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	255105	A. BUILDING _____ B. WING _____	06/22/2023

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DIVERSICARE OF TUPELO	2273 SOUTH EASON BOULEVARD TUPELO, MS 38804

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and a complaint investigation (CI) MS #21495 at the facility from 6/19/23 through 6/22/23. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F550, F558, F565, F584, F623, F625, F656, F677, F689, F690, F725, F761 and F880. The SA found the facility to not be in compliance related to CI MS #21495 and cited F565, F677, F 689, F690 and F725. The census at the time of the survey was 94 and the facility was licensed for 120 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		8/4/23

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

Electronically Signed | 07/11/2023

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F 550	Continued From page 1 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and facility policy review, the facility failed to promote the dignity of a resident as evidenced by failure to change a brief when wet for one (1) of sixty-seven residents with incontinence. Resident #6 Findings include: Review of the facility policy, undated, titled "Your Resident Rights and Protection Under State and Federal Law", revealed as a resident of a nursing home, you have the same rights and protections as all United States citizens. Nursing home residents also have certain rights and protection under state and federal law. Under Quality of Life, it was revealed that a nursing home must care for	F 550	1. Resident #6 received incontinent care upon notification 06/19/2023 by Licensed Practial Nurse (LPN) #4 and Certified Nursing Assisstant (C.N.A) #3. Body audit conducted by the Director of Nursing (DON) on 06/19/2023, with no negative findings. On 6/19/2023, LPN #4 and C.N.A #3 received education by the Director of Nursing regarding the facility policy for ADL/incontinent care. 2. All residents have the potential to be affected by this practice. 3. Beginning 06/26/2023, the Administrator in-serviced licensed staff	

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F 550	Continued From page 2 you in a manner and environment that promotes the maintenance and enhancement of your quality of life. Under Dignity and Respect, you have the right to be treated with consideration and respect in full recognition of your dignity and individuality. During an interview, on 06/19/23 at 12:45 PM, Resident #6 stated he was wet and that he had not been changed since the night shift. An observation and interview on 6/19/23 at 12:48 PM revealed Licensed Practical Nurse (LPN) #4 and Certified Nursing Assistant (CNA) #3 provided incontinent care to Resident #6. The resident's brief was saturated with urine. CNA #3 stated the resident's brief should not be that wet and that he should have already been changed. LPN #4 confirmed the resident probably needed changing earlier in the day. An interview, on 6/21/23 at 4:30 PM, with Resident #6 revealed when asked how he felt being left in a wet brief for so long, he stated that it made him feel bad. An interview, on 06/22/23 at 8:16 AM, with the Administrator (ADM) revealed that she felt this was a dignity issue for this resident. Review of the facility Admission Record for Resident #6 revealed an admission date of 8/19/2010 with diagnoses that included Spastic Hemiplegia affecting left dominate side, Need for assistance with Personal Care, Generalized Muscle Weakness, and Neuromuscular Dysfunction of Bladder. Review of the Minimum Data Set (MDS) with an	F 550	regarding the facility policy regarding Resident Rights and Actvities of Daily Living (ADL) care. 4. Beginning the week of 06/26/2023, the Director of Nursing/Unit Manager to conduct monitoring rounds of five residents to assure incontinent care provided to residents as ordered. Rounds to be conducted three times a week for four weeks, then weekly for eight weeks. Any negative findings will be corrected immediately. Findings of audit will be brought to the Quality assurance Performance Improvement Committee 7/26/2023 for review and revision as necessary monthly for three months.	

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F 550	Continued From page 3 Assessment Reference Date (ARD) of 6/20/23 revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated Resident # 6 was cognitively intact.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and facility policy review, the facility failed to maintain call lights within reach of the resident for two (2) of twenty-six residents reviewed. Residents #6 and Resident #20 Findings include: Review of the facility policy titled, "Call Lights: Accessibility and Timely Response", undated, revealed the purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow the residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. The policy explanation and compliance guidelines reveal each resident will be evaluated for unique needs and preferences to determine special accommodation that may be needed in order for them to utilize the call system. Call light is within reach of the resident and secured as needed. All staff members who see or hear an	F 558	1. On 06/19/2023 upon notification the call light was readjusted and secured within reach of the resident. On 06/21/2023, the call ligt was replaced with an adaptive call light to assure Residennt #6 is able to utilize the call light. 2. All residents have the potential to be affected by this practice. 3. On 06/26/2023, the Administrator, Director of Nusing conducted an audit of call lights to assure the call light can be secured in reach of the resident with a clip. Negative findings were addressed at that time. Beginning 06/26/2023, the Administrator and Director of Clinical Education began education with staff regarding the facility policy on Resident Rights and call light accessibility and placement.	8/4/23

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F 558	Continued From page 4 activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. Resident #6 An observation and interview on 06/19/23 at 10:52 AM, with Licensed Practical Nurse (LPN) #4 revealed Resident #6 in bed. The call light was on the floor by the bed. He stated he can use his call light if it is where he can reach it, but that it falls on the floor a lot. LPN #4 placed the call light within the resident's reach and confirmed he could not reach the call light and that it should be always within reach. An observation and interview, on 06/19/23 at 12:45 PM revealed Resident #6 stated he was wet. The SA asked the resident to put his call light on. The resident's call light was on the floor beside the bed. CNA #3 confirmed the call light was on the floor. An observation and interview, on 6/21/23 at 3:00 PM with the Director of Nursing (DON) and the administrator (ADM) revealed that Resident #6 could not reach his call light that was wrapped around the top portion of his right upper side rail. Resident #6 had very spastic movements of his upper extremities and was not able to get to his call light. The Administrator (ADM) removed the call light and placed it on the bed. The resident's hand fumbled between the call light and the wrinkles in the sheet several times and was not able to pick the call light up until the ADM held the sheet down. After several attempts, the resident managed to get the call light. The DON stated that the resident needed a touch pad call light.	F 558	4. Beginning week of 7/1/2023, the Administrator, Director of Nursing will conduct monitoring rounds to check call light placement three times weekly for four weeks, then weekly for eight weeks to assure call lights are accessible and secured within reach of the resident. Findings of the audit will be brought to the Quality Assurance Performance Improvement Committee on 7/26/2023, then monthly for three months for review and revision if necessary.	

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F 558	Continued From page 5	F 558		

The ADM stated that her observation was that the resident was able to use the call light once it was put within reach but was not able to initially.

Resident #20

An observation and interview on 06/19/23 at 12:30 PM, with Resident #20 revealed the call light wrapped around the quarter length side rail on the left side of the bed. The side rail was raised up to accommodate his overbed table for the lunch meal. The resident stated he could not reach his call light and demonstrated to the State Agency (SA) that he could not reach it.

An observation and interview, on 06/21/23 at 2:53 PM with Resident #20 revealed that he stated he cannot always reach his call light, that he has stiff straight fingers and had difficulty reaching his call light that was tied around the left upper bed rail. After two (2) attempts he had to let the head of the bed down to be able to reach it. He stated that when he can't reach it, he just must wait for somebody to come in the room.

On 6/21/23 at 3:30 PM, an observation and interview with the Director of Nursing (DON) and the Administrator (ADM) confirmed it was difficult for Resident #20 to reach his call light where it was placed and stated it should be clipped to the bed. The DON moved the call light to the resident's lower chest area and clipped it to the sheet. The resident confirmed that it would easier to reach there.

