| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 255207 | A. BUILDING _____ B. WING _____ | 05/25/2023 |

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| PLAZA COMMUNITY LIVING CENTER | 4403 HOSPITAL ROAD PASCAGOULA, MS 39581 |

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| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an annual recertification survey, along with two (2) Complaint Investigations (CI) MS #21491 and CI MS #21492, at the facility from 05/21/23 through 05/25/23. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid. The SA investigated MS #21491 related to pressure sore precautions and there were no deficiencies cited related to the complaint. MS #21492 was investigated related to neglect and facility staffing and F725 was cited. The SA also cited F550, F584, F644, F645, F656, F677, F684, F690, F732, and F761 during the survey.<br><br>The facility held a license for 100 beds with a census of 93. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal | F 550 | | 6/20/23 |

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

Electronically Signed | 06/17/2023

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| F 550 | Continued From page 1<br>access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, record review, and facility policy review, the facility failed to maintain the dignity of a resident during mealtime for one (1) of 22 sampled residents. Resident #25<br><br>Findings include:<br><br>A record review of the facility's policy "Dignity and Respect", undated, revealed " ... It is the policy of this facility to treat each resident with respect and dignity and care for each resident in a manner and environment that promotes maintenance or enhancement of his or her quality of life.<br>Procedure 1. The staff shall display respect for | F 550 | The facility failed to maintain the dignity of a resident during meal time for resident #25. Resident #25 was interviewed by the Administrator on 05/23/2023, educated on her resident rights and the facility policy on dignity and respect. The Certified Nursing Assistants (CNA) and Nurses that were on duty on 05/21/2023 were educated by the Administrator on resident rights, dignity and respect, activities of daily (ADL) care and routine check policies on 5/23/2023.<br><br>All residents who require assistants with | |

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| F 550 | Continued From page 2<br>residents ... as constant affirmation of their individuality and dignity as human beings ...Definition: Dignity means that in their interactions with residents, staff carries out activities that assist the resident to maintain their self-esteem ... Examples ...10. Honoring requests to be toileted during meals ..."<br><br>On 05/21/23 at 12:20 PM, during an observation and interview with Resident #25, she was lying in bed with her lunch meal tray on the bedside table, and there was a strong foul odor in the room. Resident #25 stated she was not sure how long the meal tray had been sitting there because she was unable to eat. She explained that she had a bowel movement around 10:00 AM, but no one had come to change her. She said that she had told a Certified Nurse Aide (CNA) that she needed assistance, but the CNA did not come back to clean her up. Resident #25 said she had to eat lunch while sitting in her dirty brief and it made her feel disgusted. She further explained that she was embarrassed because her roommate had to smell the odor from her bowel movement during the lunch meal.<br><br>On 05/21/23 at 12:40 PM, in an observation of incontinence care with CNA #1 and CNA #3, Resident #25 had a large, loose bowel movement that had saturated and leaked through her brief onto the incontinence pad on the bed.<br><br>On 05/23/23 at 3:00 PM, during an interview with the Director of Nursing (DON), she explained that it was not acceptable for a resident to have to wear a soiled, dirty brief while eating lunch or for any long period of time.<br><br>On 05/23/23 at 3:30 PM, during an interview with | F 550 | Activities of Daily Living have the potential to be affected.<br><br>All staff were educated beginning 05/23/2023 ending 06/16/2023 on residents' rights as well as dignity and respect policy by the Social Worker.<br><br>The Quality Assurance Performance Improvement Team (QAPI) met on 5/24/2023 and discussed policy and procedure on dignity and respect, ADL care and routine checks, with no revisions needed at this time. The Social Worker will use a daily monitoring tool beginning 05/30/2023 ending 08/31/2023 to ensure that Resident #25 and all current residents are being treated with a dignified existence and their resident rights are being followed. This will be completed through observation and communication with residents. Any adverse findings will be addressed and resolved immediately and reported to the Administrator or Director of Nursing by the Social Worker. All findings will be reported to the QAPI Team monthly beginning 06/20/2023 and ending 08/31/203 for review and recommendations. | |

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| F 550 | Continued From page 3<br>the Administrator, she explained she expected all staff to treat residents with dignity and respect and not allow a resident to wear a soiled brief during meals.<br><br>A record review of the "Admission Record" revealed the facility admitted Resident #25 on 8/24/17 and she had diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side and Type 2 Diabetes Mellitus.<br><br>A record review of the "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 4/13/23 revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Further review revealed she required extensive assistance with toilet use and was always incontinent of bowel. | F 550 | | |
| F 584 SS=D | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>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.<br><br>The facility must provide-<br>§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.<br>(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. | F 584 | | 6/20/23 |

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| F 584 | Continued From page 4<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§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<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, record review, and facility policy review, the facility failed to ensure the residents had a safe, clean, homelike environment in the main dining room for one (1) of four (4) communal areas observed.<br><br>Findings include:<br><br>A record review of the facility's policy, "Resident Rights, "with a revision date of 11/28/2016 revealed, " ...The resident has a right to a safe, clean, comfortable and homelike environment ..." | F 584 | The facility failed to ensure that resident #78 and all other residents had a safe, clean and homelike environment in the dining room area.<br>The facility initiated a resident council on 05/30/2023 to ensure that Resident #78 and all other attendees were informed of the plan of correction to correct the roof leak in the dining room area. The facility Administrator and Maintenance Supervisor made rounds in the facility, viewed the facility walls and roof on 05/30/2023 to ensure that there were no | |

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| F 584 | Continued From page 5<br>On 05/21/23 at 02:23 PM, in an interview with Resident #78, he revealed it has been raining in the main dining room for the past 13 months. He stated the facility painted the ceiling white about a month ago after it rained, because of the green spots on the ceiling. He stated they put pans down to catch the water when it rains.<br><br>On 05/21/23 at 02:35 PM, an observation of the main dining room revealed brown stains in the light fixtures and orange stains on the ceiling near the light fixtures.<br><br>On 05/22/23 at 09:20 AM, in an interview with Licensed Practical Nurse (LPN) #2, she confirmed when it rains, the ceiling leaks in the main dining room.<br><br>On 05/22/23 at 3:00 PM, an observation of the main dining room revealed water on the floor near entry below the light fixtures, with brown water in the light fixtures.<br><br>On 05/25/23 at 09:45 AM, in an interview with the Maintenance Director, he confirmed it leaks in the main dining room when it rains. The Director stated he was hired in April 2019, and since his employment, he had observed issues with the building leaking off and on when it rains. The Maintenance Director also revealed that when it rains in the main dining room, he has even observed smoke coming from the lights, as the water evaporates. The Director explained that prior to the roof being replaced in January of this year, he had patched the roof several times in various places, trying to stop the roof from leaking. However, despite the roof being replaced in January, they have continued to have problems with leaking in the main dining room and have | F 584 | visible mold or mildew growth and there were no safety risks related to this found at this time.<br><br>It was determined by the Administrator that all residents that reside in the facility have the potential to be affected.<br><br>The old equipment was removed on 05/23/2023 and the dining room roof will be resealed to prevent any further leaks on or before 06/20/2023. Beginning on 05/30/2023 ending 06/14/2023 the Maintenance Supervisor in-serviced all staff on when and how to report environmental issues.<br><br>The Quality Assurance Improvement (QAPI) Team met on 05/24/2023 and discussed the roof issues within the facility and the plan to correct the issues. Environmental policies and procedures were reviewed with no revisions required at this time. The roof was repaired in January 2023, the dining room area continued to leak due to old equipment that remained on the roof. The equipment was removed on 05/23/2023 and the roof will be resealed to prevent any further leaks on or before 06/20/2023. The Maintenance Supervisor, or the Administrator will make daily rounds to ensure that the facility remains free of leaks in the dining room beginning 05/30/2023 ending 08/31/2023. Any leaks found will be addressed by the Maintenance Supervisor and the Administrator immediately and findings will be reported to the QAPI Team monthly | |

