STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255264	A. BUILDING _____ B. WING _____	07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD COMM LIVING CENTER	200 LONG STREET BOONEVILLE, MS 38829

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 7/05/23 through 7/6/23. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation related to F583, F584, F656, F677, F758, F812. The census at the time of the survey was 47 and the facility is licensed for 64.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure	F 583		8/9/23

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

Electronically Signed | 07/21/2023

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F 583	Continued From page 1 and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and facility policy review the facility failed to ensure that a resident who was unclothed had privacy and was free from view to maintain personal privacy for one (1) of 47 residents reviewed during initial tour. Resident #38 Findings include: Record review of the undated facility policy entitled, "Dignity and Respect", undated, revealed, "Policy Statement It is the policy of this facility to treat each resident with respect and dignity...Procedure...3. Residents shall be examined and treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the resident from passers-by..." On 07/05/23 at 11:00 AM an observation was made of Resident #38 lying in bed with no shirt on and was covered with a blanket from his waist down. His door was not closed, and the resident was visible to anyone passing down the hallway. Resident #38 was lying in the first bed at the doorway just inside the room.	F 583	1. On 7/6/2023, Resident #38 was educated and agreed to have privacy curtain pulled while lying in bed uncovered. 2. This alleged deficient practice has the potential to affect all residents. 3. On 7/6/2023, in-service began with nursing staff on residents' rights including ensuring privacy of a residents' body shall be maintained at all times including while lying in bed uncovered, during toileting, bathing, and other activities of personal hygiene, except when staff assistance is needed for the residents' safety. Room Rounds initiated on 7/12/2023. Any privacy concerns will be corrected immediately. Medical Director also made aware of all findings. 4. Beginning 7/12/2023 Director of Nursing (DON) will observe during walking rounds 5 days per week x 4 weeks, then weekly x 2 months to ensure residents are covered appropriately during care and while in view in common areas. Any	

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F 583	Continued From page 2 On 07/05/23 at 12:00 PM, an observation was made of Resident #38 lying in bed with a brief on and with no top sheet or blanket covering him and he had no shirt or pants on. The door to the hallway was open and there was no curtain pulled to prevent exposure of resident from those ambulating in the hallway. Resident was lying flat in bed and was visible to those outside the room. On 07/05/23 at 2:00 PM, an observation of Resident #38 from the hallway, revealed the door to his room was open, and he was lying in bed with only a brief on and there was not a top sheet or blanket covering him. On 07/06/23 at 8:02 AM, an interview with Resident #38 revealed that he had trouble breathing and didn't like to wear shirts or pants. Resident stated, "I don't want to put a shirt on." Resident revealed that he tried to keep the cover over him; but he sometimes got hot and felt like he was smothering and would kick the cover off. Resident #38 revealed that he would rather not be seen by other's when he was uncovered. Resident #38 stated, "I don't want people to see my legs." On 07/06/23 at 9:20 AM, an interview with Director of Nursing (DON), revealed that Resident #38 constantly kicked his covers off, would not wear clothes, and the staff had to constantly watch him. She revealed that they had tried gowns, more comfortable shirts, and shorts; but he just took them off. She stated that the staff usually monitor him and when he was uncovered, they would go in and cover him back up. On 07/06/23 at 9:50 AM, an interview with DON,	F 583	privacy concerns will be immediately corrected. Director of Nursing will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months starting 8/8/2023 and as needed for review/revision.	

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F 583	Continued From page 3 revealed that she agreed one hundred percent that the resident lying in bed uncovered with only a brief on was a personal privacy issue, especially because he didn't want anyone to see his legs. On 07/06/23 at 10:00 AM, an interview with the Administrator (ADM), revealed that she was made aware of the concern with Resident #38 today. The ADM confirmed that this resident lying in his bed unclothed and uncovered with the door to his room left open was a privacy issue. Record review of Resident's Admission Record revealed an admission date of 06/02/23 with the following diagnoses to include Heart Failure, Chronic Obstructive Pulmonary Disease, Morbid Obesity, Restlessness and Agitation, and Weakness. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 06/08/23, documented under Section C a Brief Interview for Mental Status (BIMS) Score of 08 which indicated that resident had moderate cognitive deficits.	F 583		
F 584 SS=E	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	F 584		8/9/23

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F 584	Continued From page 4 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 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 observations, staff and resident interviews and facility policy review the facility failed to provide furniture in the resident's room that was not broken and failed to provide warm water in resident's rooms for four (4) of 47 residents reviewed during initial tour. Resident #1 for furniture and Residents #18, Resident #25 and Resident #42 for water.	F 584	1. On 7/5/2023, Resident 1 side table and chest of drawers was replaced immediately and moved to allow opening of bottom drawer by Maintenance. On 7/5/2023, the pilot light was noted to be out and immediately corrected. Hot-water pump was ordered on 7/5/2023 and installed on 7/17/2023.	