Record review of the Admission Record for Resident #20 revealed an admission date of 7/5/21 with diagnoses that included Nontraumatic Intracerebral Hemorrhage, Weakness, and other

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F 558	Continued From page 6 Reduced Mobility. Record review of the MDS with an ARD of 5/29/23 revealed a BIMS score of 11 which indicated Resident #20 had moderately impaired cognition. Record review of an in-service training record revealed CNA #2 and CNA #3 attended an in-service on 3/2/23 concerning call lights.	F 558		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.	F 565		8/4/23

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F 565	Continued From page 7 §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review and facility policy review the facility failed to resolve a resident grievance in a timely manner for five (5) of 17 residents reviewed for unresolved grievances in the resident council meeting. Resident #26, 38, 51, 55 and 80 Findings Include Review of the facility policy titled, "Customer Concern Grievance Policy" with a revision date of July 2018 revealed under "Purpose ...Support each customer's (patient's/resident's) right to voice concerns (grievances) and to ensure after receiving a concern, the center actively seeks a resolution and keeps the customer appropriately apprised of its progress toward resolution. The goal is to encourage open communication of customer concerns in an environment free from reprisal, retaliation, or discrimination. We have a commitment to customer service and have systems in place to address concerns. Our Grievance Official is the center Administrator. The Grievance Officials contact information, including phone number and email address, will be readily available to any resident or family member who request it."	F 565	1. On 6/26/2023, the Administrator interviewed Resident #51, Resident #55, and Resident #80 regarding missing clothing items.. Resident #55 denied having missing items. Resident #80 reported previously missing a compression sock for his stump but confirmed that it was located and returned. Resident #51 reported a pair of gray pants as missing After search completed by the Environmental Services Supervisor, missing item for Resident #51 was ordered and arrived to the facility on 7/10/2023. On 6/26/2023, the Director of clinical Education and Director of Nursing began an audit of resident regarding call light response time. Negative variances noted and staff education initiated at that time regarding call light response time. On 6/26/2023, the Administrator and Activity Director began interviewing residents to determine if additional concerns regarding missing items were reported. Three residents reported missing items that were subsequently	

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F 565	Continued From page 8 During the resident council meeting held 6/20/23 at 2:30 PM with 17 residents in attendance, it was revealed by five resident's that when they have a grievance voiced in resident council they do not always hear back about the progress for solutions. Five residents revealed that staff still take a long time to answer call lights and there is still missing clothing that has not been replaced or found. All resident's agreed that these things had been discussed on numerous resident council meetings. Resident #55 revealed he has had Certified Nurse Assistants (CNA's) come in his room, turn his light off, tell him they would be back, but never come back. He revealed he has complained about this to staff and in previous resident council meetings, but it had not got any better. Resident #38 agreed with Resident #55 and stated that he had to lay in urine for an hour and a half before because they had done that to him but had no negative outcome. Resident #51, Resident #80 and Resident #26 agreed that staffing on 3 PM-11 PM and 11 PM-7 AM were slow to answer the call lights. Resident #55, Resident #80 and Resident #51 revealed they had missing articles of clothing that had not been found or replaced and they had complained about this on several occasions. These complainants confirmed that they had discussed all of this in previous resident council meetings, but it had not been resolved and feel like the facility does not have enough staff on duty and that they do not answer their grievances. An interview on 6/20/23 at 3:45 PM with Social Services revealed that sometimes she or the Activities Director holds the monthly resident council meetings. She stated that if the residents have complaints, then she takes them to the Administrator to confirm that they are a	F 565	located in laundry and returned. On 6/26/2023, the Administrator interviewed the Resident Council President who agreed to increase resident council meetins in frequency to every two weeks. Resident Council meeting scheduled for 7/15/2023. 2. All residents have the potential to be affected by this practice. 3. Systemic corrections to avoid this deficient practice from reoccurring include education by the Administrator and Director of Clinical Education to all staff beginning the week of 6/26/2023 regarding the facility Grievance Process and Resident Rights. 4. Beginning the week of 6/26/2023, the Social Services Director will report new and unresolved grievances five times weekly during the morning meeting. Reporting will occur five times weekly for four weeks, then three times weekly for eight weeks to assure concerns are addressed and resolved timely. Beginning 7/1/2023, the Social Services Director and Activities Director will conduct resident interviews for five (5) residents per week for eight weeks to check for reports of missing items and call light response time. Beginning in July, Resident Council meetings will increase in frequency to two times a month for two months to provide solutions to grievances, monitor call light	

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F 565	Continued From page 9 grievance, if they are then she fills out a grievance form and gives it to whatever department the grievance is about. When the State Agent (SA) ask if she was the grievance officer, she stated I guess so, I'm not sure. She revealed that she realized that the complaint about staff not answering the call lights has been ongoing, but thought it was getting better. She stated she also knew that residents still complain about missing clothing. She stated the facility has had an issue at times getting the grievance form back from whatever department has it, so she thinks that is what's happened with some of these grievances not being resolved. She revealed that she held the Resident Council meeting in April 2023 and admitted she does not have a grievance form completed for the complaint of call lights not being answered. An interview on 6/21/23 at 10:00 AM, with the Administrator confirmed that the complaint of call lights not being answered is still ongoing. She revealed that they have done education and in-services with staff regarding the importance of answering the call light in a timely manner. She stated that sometimes the staff will go in the resident's room, turn off the light and tell them they will be back if there is something they need to do that is more pressing, but then they do not go back, so we have educated on that. She confirmed that the grievance forms from the resident council meetings go to whatever department the grievance is about and they follow up on that but was not aware there was a delay in getting them back. An interview on 6/21/23 a 3:45 PM, with the Administrator revealed that Social Services had mentioned to her before that there was a delay in	F 565	response time and assure areas of concern that are voiced show improvement. The Administrator will monitor call light response time by means of resident interviews and observations three times weekly for four weeks, then weekly for eight weeks. Negative variances identified will be corrected immediately. Findings of interview and resident council meetings will be brought to the Quality Assurance Performance Improvement Committee on 7/26/2023, then monthly for three months to evaluate the continued compliance with this corrective action.	

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getting the grievance forms back from the department heads. She stated that they talk about grievances in every stand-up meeting, and she told Social Services to start mentioning the missing grievance forms during those meetings. She confirmed that there were no grievance forms filled out for the complaints of call lights not being answered or the complaints of missing clothes that had been mentioned during the resident council meetings since 01/2023. She confirmed the facility has an issue with unresolved grievances and have had issues with the process, but they are going to work on it.

Record review of the Resident Council Meeting Minutes revealed the following:
" 01/20/23- complaint of call light response with no grievance resolution listed.
" 03/30/23- complaint of missing clothing with no grievance resolution listed.
" 04/2023- complaint of call lights not being answered or long waits per resident #38 and 55 with no grievance resolution listed.
" 05/31/23- complaint of Resident #38 complained of no response to call light and stayed in urine for four (4) hours; late slow call light response and missing clothing was mentioned with no grievance resolution listed.

Record review of the grievance forms for the months of 01/2023 through 06/2023 revealed there were no forms completed for the grievances from the resident council meeting minutes reviewed.

Record review of Resident #26's Admission Record revealed the resident was admitted to the facility on 4/14/23 with medical diagnoses that included Unspecified Chronic Obstructive

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Pulmonary Disease. Record review of Resident #26's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/1/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.

Record review of Resident #38's Admission Record revealed the resident was admitted to the facility on 4/15/19 with medical diagnoses that included Unspecified Type 2 Diabetes Mellitus with Diabetic Neuropathy. Record review of Resident #38's MDS with an ARD of 4/6/23 revealed in Section C a BIMS score of 10, which indicated the resident is moderately cognitively impaired.