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| F 584 | Continued From page 6<br>been unable to identify where the water is coming from. The Maintenance Director denied seeing mold or mildew in the building.<br><br>On 05/25/23 at 10:30 AM, in an interview with the Administrator, she revealed that she started working at the facility in February of this year. She confirmed that the dining room leaks when it rains, and from what she has been told by the Maintenance Director, the problems with the roof leaking have been an ongoing problem. The Administrator noted that her concern is that the leaking has the potential to cause problems related to resident health and safety.<br><br>On 05/25/23 at 11:20 AM, an observation in the main dining room revealed four small puddles of water on the floor near the entry, under the light fixtures.<br><br>On 05/25/23 at 01:09 PM, in an interview with the Maintenance Director, he confirmed the puddles of water that had been observed earlier that day on the floor in the main dining room came from rain. | F 584 | beginning 06/20/2023 for review and recommendation. Recommendations will be forwarded to the Regional Director of Operations and the Regional Director of Maintenance beginning 06/20/2023 and ongoing thereafter for further review and assistance in completing repairs that may be needed. | |
| F 644 SS=D | Coordination of PASARR and Assessments<br>CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br>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:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the | F 644 | | 6/20/23 |

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| F 644 | Continued From page 7<br>PASARR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interview, and facility policy review, the facility failed to complete a Level I Pre-Admission Screening and Resident Review (PASARR) evaluation for one (1) of three (3) residents reviewed for Pre-Admission Screens (PAS). A Level II screening was not performed for this resident because the Level I PAS was not completed. Resident #11<br><br>Findings include:<br><br>Record review of the facility's policy, "Admission Criteria", reviewed 4/25/23, revealed, "...All new admission and readmissions are screened for mental disorders (MD)...per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions...to determine if the individual meets the criteria for a MD. b. If the level I screen indicates that the individual may meet the criteria for a MD...he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process..."<br><br>Record review of the facility's policy "Physician Certification for Nursing Facility and MI/MR | F 644 | The facility failed to complete a level I and level II pre-admission screening (PASSAR) on resident # 11 upon admission and readmission. The Social Worker performed and successfully submitted a PASSAR on resident #11 on 05/22/2023.<br><br>All residents, both current and newly admitted to the facility have the potential to be affected.<br><br>The Administrator conducted a direct in-service with the Social Worker and the Admissions Coordinator on 5/30/2023 related to the requirements to complete a successful level I and Level II PASSAR for new admissions and readmissions. The Social Worker and the Admissions Coordinator conducted a chart audit on 100% of all residents, beginning 06/12/2023 ending 06/16/2023 to verify that all residents' have a PASSAR in their medical record. A list was conducted of any residents that do not have a PASSAR and the Social Worker will perform and successfully submit all missing PASSAR's no later than 06/20/2023. | |

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| F 644 | Continued From page 8<br>Screening", revised 9/15/2014, revealed, " ...The Admission Coordinator or designee will obtain a current ...PAS (MS), and PASRR if required on all Medicare Part A admissions ..."<br><br>A review of the medical record revealed there was no copy of a Level I or Level II PASSAR document located in the resident's chart.<br><br>Record review of the "Admission Record" revealed the facility admitted Resident #11 on 1/5/2021 and he had an original admission date of 3/7/2006. He had a diagnosis of Bipolar Disorder with an "Onset Date" of 3/7/2006.<br><br>During an interview on 05/23/23 at 11:00 AM, with the Administrator, she stated the facility was unable to locate a copy of the Level 1 PASARR that should have been completed for Resident #11 when he was admitted to the facility in 2006. | F 644 | The Quality Assurance Team (QAPI) met and discussed the systematic failure related to resident #11 and all residents that could be affected on 5/24/2023. The QAPI Team implemented a plan of correction to perform an audit of all current residents' medical records to ensure a PASSAR has been completed for level I and level II screenings. For all new admissions and readmissions, the PASSAR will be reviewed in the weekly Person's at Risk (PAR) meeting beginning 05/31/2023 and on going thereafter to ensure completion. All findings will be reviewed by the QAPI Team monthly beginning 06/20/2023 and on going thereafter for review and recommendation. | |
| F 645 SS=D | PASARR Screening for MD & ID<br>CFR(s): 483.20(k)(1)-(3)<br><br>§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.<br><br>§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:<br>(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; | F 645 | | 6/20/23 |

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| F 645 | Continued From page 9<br>and<br>(B) If the individual requires such level of services, whether the individual requires specialized services; or<br>(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-<br>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and<br>(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.<br><br>§483.20(k)(2) Exceptions. For purposes of this section-<br>(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.<br>(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-<br>(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,<br>(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and<br>(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. | F 645 | | |

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| F 645 | Continued From page 10<br><br>§483.20(k)(3) Definition. For purposes of this section-<br>(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).<br>(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interview, and facility policy review, the facility failed to accurately complete the Pre-Admission Screening (PAS) to indicate residents who had a diagnosis of a major mental illness for two (2) of three (3) residents reviewed. Level II screenings were not completed for these residents because of the inaccurate PAS. Resident #23 and Resident #40<br><br>Findings include:<br><br>Record review of the facility's policy, "Admission Criteria", reviewed 4/25/23, revealed, "...All new admission and readmissions are screened for mental disorders (MD)...per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions...to determine if the individual meets the criteria for a MD. b. If the level I screen indicates that the individual may meet the criteria for a MD...he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process..." | F 645 | The facility failed to complete a level II pre-admission screening (PASSAR) on Residents #23 and #40 based on level I PASSAR results and a serious mental disorder diagnosis upon admission and readmission. The Social Worker performed and successfully submitted a PASSAR on Residents #23 on 05/23/2023 and #40 on 06/14/2023.<br><br>All residents, both current and newly admitted, have the potential to be affected.<br><br>The Administrator conducted a direct in-service with the Social Worker and the Admissions Coordinator on 5/30/2023 related to PASSAR information and requirements to complete a successful PASSAR for new admissions and readmissions. The Social Worker and Admissions Coordinator conducted a chart audit on 100% of all current residents, beginning June 12th ending June 16th to verify that all residents have a PASSAR in their medical record. A list | |