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F 584	Continued From page 5 Findings include: Record review of the facility policy titled, "Resident Rights" with a revision date of 11/28/16 revealed under section (i)," Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment...." Also revealed under, " (2) Housekeeping and maintenance services necessary to maintain sanitary, orderly, and comfortable interior; ... (6) Comfortable and safe temperature levels...." Record review of the typed statement on facility letterhead July 6, 2023 and signed by the Administrator revealed the facility does not have a policy regarding replacing broken furniture. Record review of the policy titled, "Weekly Water Temperature Checklist-Notes" with no revision date revealed "Resident room temperatures should be no less than 100 degrees and no more than 115 degrees". Resident #1 An observation and interview on 07/05/23 at 11:28 AM, revealed Resident #1 had a side table with a missing top drawer and a small chest of drawers with 3 out of six (6) that were missing handles and a bottom drawer that could not be opened all the way. Resident #1 revealed the missing top drawer had been that way since she moved in that room about 3 weeks prior and she just sits stuff around because she doesn't always have room with only two drawers in her nightstand. She stated the chest of drawers in the closet cannot be opened all the way because it sits in the corner and it hits the inside edge of	F 584	2. This alleged deficient practice has the potential to affect all residents. 3. On 7/5/2023, Administrator in-serviced Maintenance Director regarding water temperatures, frequency of temperature checks, and keeping logs of temperatures, broken equipment/furniture, and resident ability to use furniture. Water temperature checks initiated on 7/18/2023 by Maintenance Director. On 7/6/2023 staff were in-serviced regarding homelike environment, including notification of administrator and maintenance of broken equipment, furniture, and inability of resident to use furniture by Director of Nursing (DON). Room Checks initiated on 7/12/2023. Any broken equipment/furniture will be replaced immediately, and Administrator notified. Any water temperatures outside of 100 to 115 degrees Fahrenheit will be reported to Administrator immediately and corrected. Medical Director also made aware of findings. 4. Beginning 7/18/2023, Maintenance Director will check water temperatures to ensure water temperature is within range of 100 to 115 degrees Fahrenheit weekly x 4 weeks, then monthly x 2 months. Starting 7/12/2023, Nurse Supervisor to complete room checks weekly x 4 weeks then monthly x 2 months to ensure rooms are free of broken equipment and able to use all furniture in room. Maintenance Director will reports results of the audit to Quality Assurance Performance	

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F 584	Continued From page 6 the closet when you try to open the drawers. An observation on 7/5/23 at 4:30 PM, revealed the resident had personal belongings lying on the bed and on the overbed table. An interview and observation on 07/06/23 9:23 AM, with the Administrator confirmed that Resident #1's nightstand had a top drawer missing and needed to be replaced. She revealed that the bottom drawer of the chest of drawers in the resident's closet would not open all the way because it got stuck on the edge of the inside of the closet and needed to be moved so that all drawers could open. An interview on 7/6/23 at 3:00 PM, with the Director of Nurses (DON) revealed that when a resident is admitted or moved to another room, then the staff will review the room to make sure everything is in order and nothing needs to be replaced. She revealed that if the resident's nightstand had a missing drawer, then it should have been replaced. Resident #25: An interview with Resident # 25 during initial tour on 7/5/23 at 10:30 AM, revealed the facility staff have to come into his room to get hot water for the other residents on this hall (C hall) and stated that his room had plenty of warm water. An observation during initial tour on 7/05/23 at 10:40 AM, of the bathroom water in Resident #25's bathroom revealed that the water was cold and had no warmth after running the faucet for 3-5 minutes.	F 584	Improvement Committee (QAPI) monthly x 3 months starting on 8/8/2023 and as needed for review/revision.	

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F 584	Continued From page 7	F 584		

An interview on 7/05/23 at 11:02 AM, with Certified Nurse Aide (CNA) #2 revealed none of the water on C hall gets "real warm." She stated a couple of the rooms get warmer water because they have individual hot water heaters going to those rooms.