Record review of Resident #51's Admission Record revealed the resident was admitted to the facility on 9/9/22 with medical diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side. Record review of Resident #51's MDS with an ARD of 6/10/23 revealed in Section C a BIMS score of 15, which indicates the resident is cognitively intact.

Record review of Resident #55's Admission Record revealed the resident was admitted to the facility on 4/1/23 with medical diagnoses that included Chronic (Diastolic) Congestive Heart Failure. Record review of Resident #55's MDS with an ARD of 1/6/23 revealed in Section C a BIMS score of 15, which indicated the resident is cognitively intact.

Record review of Resident #80's Admission Record revealed the resident was admitted to the facility on 12/15/22 with medical diagnoses that

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F 565	Continued From page 12 included Encounter for Orthopedic Aftercare following Surgical Amputation. Record review of Resident #80's MDS with and ARD of 4/4/23 revealed in Section C a BIMS score of 15, which indicated the resident is cognitively intact.	F 565		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting	F 584		8/4/23

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F 584	Continued From page 13 levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and facility policy review, the facility failed to create a clean and safe environment as evidenced by a dirty wheelchair and black substance on a resident's refrigerator for two (2) of 26 residents sampled. Resident #26 and #77. Findings include: A review of the facility policy on letterhead dated June 22, 2023, revealed, "(Proper Name) utilizes the EMBRACE guideline to manage cleaning of equipment ... Observation to review ...Access wheelchairs for cleanliness." An interview and observation on 06/20/23 at 4:30 PM, Resident #26 voiced concern about his wheelchair not being cleaned. He revealed he takes a napkin and tries to clean it off but doesn't think it has ever been cleaned. The wheelchair had a thick black and gray substance on the frame and the spokes of the wheels. An interview on 06/21/23 at 8:15 AM, with the Director of Nurses (DON) revealed the nurses and Certified Nursing Assistants (CNAs) are supposed to clean the wheelchairs on the 11 PM-7 AM shift. She revealed we don't have a	F 584	1. Resident #26 wheelchair was cleaned by the Director of Nursing on 6/20/2023. Resident #77 refrigerator was cleaned by housekeeping on 6/20/2023. 2. All residents have the potential to be affected by this deficient practice. On 6/23/2023, the Administrator and Director of Nursing conducted an audit of wheelchairs to determine if other residents had been affected. Affected wheelchairs were cleaned at that time. On 6/26/2023, the Administrator conducted an audit of resident refrigerators. There were no additional concerns with cleanliness found. 3. Beginning the week of 6/26/2023, the Director of Nursing and Director Clinical Education began staff education regarding the cleaning of resident equipment. Beginning the week of 6/26/2023, the Housekeeping Supervisor began education with Environment Services staff regarding the cleaning of resident refrigerators. 4. Monitoring of continued compliance of	

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F 584	Continued From page 14 checklist that shows if it's been done but the floor nurses are supposed to ensure that the staff is cleaning the equipment. An observation and interview on 06/21/23 at 8:25 AM, the DON confirmed that Resident #26's wheelchair was dirty and needed to be cleaned and would make sure that it got done. She revealed that it should have been cleaned on Thursday night and she wasn't sure when the last time it was cleaned. A record review of Resident #26's Admission Record revealed the resident was admitted on 04/14/2023 with diagnoses including Chronic Obstructive Pulmonary Disease, muscle weakness, Peripheral Vascular Disease, and Anxiety disorder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/01/23, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) of 15, which indicated the resident is cognitively intact. Resident #77 Review of the facility policy titled "Personal Food Storage" with an effective date of 7/30/22 revealed under, "Procedure ..., #7. Cleanliness of the refrigerator shall be the responsibility of the family or the assigned department." An observation on 6/20/23 at 2:00 PM, of Resident # 77's small glass refrigerator revealed a black substance adhering to the lower portion of the outer glass that extended to the lower rubber door seal.	F 584	corrective actions include beginning 7/1/2023 having the Director of Nursing conduct audits of wheelchair cleanliness weekly for eight weeks to assure chairs are clean. Beginning the week of 7/3/2023, the Administrator and Housekeeping Supervisor will conduct an audit of refrigerators weekly for eight weeks, then monthly thereafter to assure refrigerators are clean. Negative findings will be corrected immediately and will be brought to the Quaity Assurance Performance Improvement Committee on 7/26/2023, then monthly for three months for review and recommendations.	

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An interview and observation on 6/20/23 at 2:05 PM, with CNA #1 acknowledged that Resident # 77's refrigerator had a black substance adhering to the lower outer glass and lower door seal. She stated, "It's dirty; It looks like mold." She revealed that this black substance could be a health concern for the resident, as this was where he stored his food and beverages. CNA # 1 revealed she was not sure but thinks that the aides were responsible for cleaning the residents' personal refrigerators.

An interview and observation on 6/20/23 at 2:10 PM, with Housekeeper # 1, acknowledged that Resident # 77's refrigerator had a black substance on the lower glass, and he stated that housekeeping was responsible for cleaning residents' personal refrigerators.

An interview and observation on 6/20/23 at 2:15 PM, with the Administrator (ADM) acknowledged that Resident #77's personal refrigerator had a black substance on the lower glass. She revealed that the resident had brought the refrigerator from home, and it was the family's responsibility to clean and defrost the refrigerator. She stated that the facility checks the refrigerator temperatures, but they do not clean them.

An interview with the Director of Nursing (DON) on 6/21/23 at 4:55 PM, revealed that they (the facility) make the families aware that it's their responsibility to clean the refrigerators when they are brought into the facility. She revealed that the facility has no refrigerator monitoring in place apart from the daily temperature checks. SA inquired whether Resident #77 should have to wait until his family was available to come to the facility and clean his refrigerator, and she replied,

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F 584	Continued From page 16 "It was probably brought into the facility like that." The Survey Agent (SA) inquired whether there was a concern that staff were monitoring daily temperature checks and ignoring the black substance on the refrigerator glass and outer seal, and she stated, "They know that the families are responsible for the cleaning." An interview with the ADM on 6/23/23 at 8:22 AM, revealed the facility gets in touch with the families about coming into the facility to clean the refrigerators. ADM stated, "If they cannot come, then we will get it clean; we're not going to let things be dirty." Review of the Admission Record for Resident #77 revealed resident was admitted to the facility on 4/14/2023 with medical diagnoses that included Unspecified Fracture of Right Acetabulum, Parkinson's Disease and Alzheimer's Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/21/2023 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 13, which indicates Resident #77 is cognitively intact.	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State	F 623		8/4/23

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Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;

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(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure

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F 623	Continued From page 19 to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to send a written transfer/discharge notice to a resident or resident representative for a hospital transfer for one (1) of five (5) residents reviewed for hospitalization. Resident #84 Findings Include: Review of the facility policy titled, "Transfer & Discharge" with a revision date of November 1, 2016, revealed under "Notice Requirements ...#4 Before (Proper name of the facility) transfers or discharges the Resident, it shall notify the Resident and the Resident's Representative of the basis for the transfer or discharge in a language and manner they understand; and will also notify the State Long-Term Care Ombudsman". Record review of Resident #84's electronic record revealed there was no discharge/transfer notice for the resident's hospital stay on 5/1/23. An interview on 6/20/23 at 1:30 PM, with the Administrator confirmed that Resident #84 was discharged to the hospital on 5/1/23 and did not have a discharge/transfer notice given to the resident or the resident's representative but should have. She revealed she had discovered there is a problem with consistency in sending	F 623	1. On 06/20/2023, the Administrator and Director of Nursing conducted an audit of transfers in the past 30 days. Three of three residents transferred without notice of discharge. On 6/20/2023, the Administrator inserviced the Director of Nursing and Business Office Manager regarding the facility policy for Transfer/Discharge and Notice of Bed hold policy. 2. All residents have the potential to be affected by this practice. 3. Systemic corrections to avoid this deficient practice from reoccurring include: On 6/26/2023, the Administrator and Director of Nursing began staff education regarding the policy for notification of transfer/discharge and bed hold policy. Each nursing station has a prepared Transfer/Discharge packet containing required notifications of transfer/discharge and bed hold to assure completion and copy provided to the resident or resident representative at time of discharge or within twenty-four (24) hours of discharge. 4. Plans to monitor compliance of	