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| F 645 | Continued From page 11<br><br>Record review of the facility's policy "Physician Certification for Nursing Facility and MI/MR Screening", revised 9/15/2014, revealed, " ...The Admission Coordinator or designee will obtain a current ...PAS (MS), and PASRR if required on all Medicare Part A admissions ..."<br><br>Resident #23<br><br>Record review of the "PAS Summary and Physician Certification", dated 3/4/2020 revealed, "...Part B - Level II Referral Criteria ...Person has a diagnosis of a major mental illness?" the facility indicated "No".<br><br>Record review of the "Admission Record" revealed the facility admitted Resident #23 on 2/24/20 with a diagnosis "Onset Date" of 2/24/20 for Paranoid Schizophrenia, which is classified as a major mental illness.<br><br>Resident #40<br><br>Record review of the "Pre-Admission Screening (PAS) Application for Long Term Care", dated 10/12/20, revealed, "...B. Level II Referral ...Person has a diagnosis of a major mental illness?" the facility indicated "No".<br><br>Record review of the "Admission Record" revealed the facility admitted Resident #40 on 9/2/2020 with a diagnosis of Schizophrenia "Onset Date" of 9/2/2020.<br><br>On 05/22/23 at 11:20 AM, during an interview with Admission Nurse/License Practical Nurse (LPN) #5, she stated she did not know the purpose of the PASSAR. LPN #5 confirmed Resident #23 | F 645 | was conducted of any residents that do not have a PASSAR in their medical record and a diagnosis that triggers a level II screening.<br><br>The Quality Assurance Improvement (QAPI) Team met and discussed the systematic failure on PASSAR level I and level II directly related to Resident #23 #40 and all residents that could be affected on 5/24/2023. The QAPI Team implemented a plan of correction to perform an audit of all residents' medical records that reside in the facility to ensure that they have a PASSAR completed. The Social Worker will perform and successfully submit all missing PASSAR's and level II's no later than 06/20/2023. For all new admissions and readmissions, the PASSAR will be reviewed in the weekly Person's at Risk (PAR) meeting beginning 05/31/2023 and on going thereafter to ensure completion. All findings will be reviewed by the QAPI Team monthly beginning 06/20/2023 and on going thereafter for review and recommendation. | |

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| F 645 | Continued From page 12<br>was marked as not having a mental illness on the PAS, but she had a diagnosis of Schizophrenia upon admission. LPN #5 also confirmed that the admission PAS reflected that Resident #40 had no mental illness diagnosis, but she also had a Schizophrenia diagnosis upon admission.<br><br>An interview on 5/24/23 at 1:00 PM, with the Director of Nursing (DON) confirmed that Resident #23 and Resident #40 had diagnoses of Schizophrenia upon admission. She commented that if the residents needed a PASARR Level 2 screening, then the resident should have had it completed so they could receive any recommended services based on the results of the Level II evaluation.<br><br>An interview on 5/24/23 at 1:30 PM, with the Administrator, revealed the purpose of the PAS is to determine if the residents are appropriate for nursing home placement. She revealed that a PASARR Level 2 is used to determine if there are any special services that the resident might need based on their diagnosis. She said that if the Resident had a diagnosis of Schizophrenia and was not evaluated for a PASARR Level 2, the resident might have missed some needed services. | F 645 | | |
| F 656 SS=G | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 | F 656 | | 6/20/23 |

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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-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:

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| F 656 | Continued From page 14<br>Based on interviews, record review and facility policy review the facility failed to develop and/or implement an individualized person-centered care plan for two (2) of 22 care plans reviewed. Resident's #7 and #25<br><br>Findings include:<br><br>A record review of the facility's policy "Using the Care Plan" with no date revealed, " ... It is the policy of this facility that the care plan be used in developing the resident's daily care routines ... 3. Changes in the resident's condition should be reported to the MDS (Minimum Data Set) assessment coordinator and or nurse supervisor so that a review of the resident's assessment and care plan can be made. 4. Daily care and documentation should be consistent with the resident's care plan."<br><br>A record review of the facility's policy "Care Plan-Comprehensive" with no date revealed, " ... It is the policy of this facility to develop comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs. Procedure ... 4. Care plans are revised as changes in the resident's condition dictates ..."<br><br>Resident #7<br><br>A record review of Resident #7's Admission Record revealed an admission date of 08/10/18 and a readmission date of 12/13/22, with diagnosis of Functional Quadriplegia, Type 2 Diabetes Mellitus, and Expressive Language Disorder. | F 656 | Resident #7 and resident #25 care plan's have been updated to show person-centered care was addressed on 5/24/2023.<br><br>All residents that reside in the facility have the potential to be affected.<br><br>A direct in-service was performed with the Care Plan Nurse and the Minimum Data Set (MDS) Coordinator by the Regional MDS Nurse on 06/12/2023 to include individualized and person-centered care plan's along with proper daily documentation. All Nursing staff were in-serviced beginning 05/30/2023 ending 06/16/2023 on activities of daily living (ADL) care, routine checks, and peri-care policy. The Care Plan Nurse performed a 100% audit of Care plans on 06/13/2023 to include updating and defining person-centered care.<br><br>The Quality Assurance Performance Improvement (QAPI) Team met on 05/24/2023 to discuss the systematic failure and how to improve the daily outcome to follow resident #7 and #25's individualized care and resident rights to attain their highest quality of care and psychosocial well-being. The Care Plan, both comprehensive and person-centered policy, ADL, routine checks and peri-care policy were reviewed with no revisions needed at this time. The QAPI Team will meet weekly beginning 05/31/2023 during the Person's at Risk (PAR) meeting and review two (2) additional resident care plans per week to ensure accuracy and | |

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| F 656 | Continued From page 15<br>On 05/21/23 at 12:45 PM, in an interview and observation with the spouse/Resident Representative (RR) of Resident #7, she revealed when she arrived at the facility today, the resident was double briefed and saturated in urine. The RR had just completed the resident's care and was able to reveal the saturated briefs that had been removed. The spouse explained that during her visits, she had often noted that the resident had been wearing double briefs that were saturated in urine and she was concerned that this could possibly cause the resident to develop another urinary tract infection (UTI). The spouse explained Resident #7 had been hospitalized several times due being septic related to a UTI, with the last UTI being diagnosed and treated in May.<br><br>Record review of the Care Plan revealed that the resident is incontinent of bowel and bladder and the resident's risk for septicemia will be minimized/prevented by recognition and treatment of symptoms of UTI. Review of the interventions revealed an intervention to check for incontinence and provide peri care as needed.<br><br>On 05/23/23 at 03:10 PM, during an interview with the Director of Nursing (DON), she explained she expects staff to assist residents when residents request and to provide care every two (2) hours and to follow the resident's plan of care.<br><br>Resident #25<br><br>A record review of Resident #25's "Admission Record" revealed the facility admitted Resident #25 initially on 09/16/16 and readmitted on 08/24/17 with the diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction | F 656 | person-centered care is being achieved daily. This will be completed on a weekly on going basis and any negative findings will be addressed immediately and corrected according to facility policy. All findings will be reviewed by the QAPI Team monthly beginning 06/20/2023 and on going thereafter for review and recommendation. | |

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Affecting Left Non-Dominant Side, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified, and Tobacco Use.