An interview with the Maintenance Director on 7/05/23 at 11:10 AM, revealed he had not been told anything about the water on C hall being cold. He revealed the warmness of the water temperature depended on how close the resident's room was to the water heater. The State Agent (SA) requested temperature check on the hot water in Resident #42's and Resident 18's bathrooms. The SA observed the temperature in Resident #42's bathroom to be 75 degrees Fahrenheit and in Resident #18's bathroom the water temperature was 80.2 degrees Fahrenheit.

An interview with the Administrator (ADM) on 7/5/23 at 11:45 AM, revealed that she had not been told by any of the residents that the hot water was not working on C hall. She revealed that they have had issues in the past with the mixing valve on the hot water tank.

Resident #18

An interview with Resident # 18 on 7/5/23 at 11:52 AM, revealed he has not had warm water in his bathroom since Christmas time. He stated he has told the maintenance man about the water in the past, but that particular maintenance man was no longer employed at the facility. Resident #18 stated, "The pilot light has gone out several times and they have replaced the tank.He stated, "I would like to have warm water to at least wash

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F 584	Continued From page 8	F 584		

my face." He revealed he goes down the hall to get his shower and the water is always warm there.

Resident #42

An interview with Resident # 42 on 7/5/23 at 12:01PM, revealed she has not had warm water in her bathroom for months. She stated, "I like to wash my hair in the bathroom, and I would like warm water to do that." She revealed she has not had any issues with hot water in the shower room just in her bathroom in her room.

An interview with the Maintenance Director on 7/05/23 at 12:35 PM, revealed when he started to work here 2 weeks ago the hot water was on his list of things to check. He stated that he had many other electrical issues on his list to fix first, as he felt that took top priority. He stated that he had not been doing any monitoring of the water in the facility to see if it was warm enough.

An interview with the ADM on 7/05/23 at 1:00PM, revealed that the facility does not do any water temperature monitoring.

An observation and interview with the ADM on 7/06/23 at 4:06 PM of the hot water Resident #18's bathroom confirmed the water was only tepid. She stated that they had replaced the water heater before and recently had issues with the pilot light going out. She stated, "I'm not going to have the residents without hot water. "

Record review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/8/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 12,

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F 584	Continued From page 9 which indicated the resident has moderate cognitive impairment. Record review of the MDS with an ARD of 5/10/23 revealed under section C a BIMS score of 15, which indicated Resident #25 is cognitively intact. Record review of the MDS with an ARD of 6/21/23 revealed under section C a BIMS score of 15, which indicated Resident #18 is cognitively intact. Record review of the MDS with an ARD of 05/12/23 revealed under section C a BIMS score of 15, which indicated Resident #42 is cognitively intact.	F 584		
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	F 656		8/9/23

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F 656	Continued From page 10 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review the facility failed to implement a comprehensive care plan for a resident who required assistance with Activities Daily Living (ADL) nail care for one (1) of 12 residents sampled. Resident #40 Findings include: Record review of the facility's "Using the Care Plan" policy (undated) revealed "It is the policy of	F 656	1. On 7/5/2023, Resident 40 nail care was provided immediately by the Director of Nursing (DON). 2. This alleged deficient practice has the potential to affect all residents. 3. On 7/5/2023 DON and Nursing Supervisor performed nail care for all residents. Starting 7/6/2023, staff were in-serviced regarding use of care plan and	