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F 623	Continued From page 20 these notices and stated the purpose of the transfer/discharge notice is to make the family aware of the resident's transfer or discharge. An interview on 6/21/23 at 8:20 AM, with the Administrator revealed that she has discovered that no one knows who was supposed to be sending out the transfer/discharge notices and confirmed that was the problem. Record review of the facility "Census List" for Resident #84 revealed the resident was transferred out to the hospital on 5/1/23 and was transferred back to the facility on 5/4/23. Record review of Resident #84's Admission Record revealed the resident was admitted to the facility on 3/3/23 with medical diagnoses that included Stage 5 chronic kidney disease. Record review of Resident # 84's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/11/23 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	F 623	corrective action include: Beginning 6/26/2023, Director of Nursing and Business Office Manager will audit transfers to assure the notification of transfer/discharge and bed hold policy are completed and provided to the resident or resident representative. Audits will be conducted weekly for four weeks, then monthly thereafter. Audit findings will be brought to the Quality Assurance Performance Improvement Committee on 7/26/2023 for review and recommendation monthly for three months.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if	F 625		8/4/23

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F 625	Continued From page 21 any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to notify the resident or resident representative of the bedhold amount for a hospital discharge for one (1) of five (5) residents reviewed for hospitalization. Resident #84 Findings Include Review of the facility policy titled, "Bed Hold Policy" with a revision date of November 1, 2016 revealed under "Policy Statement...(the facilities proper name) will, in accordance with Federal and State regulations, hold a Resident's bed during a temporary hospitilazation or therapautic leave". This review revealed under "Procedure...#1 Before the Center transfers a Resident to a hospital or the Resident goes on	F 625	1. On 06/20/2023, the Administrator and Director of Nursing conducted an audit of transfers in the past 30 days. Three of three residents transferred without notice of discharge. On 6/20/2023, the Administrator inserviced the Director of Nursing and Business Office Manager regarding the facility policy for Transfer/Discharge and Notice of Bed hold policy. 2. All residents have the potential to be affected by this practice. 3. Systemic corrections to avoid this deficient practice from reoccurring include:	

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F 625	Continued From page 22 therapeutic leave, the Center shall provide Resident or his or her Resident Representative this Bed Hold Policy". Record review of Resident #84's electronic record revealed there was no bedhold notice for the resident's hospital stay on 5/1/23. An interview on 6/20/23 at 1:30 PM, with the Administrator confirmed that Resident #84 was discharged to the hospital on 5/1/23 and did not have a bedhold notice given to the resident or the resident's representative but should have. She revealed she had discovered there is a problem with consistency in sending these notices and that the purpose of the bed hold notice is to make the family aware of the resident's bed hold amount. An interview on 6/21/23 at 8:20 AM, with the Administrator revealed that she has discovered that no one knows who was supposed to be sending out the bedhold notices and confirmed that was the problem. Record review of the facility "Census List" for Resident #84 revealed the resident was transferred out to the hospital on 5/1/23 and was transferred back to the facility on 5/4/23. Record review of Resident # 84's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/11/23 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Record review of Resident #84's Admission Record revealed the resident was admitted to the	F 625	On 6/26/2023, the Administrator and Director of Nursing began staff education regarding the policy for notification of transfer/discharge and bed hold policy. Each nursing station has a prepared Transfer/Discharge packet containing required notifications of transfer/discharge and bed hold to assure completion and copy provided to the resident or resident representative at time of discharge or within twenty-four (24) hours of discharge. 4. Plans to monitor compliance of corrective action include: Beginning 6/26/2023, Director of Nursing and Business Office Manager will audit transfers to assure the notification of transfer/discharge and bed hold policy are completed and provided to the resident or resident representative. Audits will be conducted weekly for four weeks, then monthly thereafter. Audit findings will be brought to the Quality Assurance Performance Improvement Committee on 7/26/2023 for review and recommendation monthly for three months.	

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F 625	Continued From page 23 facility on 3/3/23 with medical diagnoses that included Stage 5 chronic kidney disease.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		8/4/23

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F 656	Continued From page 24 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility policy review and record review the facility failed to develop or implement a care plan for four (4) of 26 care plans reviewed. Resident #6, 20, 25, 30. Findings include: Review of the facility policy, titled, "Care Plans", revealed care plans will be developed for all residents based upon RAI (Resident Assessment Instrument) manual guidelines. Care plans are developed by the interdisciplinary team and revised as needed according to resident and patient status or change. Resident #6 Record review revealed a care plan in place for Resident #6 with a focus of alteration in elimination related to bladder and bowel incontinence with an intervention to check and change every two (2) hours and prn (as needed). Record review revealed a care plan in place for Resident #6 related to risk for fall and an intervention to place call light in easy reach on	F 656	1. On 6/19/2023, incontinent care provided to Resident #6 by Licensed Practical Nurse #4 a Certified Nursing Assistant #3 Body audit was conducted by the Director of Nursing on 6/19/2023, with no skin concerns noted. On 6/19/2023, C.N.A #3 was in-serviced by the Director of Nursing regarding Activity of Daily Living (ADL) care and frequency of incontinent care. On 6/19/2023, the Director of Nursing placed the call light on the right side for Resident #6. On 6/21/2023, the Maintenance Directorreplaced the existing call light with calllight adapted to assure resident able to utilize. On 6/21/2023, the call light for Resident #20 was placed and secured to the residents bedding by the Director of Nursing. Resident was able to access and utilize the call light. The administrator and Director of Nursing conducted an audit of call light placement on 6/21/2023.	

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F 656	Continued From page 25 right side. An interview on 06/19/23 at 12:45 PM revealed Resident #6 stated he was wet and that he had not been changed since the night shift. The state agency (SA) asked Resident #6 to put his call light on, but the call light was on the floor. The SA informed Licensed Practical Nurse (LPN) #4 that the resident needed assistance. LPN #4 was told by the resident he was wet and had not been changed since the night shift. Observation on 6/19/23 at 12:48 PM revealed LPN #4 and Certified Nursing Assistant (CNA) #3 provided incontinent care to Resident #6. The resident's brief was saturated with dark yellow colored urine. CNA #3 stated the resident's brief should not be that wet and that he should have already been changed. Licensed Practical Nurse (LPN) #4 confirmed the resident probably needed changing earlier. Certified Nursing Assistant (CNA) #3 confirmed the call light was on the floor. An observation and interview, on 6/21/23 at 3:00 PM with the DON and the ADM revealed that Resident #6 could not reach his call light that was wrapped around the top portion of his right upper side rail. Resident #6 had very spastic movements of his upper extremities and was not able to get to his call light. Record review of the facility Admission Record for Resident #6 revealed an admission date of 8/19/2010 with diagnoses that included Spastic Hemiplegia affecting left dominate side, Need for assistance with Personal Care, Generalized Muscle Weakness, Bell's Palsy, and Neuromuscular Dysfunction of Bladder.	F 656	Any concerns were identified were immediately corrected at that time. On 6/21/2023, the Director of Nursing performed nail care to Resident #25. Resident #30 received a shower by Certifed Nursing Assistant #3 on 6/20/2023. Minimum Data Set Nurse completed Activity of Daily Living care plan for Resident #30 on 6/22/2023. 2. All residents have the potential to be affected by this practice. On 6/26/2023, ADL care plan audit initiated by the Minimum Data Set (MDS) nurses to assure care plan includes care areas (i.e. nail care, bathing, and incontinent care). Negative findings were addressed at that time. 3. Beginning 6/26/2023, the Director of Clinical Education and Administrator in-serviced direct care staff regarding Activities of Daily Living (ADL) care, the facility schedule for baths/showers and the Certified Nursing Assistant Kardex location which details each residents care needs. On 6/26/2023, the Administrator in-serviced the Minimum Data Set (MDS) nurses regarding the care planning process and completion of care plans to include interventions to address care needs. 4. Plan to monitor continud facility compliance includes the following:	