A record review of Resident #25's "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 4/13/23 revealed a Brief Interview for Mental Status (BIMS) Score of 15, which indicated cognitively intact. Further review of the MDS revealed Resident #25 is frequently incontinent of urine and always incontinent of bowel and requires two (2) person assist for personal hygiene.

On 05/21/23 at 12:07 PM, Resident #25 observed lying in bed with head of bed elevated, resident's lunch tray on tray table and resident not eating very much. Resident #25 reported at 10:00 AM, she informed the CNA that she needed assistance with being changed to a clean brief due to having a bowel movement (BM), but the CNA did not come back, and she had not been changed at the time of this interview. Resident's lunch tray was on the table. Resident confirmed that she was served her lunch tray and had to eat her lunch while sitting in bowel. A strong foul odor was present while talking to the resident. Resident #25 reported somedays it may take hours before she gets changed.

On 05/21/23 at 12:40 PM, observed incontinent care of Resident #25 provided by CNA #1 and CNA #3. Prior to care, observed large loose watery diarrhea leaking through Resident #25's brief and on the incontinent pad. Observed the loose diarrhea from top of Resident #25's pubic hair, in-between thighs, and entire buttocks with moderate excoriated redness noted to entire buttocks, sacrum, thighs. Resident #25 was

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| F 656 | Continued From page 17<br>crying during entire incontinent care and saying it hurts so bad.<br><br>A record review of Resident #25's Comprehensive Care Plan revealed care plans for bladder and bowel incontinence with target dates of 02/19/23 with goals " ... I will remain free from skin breakdown due to incontinence and brief use through the review date ... and ... I will have less than two episodes of incontinence per day through the review date ... with interventions ... Clean peri-area with each incontinence episode ... incontinent: check Q (every) shift and as required for incontinence ... check resident every two hours and assist with toileting ..."<br><br>On 05/23/23 at 03:00 PM, during an interview with the Director of Nursing (DON), she explained it is not acceptable for a resident to have to lay in a soiled dirty brief with BM while eating lunch or any other time for a long period of time. She explained she expects staff to assist residents when residents request and to provide care every two (2) hours and follow the resident's care plan. | F 656 | | |
| F 677 SS=G | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2)<br><br>§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;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident who was dependent on staff for incontinence care received those services for one (1) of five (5) residents reviewed for incontinence | F 677 | Resident #25 was interviewed by the Administrator on 05/23/2023, educated on her resident rights and the facility policy on dignity and respect. The Certified Nursing Assistants (CNA) and Nurses that | 6/20/23 |

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| F 677 | Continued From page 18<br>care. Resident #25.<br><br>Findings Include:<br><br>A review of the facility's policy "Routine Resident Checks", dated 6/1/2000, revealed, " ...It is the policy of this facility to make routine resident checks to assure that the resident's safety and wellbeing are maintained. Procedure 1. To ensure the safety and well-being of our residents, a resident check will be made every two (2) hours by nursing service personnel ..."<br><br>On 05/21/23 at 12:07 PM, in an interview and observation with Resident #25, she reported that at 10:00 AM this morning, she informed a Certified Nurse Aide (CNA) that she needed to be changed because she had a bowel movement. She stated the CNA did not come back, and she still had not been changed and she had to eat her lunch meal while sitting in a soiled brief. There was a strong, foul odor in the resident's room.<br><br>During an observation and interview on 05/21/23 at 12:20 PM, CNA #1 entered the resident's room and explained she arrived to work today around 10:00 AM and was assigned Resident #25. CNA #1 said that she answered Resident #25's call light around 10:00 AM, but the resident had only asked who her aide was, and did not mention that she had a bowel movement or that she needed to be changed. She said that she explained to the resident that she was starting her rounds at the beginning of the hall and working her way back to her. Resident #25 insisted that she did tell someone that she needed to be changed and that she could have told another CNA.<br><br>On 05/21/23 at 12:40 PM, during an observation | F 677 | were on duty on 05/21/2023 were educated by the Administrator on resident rights, dignity and respect, activities of daily (ADL) care and routine check policies on 5/23/2023.<br><br>All residents who require assistants with Activities of Daily Living have the potential to be affected.<br><br>All staff were educated beginning 05/23/2023 ending 06/16/2023 on residents' rights along with the dignity and respect policy by the Social Worker.<br><br>The Quality Assurance Performance Improvement Team (QAPI) met on 5/24/2023 and discussed policy and procedure on dignity and respect, activities of daily (ADL) care and routine check with no revisions needed at this time. The Social Worker will use a daily monitoring tool beginning 05/30/2023 and ending 08/31/2023 to ensure that Resident #25 and all current residents are being treated with a dignified existence and their resident rights are being followed. This will be completed through observation and communication with residents. Any adverse findings will be addressed and resolved immediately and reported to the Administrator or Director of Nursing by the Social Worker. All findings will be reported to the QAPI Team monthly beginning 06/20/2023 and ending 08/31/203 for review and recommendations. | |

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of incontinence care with CNA #1 and CNA #3, Resident #25 was wearing a brief that was saturated with loose feces that had leaked through the brief and onto the incontinence pad. Her buttocks, thighs, and sacrum were red and excoriated and she was crying and stated that she was hurting.

On 05/22/23 at 02:15 PM, during an interview with Registered Nurse (RN) #2, she explained Resident #25 did tell her at 9:00 AM on 5/21/23 that she needed to see an aide and she told Resident #25 that she would get someone, but she did not see any CNAs and she went on to pass out breakfast trays. She said the resident did not express why she needed assistance and she did not ask the resident what she needed. She confirmed that she told Resident #25 to be patient and the CNAs would be on the way and that Resident #25 asked again to see an aide and she told her to use the call light and give it 15 minutes to see if they arrive.

On 05/22/23 at 02:22 PM, during an interview with CNA #1, she reported that she answered the call light for Resident #25 when she first arrived at 10:00 AM, but Resident #25 only asked her who her aide was, and she did not specify what she needed, and she (CNA #1) did not ask the resident what she needed. She stated that she did not provide any care for Resident #25 on 05/21/23 until 12:20 PM.

On 05/22/23 at 02:45 PM, during an interview with CNA #2, she stated that she was unaware that Resident #25 needed to be changed. CNA #2 confirmed that she did not complete rounds or provide care to Resident #25 while she was at the facility on 5/21/23.

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On 05/22/23 at 03:00 PM, during an interview CNA #3, she confirmed she was working on 05/21/23 day shift and she never assisted or provided care for Resident #25 until she assisted CNA #1 with incontinence care around 12:30 PM.