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F 656	Continued From page 11 this facility that the care plan be used in developing the resident's daily care routines ...4. Daily care and documentation should be consistent with the resident's care plan. Record review of Resident #40's care plan revealed " I have an ADL self-care performance deficit .... date initiated 09/09/2021... Interventions/Tasks... Routine nail care weekly on Saturday, Bathing/Showering: Check nail length and trim and clean on bath day as necessary. Report any changes to the nurse..." During an observation and interview on 07/05/23 at 3:15 PM, revealed Resident #40's fingernails on both hands was approximately one-half (1/2) inch long and jagged past the tip of the fingers, and had a brown substance underneath the nails. The resident revealed he wasn't sure when the last time they were cut, and he would like for them to be cut. The Director of Nurses (DON) reported during an observation and interview on 07/05/23 at 3:25 PM that according to Resident #40's physician orders the resident is supposed to get routine nail care weekly on Saturday. She revealed the residents are supposed to have their nails cleaned every day when they are bathed or cleaned up. She confirmed that Resident #40's nails were long and jagged and needed to be cleaned. She revealed with his nails long and dirty he could cut his skin and could also possibly spread infection. She stated "I will make sure they get cleaned and cut right now." An interview on 07/06/23 at 2:40 PM, the DON confirmed Resident #40's ADL care plan was not being followed when she observed his long and	F 656	nail care by the DON. Starting 7/12/2023, DON will monitor nail care and correct any nail care concerns immediately. Medical Director also made aware of all findings. 4. Starting 7/12/23 ADL care plans for all residents were reviewed by Minimum Data Set (MDS) Nurse for accuracy. Beginning 7/12/2023, DON will monitor nail care is being completed according to the care plan through rounds weekly x 4, then monthly x 2. DON will report all results of audit to Quality Assurance Performance Improvement (QAPI) monthly x 3 starting on 8/8/2023 and as needed for review/revision	

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	255264	A. BUILDING _____ B. WING _____	07/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONGWOOD COMM LIVING CENTER	200 LONG STREET BOONEVILLE, MS 38829

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F 656	Continued From page 12 dirty nails yesterday. An interview on 07/06/23 at 3:54 PM with the Minimum Data Set (MDS) Coordinator revealed she along with the interdisciplinary team is responsible for developing the residents' care plan. She revealed the care plan guides us on how to care for them and is individualized for each resident. A record review of Resident #40's Admission Record revealed the resident was admitted to the facility on 9/1/21 with diagnoses that included Depressive episodes, Chronic Respiratory failure, and Tachycardia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/12/23 revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the 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 observation, staff and resident interviews, record review, and facility policy review the facility failed to provide personal hygiene as evidenced by long, jagged fingernails with a brown substance underneath the nails for one (1) of 12 sampled residents. Resident #40 Findings include:	F 677	1. On 7/5/2023, Resident 40 nail care was provided immediately by the Director of Nursing (DON). 2. This alleged deficient practice has the potential to affect all residents. 3. On 7/5/2023 DON and Nursing	8/9/23

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F 677	Continued From page 13 Record review of the facility policy titled, "Fingernails/Toenails, Care of" with a revised date of February 2018, revealed, "Purpose: The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections..." An observation and interview on 07/05/23 at 3:15 PM, revealed Resident #40's fingernails on both hands were approximately one-half (1/2) inch long and jagged past the tip of the fingers and had a brown substance underneath the nails. The resident revealed he wasn't sure when the last time they were cut and he would like for them to be cut. An interview on 07/05/23 at 3:20 PM, Certified Nurse Aide (CNA) #1 revealed we are responsible for making sure the resident's nails are cleaned each time they are bathed but the nurses trim their nails on the weekends. She revealed she is assigned to Resident #40 but just came in to work and wasn't sure what was done today. An observation and interview on 07/05/23 at 03:25 PM, the Director of Nurses (DON) revealed according to Resident #40's physician orders the resident is supposed to get routine nail care weekly on Saturday. She revealed the residents are supposed to have their nails cleaned every day when they are bathed or cleaned up. She confirmed that Resident #40's nails were long and jagged and needed to be cleaned. She revealed with his nails long and dirty he could cut his skin and could also possibly spread infection. She stated "I will make sure they get cleaned and cut right now."	F 677	Supervisor performed nail care for all residents. Starting 7/6/2023, staff were in-serviced regarding use of care plan in residents care and providing nail care by DON. Starting 7/12/2023, DON will monitor nail care and correct any nail care concerns immediately. Medical Director also made aware of findings. 4. Beginning 7/12/2023, DON will monitor nail care is being completed according to the care plan through rounds weekly x 4, then monthly x 2. DON will report all results of audit to Quality Assurance Performance Improvement (QAPI) monthly x 3 starting on 8/8/2023 and as needed for review/revision.	