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F 656	Continued From page 26 Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/20/23 revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated Resident # 6 was cognitively intact. Resident #20 Record review revealed a care plan in place for Resident #20 related to risk for falls and an intervention for call light in easy reach. An observation and interview, on 06/19/23 12:30 PM, with Resident #20 revealed the call light wrapped around the quarter length side rail on the left side of the bed. The resident stated he could not reach his call light and demonstrated to the state agency (SA) that he could not reach it. During an observation and interview with Resident #20 on 06/21/23 at 2:53 PM, it was revealed that he stated he cannot always reach his call light. Resident #20 is observed to have stiff straight fingers and have difficulty reaching his call light that was tied around the left upper bed rail. After two (2) attempts he had to let the head of the down to be able to reach it. He stated that when he can't reach it, he just has to wait for somebody to come in the room to assist him. During an observation and interview on 6/21/23 at 3:30 PM, with the Director of Nursing (DON) and the Administrator (ADM) confirmed it was difficult for Resident #20 to reach his call light where it was placed and stated it should be clipped to the bed. The DON moved the call light to the resident's lower chest area and clipped it to the sheet. The resident confirmed that it would easier to reach there.	F 656	Beginning 7/1/2023, the Minimum Data Set (MDS) nurses to begin an audit of resident care plans in conjunction with the MDS completion schedule to assure care plans are accurate and include appropriate interventions. The Administrator, Director Nursing will conduct weekly audit utilizing care plan audit sheet of ten residents to assure care provided as directed on the care plan for four weeks, then monthly for two months. Any negative findings will be corrected immediately. Findings of the audit will be brought to the facility Quality Assurance Performmance Improvement Committee on 7/26/2023 for review and recommedations monthly for three months..	

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Record review of the facility Admission Record for Resident #20 revealed an admission date of 7/5/21 with diagnoses that included Nontraumatic Intracerebral Hemorrhage, Weakness, and other Reduced Mobility.

Record review of the MDS with an ARD of 5/29/23 revealed a BIMS score of 11 which indicated Resident #20 had moderately impaired cognition.

An interview on 06/22/23 at 10:00 AM with Registered Nurse (RN) #1 stated that the purpose of the care plan is to help guide the staff with daily care and what is to be done for the residents. She stated she would expect the resident to be able to reach the call bell. She stated the care plan was not followed if the call light was in the floor or where the resident could not reach it and if Resident #6 was not checked and changed due to incontinence, the care plan was not followed.

On 06/22/23 at 10:45 AM, an interview with the Director of Nursing (DON) confirmed that the care plans were not followed for Resident #6 related to bladder incontinence and call light placement, and for Resident #20 related to call light placement.

Resident #25

An interview with the DON on 6/22/23 at 8:50 AM confirmed that the MDS nurses should have developed a care plan for Resident #25's nail care and this would have flagged the task for the CNA's on the floor to perform.

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An interview with the DON on 6/21/23 at 5:10 PM confirmed that Resident #25 did not have a care plan for nail care. She stated, "No, I don't see it on there." She revealed the purpose of the care plan was to be able to know everything about the resident and how to care for the resident.

An interview with the Minimum Data Set (MDS) Nurse #2 on 6/22/23 at 8:40 AM, revealed the purpose of the care plan was to ensure the diagnosis, orders and resident needs are met in a clear and concise way so that the resident needs are met.

An interview with the MDS Nurse #1 on 6/22/23 at 8:45 AM confirmed that Resident #25 did not have a care plan on nail care. She revealed that it is the company policy to perform routine nail care with bathing. She stated, "That's something the CNA's just know to do."

Record review of Resident #25's Admission Record revealed the resident was admitted to the facility on 8/28/18 with medical diagnoses that included Major Depressive Disorder, Anxiety Disorder, and Contracture, Right Hand.

Record review of Resident # 25's MDS with an ARD of 5/10/23 revealed a Brief Interview for Mental Status (BIMS) score of 08, which indicates the resident is moderately cognitively impaired.

Resident #30

An interview with the DON on 6/21/23 at 5:20 PM, confirmed that Resident # 30 did not have a bathing care plan. She revealed the purpose of the care plan was to notify the staff of exactly what care should be provided. She acknowledged

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F 656	Continued From page 29 that the resident should have a bathing care plan. An interview with MDS Nurse #1 on 6/22/23 at 8:45 AM, revealed she did not see a bathing care plan for Resident #30. She revealed that it was the facility protocol to offer a bath, but it was not care planned. She revealed the nursing staff are responsible for setting the day that will be scheduled for the bath, but they do not add it to the care plan. Record review of Resident # 30's Admission Record revealed the resident was admitted to the facility on 12/26/21 with medical diagnoses that included Type 2 Diabetes Mellitus with Unspecified Complications, Essential Hypertension and Other Seizures. Record review of Resident #30's MDS with an ARD of 5/17/23 revealed under section C a BIMS score of 15, which indicates resident is cognitively intact.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, facility policy review, and record review the facility failed to provide care to maintain hygiene as evidenced by failure to provide shower, and nail care for two (2) of twenty-six residents reviewed. Resident #25 and Resident #30.	F 677	1. On 6/20/2023, Resident #30 received a shower by Certified Nursing Assistant #1. Activity of Daily Living entry for 6/19/2023 recording bath as received was corrected to reflect care as given 6/20/2023.	8/4/23

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F 677	Continued From page 30 Findings include: Review of the facility policy titled, "Activities of Daily Living (ADLs) revealed under, "Policy: ... Care and services will be provided for the following Activities of Daily living: 1. Bathing, dressing, grooming, and oral care;" ... Also revealed under, "Policy Explanation and Compliance Guidelines: ...3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene." Resident #25 An observation on 06/19/23 at 10:55 AM, of Resident #25's nails revealed long nails on both hands with a brown substance underneath, fingers bent inwards toward palms and nails were impressed into the skin in the palms. An interview with Resident #25 on 6/20/23 at 2:45 PM, revealed she would like to have her nails trimmed and stated when they get long, they start digging into the palms of her hands. An observation and interview on 6/20/23 at 2:50 PM, with Certified Nurse Aide (CNA) #2 confirmed that Resident #25's nails were long with a brown substance underneath. She stated, "Yes, they do need cleaning and trimming." She revealed that the CNAs are responsible for cleaning and trimming the nails, if the resident was not a diabetic and she stated that long nails could cause skin problems to the resident's inner palms.	F 677	On 6/20/2023, the Administrator in-serviced C.N.A #1 regarding the policy for Activities of Daily Living (ADL) care, bathing schedule and policy regarding documentation. 2. All residents have the potential to be affected by this practice. 3. Beginning the week of 6/26/2023, the Director of Nursing and Director of Clinical Education began in-servicing staff regarding the policy for Activities of Daily Living (ADL) care, bathing schedules and the policy regarding documentation of care. 4. Beginning 6/26/2023, the Director of Nursing conducted monitoring rounds of ten reisdents to assure ADL care completed as ordered. Monitoring rounds to occur three times a week for four weeks, then weekly for four weeks. Direct care staff, upon completion of bathing/showers, will initial care to the shower sheet. Beginning 7/1/2023, the Director of Nursing will review shower sheets weekly to assure shower/baths given. Any negative findings will be addressed at that time. Findings of monitoring rounds and audits will be brought to the Quality Assurance Performance Improvement Committee for review and recommendatons on 7/26/2023, then monthly for three months.	