On 05/23/23 at 09:10 AM, in an observation and interview with CNA #1, Resident #25 had an opened, excoriated area to her left buttock and left abdominal fold. CNA#1 reported that the areas are new. Resident #25 said the new open areas appeared after being left in a soiled brief on 05/21/23 and she had a new Physician's Order for cream to those areas.

On 05/23/23 at 09:25 AM, during an interview with RN #3, she confirmed Resident #25 had new opened areas to her buttocks and abdominal fold and the nurse practitioner had written new orders for cream for moisture-associated areas on 05/22/23.

On 05/23/23 at 03:00 PM, during an interview with the Medical Director, he explained he was aware of the concerns with resident care, and he expected all residents to be provided with care and assistance as needed.

On 05/23/23 at 03:10 PM, during an interview with the Director of Nursing (DON), she explained that she expected staff to assist residents and to provide care every two (2) hours.

On 05/23/23 at 3:30 PM, during an interview with the Administrator, she explained she expected staff to complete care every two (2) hours.

A record review of the "Admission Record"

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| F 677 | Continued From page 21<br>revealed the facility admitted Resident #25 on 8/24/17 and she had diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side and Type 2 Diabetes Mellitus.<br><br>A record review of the "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 4/13/23 revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Further review revealed she required extensive assistance with toilet use and was always incontinent of bowel.<br><br>A record review of the "Order Summary Report" with "Active Orders As Of: 05/25/23, revealed Resident #25 had a Physician's Order, dated 05/22/23, to "Cleanse MASD (moisture associated skin damage) to bilateral buttocks with mild soap and water, pat dry, apply barrier cream with zinc...two times a day for MASD wound care."<br><br>A record review of the facility's document "Task ... Schedule for May 2023 ...", revealed on 05/21/23, there was no documentation that Resident #25 received any care during the day shift hours of 7:00 AM through 3:00 PM. | F 677 | | |
| F 684 SS=G | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in | F 684 | | 6/20/23 |

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| F 684 | Continued From page 22<br>accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, record reviews and facility's policy review the facility failed to administer intravenous (IV) antibiotics per Physician's Orders for one (1) of two (2) Residents reviewed for hospitalization. Resident #35.<br><br>Findings Include:<br><br>A record review of the facility's policy "Admission Criteria" with a review date of 4/25/23 revealed " ...Our facility admits only residents whose medical and nursing care needs can be met. Policy Interpretation and Implementation 1. The objectives of our admission criteria policy are to: ... b. admit residents who can be cared for adequately by the facility ... 7. Some examples of nursing/medical needs that can be met adequately include a. medication management ..."<br><br>A record review of the facility's policy "Physician's Orders", dated 4/13/2021, revealed, " ...Physician's orders are carried out unless the nurse or other licensed personnel believe the order to be in accurate, efficacious, or contraindicated ..."<br><br>On 05/23/23 at 04:00 PM, during a phone interview with the Resident Representative (RR) for Resident #35, she explained that she was the resident's wife and that the resident had been transferred to the hospital the other night due to behaviors. She stated he was admitted to the | F 684 | The facility failed to administer intravenous (IV) antibiotics per physicians' orders for resident #35. On 5/24/2023 the Regional Nurse Consultant in-serviced the Director of Nursing and the Assistant Director of Nursing on following physician's orders and documentation per company policy.<br><br>All residents have the potential to be affected.<br><br>The Director of Nursing and the Assistant Director of Nursing educated all nurses beginning 05/24/2023 ending 06/12/2023 on following physicians orders, who and when to notify if a medication is missed and documenting properly per facility policy.<br><br>The Quality Assurance Performance Improvement (QAPI) Team reviewed the company policy and procedures on 05/24/2023; policies reviewed were following physician's orders and documentation guidelines. No revisions were needed at this time. The Director of Nursing or the Assistant Director of Nursing will monitor the dashboard daily beginning 05/30/2023 and on going thereafter to ensure that no IV medications have been marked with a nine (9), meaning they were not administered and investigate the reason | |

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| F 684 | Continued From page 23<br>hospital because he had "another infection."<br><br>A record review of the "Order Recap Report", revealed Resident #35 had a Physician's Order, dated 5/2/23, for "Vancomycin HCl Intravenous (IV) Solution ...one time a day for Infection for 3 Days." The Order status was "Completed" with an "End Date" of 5/6/23. There was a Physician's Order, dated 5/8/23, for "Telephone call to (Proper Name of Physician). Informed him that resident missed his last dose of Vancomycin 1500 milligrams (mg), IV due to IV not functioning. Order to not restart IV but observe resident and be attentive to any labs." Resident #35 also had a Physician's Order, dated 5/21/23, to "Send to ER (Emergency Room) for eval (evaluation) and tx (treatment) r/t (related to) combative and delusional behavior."<br><br>A record review of Resident #35's "Medication Administration Record (MAR)" for 05/01/23 through 05/31/23 revealed Vancomycin HCL Intravenous Solution 1500 mg intravenously one time a day for infection for 3 days with a start date of 5/3/23. The MAR revealed that on 5/3/23 and 5/5/23 there was an entry coded as "9" which indicated the medication was not administered. On 5/4/23 there was a checkmark recorded which indicated the medication was administered.<br><br>A record review of the "Progress Notes" for Resident #35 revealed a "Health Status Note", dated 5/3/23, "Resident returned from the hospital ...DX (Diagnoses) acute encephalopathy, sepsis, hypothermia ...Will be receiving IV Vanc (Vancomycin) QD (every day) x (times) 3 more days ..." A review of the "Medication Administration Note", dated 5/4/2023 at 0127 (1:27 AM) revealed, " ...Vancomycin HCl | F 684 | why. The information will be brought to the daily stand-up meeting by the Director of Nursing or the Assistant Director of Nursing and discussed with the Administrator beginning 05/30/2023 and on going thereafter and any adverse factors will be addressed immediately. Any findings will be reviewed monthly beginning 06/20/2023 and on going thereafter by the QAPI Team for review and recommendation. | |

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| F 684 | Continued From page 24 | F 684 | | |

Intravenous Solution ...Med n order." A review of a "Medication Administration" note, dated 5/5/23, revealed " ...IV not given ...IV will not infuse." A review of a "Health Status Note", dated 5/21/23, revealed " ...Resident became physically combative ...Received order to send to ...ER ..."

On 05/24/23 at 07:00 AM, during a phone interview with Licensed Practical Nurse (LPN) #6, she explained that when a MAR entry is coded as "9", it meant the medication was not administered and the nurse had to enter a reason and it would automatically record a medication administration note in the (electronic) chart. She stated she did not administer the medication on 5/3/23 and had entered "med n order" for the reason because that is what she was told to do by management if a medication was not available. LPN #6 said that on 05/04/23, she documented that the Vancomycin was administered on the MAR, but that was an error, and she did not administer it because an RN must administer IV medications. She confirmed that Resident #35 did not receive IV Vancomycin on 05/03/23 or 05/04/23 and that all three (3) doses were in the medication room on 05/05/23 when she left the facility after her shift at 07:00 AM.