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F 677	Continued From page 14 Record review of Resident #40's Order Summary report revealed an order dated 9/1/2021 for "Routine nail care every Saturday..." Record review of Resident #40's Admission Record revealed the resident was admitted to the facility on 09/01/2021 with diagnoses that included Depressive episodes, Chronic Respiratory failure, and Tachycardia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of April 12, 2023, revealed Resident #40 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident is cognitively intact.	F 677		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		8/9/23

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F 758	Continued From page 15 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to ensure that an as-needed (prn) psychotropic drug was limited to 14 days for one (1) of four (4) residents reviewed for psychotropic medication use. Resident #10 Findings include: A review of the facility policy titled "Antipsychotic	F 758	1. On 7/6/2023, Director of Nursing (DON) notified physician regarding Ativan order. Physician provided new orders to discontinue Ativan. 2. This alleged deficient practice has the potential to affect all residents. 3. On 7/6/2023, DON reviewed all psychotropic medications for as needed	

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F 758	Continued From page 16 Medication Use", dated 10/2022, revealed, "The need to continue PRN orders for psychotropic mediations beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order." Record review of Resident #10's Order Summary Report revealed, "Lorazepam Oral Concentrate 2mg/ml (milligram/milliliter) (Lorazepam) Give 0.5ml by mouth every 2 hours as needed for air hunger related to PERSONAL HISTORY OF MALIGNANT NEOPLASM OF BREAST ...." Order start date 3/10/2023 and no end date. An interview on 07/06/23 at 9:15 AM with Registered Nurse (RN) #1 revealed when a resident is on a PRN (as needed) psychotropic medication we try to make sure they are reviewed and have a stop date and our hospice residents don't have stop dates on them because they are end of life. An interview on 07/06/23 at 9:20 AM, the Director of Nurses (DON) confirmed that Resident #10 did not have a stop date on her PRN Lorazepam and she should have. She revealed the resident is on hospice and we are still supposed to have a fourteen-day stop date. They can be re-evaluated by the physician with a continuation for the PRN medication but confirmed Resident #10 had not had a re-evaluation or a stop date on the medication. A phone interview on 07/06/23 at 9:50 AM, with the Pharmacy Consultant revealed all residents are supposed to have a stop date on PRN psychotropic medications. He revealed hospice is not an exception and he always makes sure to	F 758	use with stop date. Any psychotropic medications needing stop dates were communicated to physicians and corrected. Beginning 7/6/2023, nurses were educated regarding as needed (prn) psychotropic medications and stop dates by DON. DON will review all prn psychotropic medications for stop dates and psychotropic medications without stop dates will corrected immediately. Medical Director also made aware of findings. 4. Beginning 7/7/2023, DON will review new orders daily x 5 days a week in clinical meeting x 3 months to ensure all prn psychotropic medications have a stop date. DON will report all results of audit to Quality Assurance Performance Improvement (QAPI) monthly for 3 months starting on 8/8/2023 and as needed for review/revision.	

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F 758	Continued From page 17 put that on his gradual dose reduction documentation to the physician. He revealed the resident just received the order in March and a gradual dose reduction had not been done yet and is scheduled for this month. An interview on 07/06/23 at 10:37 AM, the Infection Preventionist/Registered Nurse confirmed that Resident #10 has the liquid Lorazepam which was ordered when she went on hospice. She confirmed that it did not have a stop date and it should have one for fourteen days. Record review of Resident #10's Admission Record revealed she was admitted to the facility on 01/27/2023 with diagnoses that included Heart Failure, Alzheimer's disease, and Personal history of malignant neoplasm of breast. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/7/23 revealed a Brief Interview for Mental Status (BIMS) score of 05 indicating severe cognitive impairment.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		8/9/23

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F 812	Continued From page 18 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review, the facility failed to ensure items in the kitchen refrigerators, dry storage room and on metal shelves were dated, labeled and discarded by the expiration date for one (1) of two (2) kitchen tours. Findings include: Review of the facility policy titled, "Food Storage" dated August 18, 2011, revealed, It is the policy of this facility that food storage areas be maintained in a clean, safe, and sanitary manner ... 8. All foods stored in refrigerators and freezers that have been opened, will be covered, and labeled with the date and name of food if appropriate, and will be discarded within the appropriate time frame. 9. All leftover foods are to be stored in covered containers, dated, & labeled ...If not used by the (3rd) day, they are to be discarded ...Cold leftovers not used by the third (3rd) day are to be discarded. An observation and interview on the initial tour of the kitchen on 07/05/23 at 10:05 AM, revealed: Refrigerator #1: A round plastic container with a date of 7/1/23 and no label. Dietary Worker #1 revealed these are great northern beans and they should have been thrown away. There was a	F 812	1. On 7/5/2023, Dietary Staff 1 and 2 were in-serviced on labeling and dating cold leftovers by Dietary Manager. On 7/5/2023, the great northern beans, tuna fish, peeled onion, opened pack of celery, sour cream, pimento and cheese, and cereal were discarded by Dietary Manager. On 7/5/2023, the Dietary Manager was in-serviced on ensuring food is to be stored in an airtight container by Administrator. 2. All residents have the potential to be affected by the alleged deficient practice. 3. Dietary Manager audited kitchen for proper storage of food and expiration date and snacks with proper names and expiration dates on 7/5/2023. On 7/5/2023, the Administrator in-serviced Dietary Manager on ensuring facility stores food in a manner that meets professional standards by labeling and dating food in the refrigerator and dry food and ensuring food is stored covered. On 7/5/2023, the Dietary Manager in-serviced dietary staff/ on ensuring facility stores food in a manner that meets professional standards by labeling and dating food in	