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On 6/20/23 at 2:56 PM, an observation and interview with Licensed Practical Nurse (LPN) #3 confirmed that Resident #25's nails were long, needed trimming and cleaning. She revealed the aides or nurses would be able to do nail care for the resident as she was not a diabetic.

An interview on 6/20/23 at 3:00 PM, with the Director of Nursing (DON) confirmed that Resident #25's nails needed trimming and cleaning and that this could cause skin concerns.

Record review of Resident #25's Admission Record revealed the resident was admitted to the facility on 8/28/18 with medical diagnoses that included Major Depressive Disorder, Anxiety Disorder, Dysphagia and Contracture, Right Hand.

Record review of Resident # 25's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/10/23 revealed a Brief Interview for Mental Status (BIMS) score of 08, which indicated the resident is moderately cognitively impaired.

Resident #30

An interview with Resident #30 on 06/19/23 at 10:30 AM, revealed she has not been receiving her showers routinely. She revealed that she likes to get her shower early in the morning right after breakfast. She stated, "I'm supposed to get my shower on Monday, Wednesday, and Friday, but they (the staff) never come to take me."

An interview with Resident #30 on 6/20/23 at 3:00 PM, revealed she did not receive her shower yesterday. She revealed CNA # 1 gave her a

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shower today and it just depends on how busy they are whether I get more than one shower a week.

Record review of Resident #30's ADLs task for 6/19/23 revealed that the bathing task was initialed as performed by CNA #1 at 13:38 (1:38 PM).

An interview on 6/20/23 at 3:55 PM, with Certified Nurse Aide (CNA) #1 confirmed that Resident #30 was supposed to receive a shower yesterday and confirmed that she did not give the resident a shower. The Survey Agent (SA) inquired why she was unable to give residents a shower yesterday, and she stated, "You all came in and then things got busy." SA inquired from CNA #1 whether she documented on the Activities of Daily Living (ADL) that a bath was completed yesterday, and she stated, "I really don't know." The CNA revealed she should not have documented the shower task as performed if it was not done.

An interview with the Administrator on 6/20/23 at 4:05 PM, acknowledged that the ADL bathing task for yesterday was initialed as completed by CNA #1 which indicated Resident #30 had received a shower. She revealed she spoke with CNA # 1 and the resident did not get a shower yesterday. She acknowledged that the resident should get her showers on the scheduled days.

Record review of Resident # 30's Admission Record revealed the resident was admitted to the facility on 12/26/21 with medical diagnoses that included Type 2 Diabetes Mellitus with Unspecified Complications, Essential Hypertension and Other Seizures.

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F 677	Continued From page 33 Record review of Resident #30 's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/17/23 revealed under section C a Brief Interview for Mental Status (BIMS) score of 15, which indicated resident is cognitively intact.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and facility policy review the facility failed to ensure the safety of resident as evidenced by failure to secure smoking materials for one (1) of 18 smokers in the facility. Resident #57. Findings include: A review of the facility policy titled, "Safe Smoking" with an effective date of November 1, 2016, revealed, "Purpose ...To maximize our ability to provide a safe environment for all residents/patients who smoke, while taking into account non-smoking residents. Procedure ...4. Staff members will monitor or obtain fire-igniting materials (matches/lighters) for the benefit of smokers at the nurses' station or other designated location... 5. Tobacco materials (cigarettes/cigars/chewing	F 689	1. On 6/19/2023, the Administrator obtained smoking items from Resident #57. 2. All residents have the potential to be affected by this practice. Administrator conducted individual interview 11 of 11 residents who smoke to assure all smoking materials secured. No further findings identified. 3. On 6/26/2023, the Administrator began in-servicing all staff regarding the facility smoking policy. 4. Beginning 6/26/2023, the Administrator will conduct interviews with residents who smoke to assure smoking materials are stored as per facility policy. The Administrator will conduct smoking rounds	8/4/23

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F 689	Continued From page 34 tobacco/snuff/electronic smoking devices) themselves, in addition to fire igniting materials, may have increased control or be removed if smoking policy violations have occurred or as a general safety policy for all residents..." An observation and interview on 06/19/23 at 02:55 PM, revealed Resident #57 sitting in her wheelchair, with a white plastic container in the shape of a cigarette box positioned between her legs, the State Agent (SA) inquired what the box was and Resident #57 stated my cigarettes and opened the lid and revealed a pack of cigarettes with approximately five (5) cigarettes remaining and a lighter. Resident #57 pulled out the lighter and then replaced it back in the box. She revealed she bought them with her when she was admitted, and she wasn't the only one with extra cigarettes and lighters in their rooms. An interview on 06/19/23 at 03:15 PM, Certified Nurse Aide (CNA) #4 revealed the CNAs are responsible for taking the residents out on smoke breaks and it is hard to keep an eye on the cigarettes and lighters because a lot of times the families bring them in to the residents. She revealed when we find them, we report it to the nurses or Administrator. She revealed it is just a cycle and we are doing the best we can to catch them because we are limited in what we can do. An observation and interview with the Administrator (ADM) on 06/19/23 at 03:35 PM, revealed Resident #57 sitting in her wheelchair in her room with the cigarette container on her lap. Resident #57 opened the white box which revealed a pack of cigarettes and a lighter. The Administrator confirmed that she was not supposed to have the cigarettes and lighter and	F 689	to assure residents do not have any smoking materials in possession. Interviews and smoking rounds will be conducted three times weekly for four weeks, then weekly for eight weeks. Any negative variances will be corrected immediately. Findings will be brought to the Quality Assurance Performance Improvement Committee on 7/26/2023, for review and recommendations monthly for thee months.	

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F 689	Continued From page 35 they were to be kept in a locked box in the utility room. An interview on 06/20/23 at 03:30 PM, with CNA #5 revealed a lot of times the smokers will be acting up, we try to keep a handle on it but sometimes they will be wanting to light their own cigarette and then fuss about returning the lighter. She revealed this has been a problem. A record review of Resident #57's Admission Record revealed the resident was admitted to the facility on 05/02/2023 with diagnoses of Cerebral infarction, Malignant neoplasm of bladder, Depression, Cognitive Communication Deficit, and Weakness. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of May 9, 2023, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had a severe cognitive impairment.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		8/4/23

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F 690	Continued From page 36 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews the facility failed to provide incontinent care in a timely manner to a resident that was incontinent for one (1) of sixty seven incontinent residents. Resident #6. Findings include: An interview, on 06/19/23 at 12:45 PM, revealed Resident #6 stated that he was wet. He stated that he had not been changed since the night shift. The State Agency (SA) informed Licensed Practical Nurse (LPN) #4 the resident needed assistance. Resident #6 told LPN #4 that he was wet and not been changed since the night shift	F 690	1. Resident #6 received incontinent care upon notification 06/19/2023 by Licensed Practial Nurse (LPN) #4 and Certified Nursing Assisstant (C.N.A) #3. Body audit conducted by the Director of Nursing (DON) on 06/19/2023, with no negative findings. On 6/19/2023, LPN #4 and C.N.A #3 received education by the Director of Nursing regarding the facility policy for ADL/incontinent care. 2. All residents have the potential to be affected by this practice.	