On 05/24/23 at 02:30 PM, during an interview with LPN #4, she explained she was working on 05/05/23, which was the last day that Resident #35 was scheduled to receive IV antibiotic medications. She stated that she informed the Assistant Director of Nursing (ADON) that Resident #35 had received "not one dose" of the IV medications. She reported the ADON went to administer the antibiotic, but she could not get the medication to infuse, and she thought the ADON was going to call the physician about the issue.

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| F 684 | Continued From page 25 | F 684 | | |

LPN #4 said that on 5/21/23, Resident #35 had behaviors and had to be sent to the emergency department. She commented that "He was probably still septic" due to not receiving the antibiotics as ordered.

On 05/24/23 at 03:25 PM, during an interview with the ADON, she explained that she could not get the IV to work and she thought RN #1 had phoned the physician about Resident #35 missing his last dose of antibiotics. The ADON was unable to explain why there was no documentation related to notifying the physician of the IV medication not being administered until 5/8/23, which was three (3) days after she became aware on 5/5/23 that the IV was not functioning. The ADON reported she was new at her job and denied that she had been told by LPN #4 that Resident #35 had missed all three doses of his IV antibiotics.

On 05/24/23 at 03:40 PM, during an interview with RN #1, she explained that on 5/5/23, which was the last day Resident #35 was scheduled to receive IV antibiotics, the ADON asked her to assess the IV line. She stated that she tried to flush the line and it would not flush, so she returned to her medication cart because she had to take care of her assigned residents. She said that she did not chart anything about the IV and did not notify the physician that the IV was not functioning. RN #1 confirmed that she did not administer any IV medications to Resident #35.

On 05/25/23 at 2:00 PM, during an interview with the Director of Nursing (DON), she explained she was not aware Resident #35 had missed all three doses of IV antibiotics after he had returned to the facility from the hospital. She explained that

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| F 684 | Continued From page 26 | F 684 | | |

she expected the ADON to notify the physician as soon as she was aware the resident had missed the medication. She explained with Resident #35 missing all three doses of the antibiotic, he would still have an infection and could become septic, which could cause behavioral issues and confusion.

On 05/25/23 at 2:30 PM, during an interview with the Administrator, she explained she would expect the ADON to notify the DON, the physician, and the family member when a resident missed a medication.

05/25/23 at 03:00 PM, during an interview with the Medical Director, he explained he was not aware that Resident #35 was readmitted to the hospital on 5/21/23 and confirmed that the missing three (3) doses of IV antibiotic medications could have caused sepsis and behavioral issues.

A record review of the "Admission Record" revealed the facility admitted Resident #35 on 5/02/23 and he had diagnoses including Pneumonia and Dementia.

Record review of the "Packing Slip", dated 05/02/23, revealed RX (Prescription) number 81824434 for Vancomycin Inj (Injection) was received by the facility for Resident #35.

A record review of the "ED (Emergency Department) Provider Notes", dated 5/21/23 revealed, " ...complaints of altered mental status aggressive behavior and hallucinations ...I see that he is been admitted in the recent past for similar and he was with apparent sepsis ...Diagnoses ... Acute UTI (urinary tract infection)

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| F 684 | Continued From page 27<br>and Acute encephalopathy ..." | F 684 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. | F 690 | | 6/20/23 |

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| F 690 | Continued From page 28<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, record review, and facility policy review, the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice, to prevent the possibility of a urinary tract infection for one (1) of five (5) residents reviewed for incontinent care. Resident #7<br><br>Findings include:<br><br>On 05/21/23 at 12:45 PM, in an interview and observation with the Spouse/Resident Representative (RR) of Resident #7, she revealed Resident #7 has been hospitalized several times with sepsis related to a urinary tract infection (UTI). The RR stated that the resident's most recent hospitalization was in May. The RR explained that during her visits, she had noted that several times, including today, the resident was double briefed with briefs that were saturated with urine. The spouse was concerned that this could contribute to the possibility of developing another UTI. An observation with the RR revealed that Resident # 7 was double briefed.<br><br>On 05/24/23 at 2:21 PM, in an interview with Licensed Practical Nurse (LPN) #4, she confirmed Resident #7 that she was aware that there are times in which the resident is double briefed. LPN #4 stated that she recalls the resident being double briefed and saturated with urine when the RR and SA observed the double briefing on 5/21/23. LPN #4 commented that no resident should be double briefed at any time, as being double briefed and saturated in urine increases a resident's chance of getting a UTI. | F 690 | Resident #7's orders and care plan were reviewed for person-centered care related to the condom catheter. The Administrator met with the resident representative on 06/08/2023 to discuss any further issues and resident rights. A care conference was held with the resident representative to address catheter care needs with the Assistant Director of Nursing, the Care Plan Nurse and the contract Wound Nurse on 06/08/2023 with an outcome to discontinue the condom catheter and educating the staff on activities of daily living care (ADL) and peri-care.<br><br>All residents who are incontinent of bowel and bladder or require catheter care have the potential to be affected.<br><br>A direct in-service was performed with the Care Plan Nurse and the Minimum Data Set (MDS) Coordinator by the Regional MDS Nurse on 06/12/2023 to include individualized and person-centered Care Plan's along with proper daily documentation. All Nursing staff were in-serviced beginning 05/30/2023 ending 06/16/2023 on activities of daily living (ADL) care, routine checks, peri-care and catheter care policy. All Nurses will have a catheter care competency check-off performed beginning 06/12/2023 and completed no later than 6/20/2023 by the Director of Nursing or the Assistant Director of Nursing.<br><br>The Quality Assurance Performance | |

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| F 690 | Continued From page 29<br>On 05/24/23 at 3:26 PM, an interview Director of Nurses (DON) confirmed that residents should not be double briefed, as this could increase the possibility of a resident developing a UTI, especially when saturated with urine, as was noted the other day on May 21, 2023.<br><br>A record review of Resident #7 Admission Record revealed an admission date of 08/10/18 and a readmission date of 12/13/22, with diagnosis of Functional Quadriplegia, Type 2 Diabetes Mellitus, and Expressive Language Disorder. | F 690 | Improvement Team (QAPI) met and discussed resident #7's history of urinary incontinence related to his resident representatives concerns and the condom catheter not being addressed daily according to his Care Plan and orders on 5/24/2023. The QAPI Team recommended to in-service all staff on ADL care, routine checks, and peri care and all Nurses to have a competency check off completed and in-service on catheter care. This is to be completed no later than 06/20/2023 and reported to the QAPI Team with any findings. The Director of Nursing or Assistant Director of Nursing will audit one (1) catheter care procedure per week for four(4) weeks and monthly thereafter for three(3) months to ensure proper technique is being performed. All findings will be reported to the QAPI Team monthly beginning 06/20/2023 and ending 9/30/2023 for review and recommendation. | |
| F 725 SS=H | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). | F 725 | | 6/20/23 |

