing, and Staff Development Coordinator will discuss trends from daily rounds and visual audits weekly x 4 weeks and monthly x 2 in Clinical Standards meeting starting 06/14/2023. Findings will be submitted to the Quality Assurance and Performance Improvement Committee monthly starting 06/21/2023 times 2 months.	

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F 812	Continued From page 25	F 812		

Director of Nurses (DON) and the Administrator confirmed that the sandwiches that were dated 5/15/23, 5/19/23 and 5/21/23 that were not refrigerated and left on Resident #60's overbed table could have made the resident sick if she had eaten them. The DON confirmed it is the responsibility of all staff to check for out of date food that we have given during snack times. The DON revealed that Resident #60 does not have a refrigerator in her room and she likes to hold on to things, but if staff sees the food is out of date then we need to educate the resident and try to get her to let us throw them away. She revealed that most likely the only way she would let us is if we replaced all three, but that would have been ok.

Record review of Resident #60's Admission Record revealed the resident was admitted to the facility on 07/14/21 with medical diagnoses that include Personality Disorder Unspecified and Anxiety Disorder Unspecified.

Record review of Resident #60's Minimum Data Set (MDS) with an Assessment Reference Date (ARD)of 5/9/23 revealed in Section C a Brief Interview for Mental Status (BIMS) with a score of 04, which indicated the resident was severely cognitively impaired.