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F 690	Continued From page 37 was there. LPN #4 requested Certified Nursing Assistant (CNA) #3 to assist with incontinent care. An observation, on 6/19/23 at 12:48 PM, revealed LPN #4 and CNA #3 provided incontinent care to Resident #6. The resident's brief was saturated with dark yellow colored urine. CNA #3 stated the resident's brief should not be that wet and that he should have already been changed. CNA #3 confirmed that she was assigned to Resident #6 and stated they get here and start checking residents and then the trays come out, so they have to stop and pass out the trays.She stated she had to help change out a mattress on a bed and that they only have two CNAs on this hall. LPN #4 stated that the resident probably needed changing earlier. LPN #4 confirmed that staying wet could cause skin breakdown. An interview on 6/21/23 at 1:30 PM, with the Director of Nursing (DON) revealed they do not have a policy on bowel and bladder, they just go by the standard of care for checking and changing every two (2) hours. She stated that not changing residents could cause skin breakdown. Record review of the facility Admission Record for Resident #6 revealed an admission date of 8/19/2010 with diagnoses that included Spastic Hemiplegia affecting left dominate side, Need for assistance with Personal Care, Generalized Muscle Weakness, and Neuromuscular Dysfunction of Bladder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/20/23 revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated	F 690	3. Beginning 06/26/2023, the Administrator in-serviced licensed staff regarding the facility policy regarding Resident Rights and Actvities of Daily Living (ADL) care. 4. Beginning the week of 06/26/2023, the Director of Nursing/Unit Manager to conduct monitoring rounds of five residents to assure incontinent care provided to residents as ordered. Rounds to be conducted three times a week for four weeks, then weekly for eight weeks. Any negative findings will be corrected immediately. Findings of audit will be brought to the Quality assurance Performance Improvement Committee 7/26/2023 for review and revision as necessary monthly for three months.	

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F 690	Continued From page 38 Resident #6 was cognitively intact.	F 690		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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). §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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §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. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews the facility failed to provide enough staff to meet the needs of the residents for four (4) of 4 days of survey.	F 725	1. On 6/19/2023, Licensed Practical Nurse #4 and Certified Nursing Assistant #3 provided incontinent care to Resident #6. On 06/19/2023, the Director of Nursing conducted a body audit of	8/4/23

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F 725	Continued From page 39 Findings include: The facility Administrator provided a statement on 6/23/23 that the facility follows the state regulations for 2.8 staffing ratio and they do not have a policy to staff according to acuity level. An interview on 06/19/23 at 12:45 PM, with Resident #6 on the A hall revealed the resident stated he was wet. He stated that he had not been changed since the night shift. An observation on 6/19/23 at 12:48 PM revealed Licensed Practical Nurse (LPN) #4 and Certified Nursing Assistant (CNA) #3 provided incontinent care to Resident #6. The resident's brief was saturated with dark yellow colored urine and CNA #3 stated the resident's brief should not be that wet. She stated that he should have already been changed and that they get here and start checking residents and then the trays come out, so they have to stop and pass the meal trays out. She stated she had to help change out a mattress on a bed. She stated that they only have two CNAs on this hall. LPN #4 confirmed the resident probably needed changing earlier but they did not have enough staff to do it all. An interview on 06/20/23 at 10:15 AM, with CNA #7 revealed the facility is short-staffed a lot she revealed today they had a call in which left them with only two aides for D hall. She revealed D hall is a very busy hall with a lot going on with the residents. During the resident council meeting held 6/20/23 at 2:30 PM, with 17 residents in attendance, it was revealed by five residents that staff still take	F 725	Resident #6 with no noted skin concerns. 2. All residents have the potential to be affected by this practice. 3. On 6/19/2023, the Administrator reviewed staffing which reflected a census of 91 with direct care Per patient day of 2.97. Interviews conducted with cognitively intact residents on the same hall as Resident #6 by the Administrator to assure no additional concerns regarding incontinent care with no further negative findings voiced. On 6/19/2023, the Administrator and Director of Nursing conducted resident interviews throughout the facility to assure no further instances of missed Activity of Daily Living care. No negative findings noted. On 6/26/2023, the Administrator provided education to the Director of Nursing, Assistant Director of Nursing, Workforce Manager, Human Resources Coordinator and Admissions regarding staffing needs and resident acuity. 4. Beginning the week of 6/26/2023, the Administrator, Human Resources Coordinator and Workforce Manager will review staffing five times a week for four weeks, then two times a week for four weeks to assure sufficient number of direct care staff scheduled and matches actual staff members clocked in to work. The process to manage call outs will	

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F 725	Continued From page 40 a long time to answer call lights. All resident's agreed that this issue had been discussed in numerous resident council meetings. Resident #55 revealed he has had CNA's come in his room, turn his light off, tell him they would be back, but never come back. He revealed he has complained about this to staff and in previous resident council meetings, but it had not got any better. Resident #38 agreed with Resident #55 and stated that he had to lay in urine for an hour and a half before because they had done that to him. Resident #51, Resident #80 and Resident #26 agreed that staffing on 3PM-11PM and 11PM-7AM were slow to answer the call lights. These complainants confirmed that they had discussed all of this in previous resident council meetings, but it had not been resolved and feel like the facility does not have enough staff on duty. An interview on 06/20/23 at 3:00 PM, with the Workforce Scheduler revealed that the facilities main issue is having trouble with call ins and staffing CNAs for the 3-11 PM shift. She stated it is just hard to find staff that would be willing to work. She revealed she has an alert system that she does by sending all the staff a text when there is a call in. She stated there are a few that will pick up an extra shift but if we can't get it covered, we do the best that we can. She revealed she is the one that decides how many aides are needed for each hall based on census and acuity of the residents. She revealed A and D halls have a heavier load since there are more bed bound residents on those halls and yesterday there were only two aides on D hall because of a call in. She confirmed that wasn't enough staff. She revealed she tries to find a replacement for the shift but is not always able to get someone to	F 725	require staff member notification to the Workforce Manger or the Administrator at least two hours prior to start of shift. Workforce Manager will utilize "On Shift" notification system to alert all direct care staff of shift availability. Additional notifications will be conducted by the Administrator, Director of Nursing, Charge Nurse or Workforce Manager by means of phone call or text messaging of team members directly. Any negative variances will be addressed immediately. Findings of staffing review will be brought to Quality Assurance Performance Improvement Committee on 7/26/2023 for review and recommendations monthly for three months.	

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F 725	Continued From page 41	F 725		

cover it.

An interview on 6/20/23 at 3:45 PM, with Social Services confirmed that the complaint about staff not answering the call lights has been ongoing, but thought it was getting better.

An interview on 6/21/23 at 10:00 AM, with the Administrator confirmed that the complaint of call lights not being answered is still ongoing. She revealed that they have done education and in-services with staff regarding the importance of answering the call light in a timely manner. She stated that sometimes the staff will go in the resident's room, turn off the light and tell them they will be back if there is something they need to do that is more pressing, but then they do not go back, so we have, educated on that.

An interview on 06/21/23 at 10:25 AM, with the Human Resources (HR) Coordinator revealed the facility has done some hiring for CNA's but not all of them have stayed and there is a lot that only want to be PRN (as needed). She revealed the facility has hired 20 CNAs with 13 of them being PRN, 7 are full time but two of those are out on sick leave and four of them just started on June 15th and are still in training.