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| F 725 | Continued From page 30<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, record reviews, and facility policy review, the facility failed to ensure there were sufficient staff to meet the needs of residents for one (1) of two (2) Units in the facility, the South Wing. This deficient practice had the potential to affect 55 residents who reside on the South Wing.<br><br>Findings include:<br><br>Review of the facility's policy, "Staffing", revised October 2017, revealed, " ...Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. Policy Interpretation and Implementation ...2. Staffing numbers ...of direct care staff are determined by the needs of the residents based on each resident's plan of care ...Direct care staffing information per day ...is submitted to the CMS (Centers for Medicare and Medicaid | F 725 | All residents were assessed by the Director of Nursing on 05/24/2023 with no adverse effects found. Ads were placed on 05/25/2023 for contract nurses and certified nursing assistants and will run continuously until all staffing needs are met. The Direct Care Staff will be increased to include weekends to ensure we are adequately staffed effective 05/25/2023 and will be maintained continuously to meet state and federal staffing requirements and to provide adequate care for all residents who reside in the facility. The on-call person will make great efforts to maintain the proper staffing ratio and make calls or texts to achieve this when a call-out has been placed by an employee effective 05/25/2023 and ongoing, if there is any issues with coverage the on- call person will notify the Director of Nursing and the Administrator for further guidance. | |

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| F 725 | Continued From page 31<br>Services) payroll-based journal (PBJ) ...no less than once a quarter ...."<br><br>A record review of the "PBJ Staffing Data Report" for October 1 through December 31, 2022, revealed "Excessively Low Weekend Staffing" was triggered which meant the data submitted by the facility indicated that weekend staffing data was excessively low.<br><br>A record review of the facility's floor plan revealed the "South Wing" consists of resident rooms 1-34.<br><br>During an interview on 10/21/23 at 11:15 AM, with CNA #2, she said she started her shift at 7:00 AM and had to leave at 11:30 AM. CNA #2 said she was assigned to the South Wing, Rooms 1-8. She confirmed she did not provide care to rooms 24-34 because there were only two (2) CNAs assigned to the South Wing, and she could not get to those residents. She said that CNA #1 had come in at 10:00 AM to care for the residents in rooms 24-34 on the South Wing.<br><br>On 05/21/23 at 12:20 PM, during an observation and interview with Resident #25, there was a strong, foul odor in the room. Resident #25 explained that she had a bowel movement around 10:00 AM, but no one had come to change her. She said that she had told a Certified Nurse Aide (CNA) that she needed assistance, but the CNA did not come back to clean her up. Resident #25 said she had to eat lunch while sitting in her dirty brief. Resident #25 also commented that the staff do not like for her to use her call light because they say they are short of staff and don't have time to answer the light. | F 725 | All residents have the potential to be affected.<br><br>The Staffing Development Nurse was in-serviced on 05/30/23 by the Director of Nursing on the importance and requirements of daily direct care staffing needs. The Certified Nursing Assistants and Nurses that were on duty on 05/21/23 were educated by the Administrator on resident rights, dignity and respect, activities of daily living (ADL) care and routine check policies on 05/23/2023. All staff were in-serviced by the Social Worker on resident rights and dignity beginning 05/30/2023 and ending 06/14/2023.<br><br>The Quality Assurance Performance Improvement (QAPI) Team met on 05/24/2023 and discussed policy related to staffing and postings according to state and federal regulations, no revisions needed at this time. The QAPI team implemented a plan that Direct care staffing needs will be maintained by Human Resource Director, records of daily staffing needs will be discussed and maintained by the Administrator and the Director of Nursing, and any critical needs will be addressed immediately beginning 05/25/2023 and ongoing thereafter. The Facility Assessment Tool Part one (1) our resident profile and part three (3) facility | |

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On 5/21/23 at 12:30 PM, in an interview with Certified Nurse Aide (CNA) #3, she stated that there were two (2) CNAs working on South Wing.

On 5/21/23 at 12:35 PM, in an interview with CNA #1, she explained she was called in around 10:00 AM and was assigned to the South Wing. CNA #1 said she answered Resident #25's call light when she came in at 10:00 AM and told the resident that she was starting her rounds at the beginning of the hall and would work her way back to her.

On 05/21/23 at 12:40 PM, during an observation with CNA #1 and CNA #3 revealed Resident #25 had a large, loose bowel movement that had saturated and leaked through her brief onto the incontinence pad on the bed. The resident's buttocks, sacrum, and thighs had red discoloration and excoriation. The resident was crying and complaining of pain during care.

A record review of the "Admission Record" revealed the facility admitted Resident #25 on 8/24/17 and she had diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side and Type 2 Diabetes Mellitus.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/13/23 revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Further review revealed she required extensive assistance with toilet use and was always incontinent of bowel.

During an interview on 5/23/23 at 10:00 AM with

resources were reviewed and will be updated no later than 06/20/2023. Ads were placed on 05/25/2023 for contract nurses and certified nursing assistants and will run continuously until all staffing needs are met. The Staff Development Registered Nurse and on- call nurse will update the Director of Nursing daily on any staffing changes or needs beginning 05/25/2023 and ongoing thereafter. The Director of Nursing, the Assistant Director of Nursing and the Human Resources Director will notify the Staff Development Registered Nurse of any new hires so they may be added to the direct care schedule accordingly effective 05/25/2023. Beginning on 05/30/2023 the Administrator will provide a weekly report to the Regional Director of Operations on direct care staffing needs and ongoing thereafter. Any findings will be brought to the monthly QAPI meeting beginning 06/20/2023 and ongoing thereafter.

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the Activity Director, she confirmed that she usually worked a double shift as a CNA twice a week due to low staffing.

During an interview on 5/24/23 at 3:30 PM, with Staff Development Registered Nurse (RN) #1, she stated that the facility had been short of staff for a while. RN #1 said that 35 of the 55 residents on the South Wing required extensive assistance and would require five (5) or six (6) CNAs to meet those residents' needs adequately. RN #1 also said she was aware that the facility only had three (3) CNAs scheduled for Sunday 5/21/23 on day shift on the South Wing. RN #1 said she tried to ask people to work extra or work a double shift and was unsuccessful. RN #1 confirmed that it would be "impossible" for two (2) CNAs to meet the needs of 55 residents.