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F 812	Continued From page 19 round plastic container with a label of "meatballs" and a date of 6/30/23, a rectangular plastic container with no label or date. Dietary Worker #1 revealed its tuna fish, but I don't know when it was put in here nor how long it's been in here. There was a peeled onion wrapped in aluminum foil, with no date or label which was identified by Dietary Worker #1. Observed a pack of opened pack of celery with no date. Dietary Worker #1 revealed I'm not sure of the date, I'm going to throw this stuff out. She confirmed we are supposed to keep the refrigerators cleaned out and confirmed the food is supposed to have a label with the name of the food item on it and the date it is put in the refrigerator, and it is supposed to be thrown away within three (3) days. Refrigerator #2: Observed a container with a manufactured label of sour cream with an open date of 6/27/23. Dietary Worker #2 revealed this was supposed to be thrown away. A white round container with two labels on the top of the lid, one label with an opened date of 6/28/23 and another label with an opened date of 6/29/23 was observed. Dietary Worker #2 revealed, I think it was opened on 6/29/23 but I'm not sure because there's another label for 6/28/23. He identified the food as Pimento and Cheese and revealed regardless, it should have been thrown away. Dietary Worker #2 revealed I usually clean out the refrigerator every week but confirmed it had not been cleaned out. Supply Room: Observed three (3) bags of opened cereal in original bags. Dietary Worker #2 identified one package of Rice Krispies, one package of Corn Flakes, and the other package as Toasted Oats.	F 812	the refrigerator and dry food, also on ensuring food is stored covered. Any mislabel food or improperly stored food will be corrected immediately. Medical Director also made aware of findings. 4. Starting on 7/12/2023, Dietary Manager will audit storage and labeling of foods 5 times a week x 3 weeks and then weekly x 8 weeks. Non-labeled food will be replaced and improper storage will corrected immediately. Dietary Manager will report results of the audit to Quality Assurance Performance Improvement Committee (QAPI) monthly x 3 months starting on 8/8/2023 and as needed for review/revision.	

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F 812	Continued From page 20	F 812		

Dietary Worker #2 confirmed these are supposed to be labeled and dated and in a plastic bag because they have been opened. He revealed I'm not sure who opened these and not sure how long they had been opened. He stated "they could get stale".

Metal Cart:
Observed a three-tier metal cart with a large clear container with plastic bowls on the bottom shelf. Dietary Worker #2 identified the items in the bowls as cereal. A plastic lid was on each bowl which was too small for the bowl leaving the cereal exposed. Dietary Worker #2 revealed the Dietary Manager (DM) is supposed to be ordering the right size lids. She ordered these but they are too small. Dietary Worker #2 revealed he should have wrapped them with plastic wrap so they wouldn't be exposed. He confirmed there was no date or label on the lids and it should be and stated with the cereal not being properly covered it leaves the food exposed and something could get on the food.

An interview on 07/06/23 at 8:45 AM, the DM revealed everyone is responsible for making sure the foods are labeled and dated. She revealed staff is being careless and not labeling, dating, and discarding out-of-date foods. She confirmed that foods that are not dated and discarded properly could possibly cause someone to get sick. The DM confirmed that the cups of cereal on the three-tier metal container should have been covered by plastic wrap being exposed like that could the food to become stale or allow something to get on the cereal.

During an interview on 07/06/23 at 8:50 AM, the Registered Dietician confirmed the food items

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F 812	Continued From page 21 that were not dated, labeled, and exposed could cause cross-contamination and a possible food-borne illness.	F 812		