An interview on 06/21/23 at 2:30 PM, with the Administrator revealed she did have some staffing issues but have been working on getting the staffing improved and confirmed that the facility was still admitting new residents to the facility that also needed additional care.

An interview on 6/22/23 at 11:10 AM, with Certified Nurse Assistant (CNA) #6 revealed that they have been told as soon as a call light goes

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off to respond to the call light and see what the resident needs even if we are tied up with something. She stated that if it is not an emergency, we tell the resident we will be back as soon as possible to assist with their needs. She revealed that if they were passing trays on the halls or in the dining room it may take a little longer to respond.

Record review of the Resident Council Meeting Minutes revealed the following:
" 01/20/23- complaint of call light response with no resident complainant listed.
" 04/2023- complaint of call lights not being answered or long waits per resident #38 and 55.
" 05/31/23- complaint of Resident #38 complained of no response to call light and stayed in urine for 4 hours; late slow call light response was mentioned with no resident names.

Record review of Resident #6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/20/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident is cognitively intact.

Record review of Resident #26's MDS with an ARD of 5/1/23 revealed in Section C a BIMS score of 15, which indicated the resident is cognitively intact.

Record review of Resident #38's MDS with an ARD of 4/6/23 revealed in Section C a BIMS score of 10, which indicated the resident is moderately cognitively impaired.

Record review of Resident #51's MDS with an ARD of 6/10/23 revealed in Section C a BIMS score of 15, which indicated the resident is

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F 725	Continued From page 43 cognitively intact. Record review of Resident #55's MDS with an ARD of 1/6/23 revealed in Section C a BIMS score of 15 , which indicated the resident is cognitively intact. Record review of Resident #80's MDS with and ARD of 4/4/23 revealed in Section C a BIMS score of 15, which indicated the resident is cognitively intact.	F 725		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §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. §483.45(h)(2) The facility must provide separately 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	F 761		8/4/23

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F 761	Continued From page 44 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review, the facility failed to store controlled medications in a separately locked permanently affixed compartment in the medication room refrigerator for one (1) of (1) medication storage rooms observed. Findings include: Record review of the facility policy titled "Controlled Substances" revealed, ... "Medications listed in Schedules II, III, IV and V shall be stored under double lock .... Charge nurse shall maintain possession of the key(s) to controlled substances secured in the medication room refrigerator including individual resident/patient refrigerated controlled substances emergency drug kit medications requiring refrigeration ...." An observation and interview on 6/21/23 at 7:55 AM, of the medication storage room with Licensed Practical Nurse (LPN) #2 revealed that the facility had a refrigerator that stored controlled substances that must be refrigerated. The State Agency (SA) observed a pad lock on the refrigerator handle. An observation inside the refrigerator revealed a small black lock box that was removed by LPN #2 and confirmed to have nine (9) vials of Lorazepam. LPN #2 confirmed that the black box stored controlled substances and was not permanently affixed inside the refrigerator. An interview and observation of the medication storage refrigerator with the Director of Nursing	F 761	1. On 6/21/2023, the Director of Nursing and Licensed Practical Nurse #2 secured nine (9) vials of Lorazepam to locked bin affixed to the refrigerator in the medication room. 2. All residents have the potential to be affected by this practice. 3. Beginning the week of 6/26/2023, the Administrator and Director of Clinical Education in-serviced licensed staff regarding storage of controlled medications that require refrigeration. 4. Beginning the week of 6/26/2023, the Director of Nursing or Administrator will conduct visual audit of refrigerated controlled medication storage in medication room weekly for four weeks, then monthly thereafter. Findings of the audit will be brought to the Quality Assurance Performance Improvement Committee on 7/26/2023, for review and recommendations then monthly for three months.	

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F 761	Continued From page 45 (DON) on 6/21/23 at 10:00 AM, confirmed that the black lock box inside the refrigerator could be removed and was not permanently affixed. She revealed that she knew the box was required to be behind two (2) locks, but she was not aware that the box had to be permanently affixed. She acknowledged that someone could remove the box from the refrigerator since the box was not secured. An interview with the Administrator (ADM) on 6/22/23 at 8:30 AM, revealed she was not aware that the refrigerator narcotic box must be permanently affixed.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		8/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF TUPELO	2273 SOUTH EASON BOULEVARD TUPELO, MS 38804

(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 880	Continued From page 46 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 47 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility policy review the facility failed to prevent the possibility of the spread of infection as evidenced by failure to use a barrier during medication administration of a respiratory inhaler, for one (1) of 37 medications observed. Resident #9 Findings include: Record review of a typed document dated 6/22/23 and signed by the facility Administrator revealed "Re: Barrier Usage with Medication Pass ... We utilize both Perry & Potter. 8th Edition, "Clinical Nursing Skills and Techniques" and "Clinical Nursing Skills & Techniques, Skills Performance Checklist" as our resource guide for clinical standards." Record review of the "PERFORMANCE CHECKLIST SKILL 21-1- ADMINISTERING ORAL MEDICATIONS" revealed ...IMPLEMENTATION: 1 ...c. Arranged medication tray and cups in preparation area or on cart outside of room ..." An observation on 06/21/23 at 9:05 AM, of Licensed Practical Nurse (LPN) #1 while preparing medications for Resident #9 revealed she placed an albuterol inhaler on the surface of the medication cart while preparing the rest of resident's medication, without the use of a barrier. LPN # 1 then placed the inhaler inside the top of the medication cart as the resident was using the	F 880	1. On 6/21/2023, the Infection Preventionist in-serviced Licensed Practical Nurse #1 regarding Medication Administration and barrier usage. 2. All residents have the potential to be affected by this practice. 3. Beginning 6/26/2023, the Infection Preventionist began in-servicing licensed staff regarding Medication Administration and Barrier Usage to prevent contamination of medications. 4. Beginning the week of 6/26/2023, the Infection Preventionist, Director of Nursing, will conduct two medication pass observations three times weekly for four weeks, then weekly for four weeks. Findings of medication pass observations will be brought to the Quality Assurance Performance Improvement Committee on 7/26/2023 for review and recommendation monthly for three months.	

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F 880	Continued From page 48	F 880		

restroom and was unable to take her medications at the time. Following administration of Resident #9 's medications, LPN #1 returned to the medication cart and placed the albuterol inhaler on the surface of the medication cart, without a barrier. The Survey Agent (SA) inquired whether she should have placed the albuterol inhaler on the medication cart, and she stated, "No, I should not have. I should have used a barrier." LPN #1 picked up a Styrofoam barrier and showed the SA. She acknowledged that lying the inhaler on the medication cart was an infection control issue and could contaminate the medication.

An interview with the Director of Nursing (DON) on 6/21/23 at 9:55 AM, confirmed that placing an inhaler on the surface of the medication cart without the use of a barrier was an infection control concern.

An interview on 6/22/23 at 9:05 AM with the Infection Preventionist revealed that placing an inhaler on the surface of the medication cart should not be done, and the nurse should have used a barrier. She revealed doing this could spread germs from surface to surface.

Record review of the "Order Summary Report" list for Resident #9 revealed an order dated 4/12/21, "Ventolin HFA (hydrofluoroalkane) 200 INH (inhaler) 90 MCG (micrograms) HFA AER (aerosol) AD (actuation device) give 2 puffs by mouth two times daily for SOB (shortness of breath) Rinse mouth after use."

Record review of Resident #9's Admission Record revealed the resident was admitted to the facility on 2/22/16 with medical diagnoses that included Peripheral Vascular Disease, Venous

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F 880	Continued From page 49 Insufficiency, Shortness of Breath and Anxiety Disorder.	F 880		