During an interview on 5/24/23 at 4:00 PM, with the Director of Nursing (DON) and the Administrator, they confirmed the facility was short of staff. The Administrator said that the facility is unionized, and the union dictates the pay and the amount of time that staff can work. The Administrator commented that new employees go to work "down the street" to make more money. The Administrator stated that she had talked with the corporate office to make them aware of the staffing concerns and the facility had discussed bonus pay for new hires. She said the facility currently hired contract workers through the facility and not through outside contract workers. The Administrator said she did not know that only three (3) CNAs were scheduled to work the South Wing on 5/21/23 and that staffing shortages were discussed during daily stand-up meetings. The DON confirmed that she was aware there were three (3) CNAs scheduled for

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| F 725 | Continued From page 34<br>Sunday, but she thought some of the staff might stay over to assist, and she thought RN #1 would call and let her know if the facility was short-staffed. She said she would have called in the admission nurse, office staff, or would have come in herself to cover staffing if she had known. The DON confirmed she has had to pull the office staff to work as CNAs to provide care.<br><br>During an interview on 5/25/23 at 3:00 PM with the Medical Director (MD), he said he was aware the facility was short of staff, however, he was not aware that the facility was extremely short of staff until today (5/25/23) and he had talked to the Administrator about it.<br><br>Record Review of the "Facility Assessment Tool", undated, revealed there was no information completed for "Part 1: Our Resident Profile" to include information regarding resident census, diseases/conditions, physical and cognitive disabilities, and resident acuity. There was also no information completed for "Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies" to include a Staffing plan to ensure a sufficient number of qualified staff are available to meet each resident's needs and there was no description of how the facility determines and reviews individual staff assignments for coordination and continuity of care for residents. | F 725 | | |
| F 732 SS=C | Posted Nurse Staffing Information<br>CFR(s): 483.35(g)(1)-(4)<br><br>§483.35(g) Nurse Staffing Information.<br>§483.35(g)(1) Data requirements. The facility must post the following information on a daily | F 732 | | 6/20/23 |

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| F 732 | Continued From page 35<br>basis:<br>(i) Facility name.<br>(ii) The current date.<br>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>(A) Registered nurses.<br>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>(C) Certified nurse aides.<br>(iv) Resident census.<br><br>§483.35(g)(2) Posting requirements.<br>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.<br>(ii) Data must be posted as follows:<br>(A) Clear and readable format.<br>(B) In a prominent place readily accessible to residents and visitors.<br><br>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to post the direct care daily staffing numbers in a location accessible to residents and visitors for four (4) of five (5) days of survey. This | F 732 | On 05/24/2023 a Quality Assurance Performance Improvement (QAPI) meeting was conducted to address and discuss the requirements for posting and | |

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| F 732 | Continued From page 36<br>affected all residents in the facility.<br><br>Findings Include:<br><br>Observations of the facility from 05/21/23 through 05/24/23, revealed there was no posting of the direct care daily staffing numbers.<br><br>On 05/24/22 at 3:32 PM, in an interview with Staff Development Registered Nurse (RN) # 1, she confirmed the facility had not posted the direct care daily staffing numbers in an area where the residents and visitors could access the information. RN #1 said she had worked the floor as a staff nurse and had not posted the information.<br><br>During an interview on 05/24/23 at 3:45 PM, with the Director of Nursing (DON), she revealed she did not know the direct care daily staffing numbers had not been posted all week. The DON said RN #1 was responsible for posting the staffing every night.<br><br>During an interview on 05/24/23 at 4:07 PM, with the Administrator, she confirmed the direct care daily staffing numbers were not on the clip board outside of her office which is where the numbers are usually posted. She said she did not realize it was not posted. | F 732 | maintaining daily Direct Care staffing information. A resident council meeting was conducted on 05/30/2023 that informed residents of the direct care staffing information that is posted on a clipboard outside of the Administrator's office door. The Regional Director of Operations educated the Administrator, the Staff Development Nurse and the Director of Nursing on 05/30/23 on requirements of posting and maintaining direct care staffing Information.<br><br>All residents have the potential to be affected.<br><br>The Regional Director of Operations educated the Administrator, the Staff Development Nurse and the Director of Nursing on 05/30/23 on requirements of posting and maintaining direct care staffing Information.<br><br>The Quality Assurance Performance Improvement (QAPI) Team met on 05/24/2023 and discussed policy related to staffing and postings according to state and federal regulations, no revisions needed at this time. Direct care staffing information will be posted daily by the Staff Development Registered Nurse on a clipboard outside the Administrator's office door beginning 05/25/2023 and on going thereafter. The Director of Nursing, the Administrator and the Staff Development Registered Nurse will verify the posting of direct care staff information is posted daily beginning 05/25/2023 and on going thereafter. On-call nurses will be updated | |

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| F 732 | Continued From page 37 | F 732 | on any changes to direct care staffing daily by the Director of Nursing, Assistant Director of Nursing or the staff Development Registered Nurse beginning 05/25/2023. Direct care staffing information will be maintained by the Administrator and brought to the monthly QAPI meeting beginning 06/20/2023 and on going thereafter to discuss staff posting verification. The Regional Director of Operations will conduct a monthly review for three (3) months with the Administrator that includes verification of daily posting of direct care staffing beginning 6/20/2023 and ending 9/30/2023. All findings will be brought to the QAPI meeting monthly beginning 06/20/2023 and ending 09/30/2023. | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately | F 761 | | 6/20/23 |

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| F 761 | Continued From page 38<br>locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, record review and facility policy review, the facility failed to remove expired insulin from medication cart for one (1) of two (2) medication carts reviewed.<br><br>Findings include:<br><br>A record review of the facility's policy, "Specific Procedure for All Medications," dated 11/1/2008, revealed, "To administer medications in a safe and effective manner ... Check expiration date on package/container. When opening a multi-dose container, place the date on the container ..."<br><br>On 5/22/23 at 2:40 PM, an observation of the North Hall medication cart with Licensed Practical Nurse (LPN) #1 revealed a vial of Novolog Injection Solution (Insulin Aspart) with an open date of 4/3/23, and Levemir Subcutaneous Solution 100 unit/ml with an open date of 4/16/23.<br><br>On 5/22/23 at 2:55 PM, in an interview with LPN #1, she revealed an open vial of insulin should not be used after 28 days, as it has expired. The LPN confirmed that expired insulin should be removed from the cart on the expiration date, as it is considered ineffective.<br><br>On 5/22/23 at 04:58 PM, in an interview with the | F 761 | On 5/24/2023 the Regional Nurse Consultant audited all medication carts to ensure that there were no expired medications. All expired medications, specifically insulin, were inspected and replaced with a new insulin supply at this time.<br><br>All residents have the potential to be affected.<br><br>All Nurses were in-serviced beginning 5/24/2023 ending 5/30/2023 on policy and procedure on medication expirations and the importance of disposal of medications form the medication cart on the day of it expires by the Assistant Director of Nursing and the Director of Nursing.<br><br>The Quality Assurance Performance Improvement (QAPI) Team met and discussed the adverse event on 5/24/2023 and the negative outcome that this will have on any resident that receives expired insulin or any other medication. The QAPI team recommended that the medication carts are audited weekly for four (4) weeks then monthly for three (3) months beginning 05/30/2023 and ending | |

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| F 761 | Continued From page 39<br>Director of Nursing (DON), she confirmed that insulin should be dated when opened, and removed from the medication cart upon the 28-day expiration date. The DON explained that expired insulin would not be effective, and she expects her staff to pull expired medications from the cart on the day they expire. | F 761 | 09/30/2023 by the Director of Nursing or the Assistant Director of Nursing. The audits will be brought to the monthly QAPI meeting beginning 06/20/2023 and ending 09/30/2023 for review and recommendation. | |