STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255232	A. BUILDING _____ B. WING _____	C 07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE REHABILITATION AND HEALTHCARE CENTER	**302 ALCORN DRIVE CORINTH, MS 38834**

(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 a Complaint Investigation (CI MS #21948, CI MS #22024, CI MS #22026, CI MS #22027, CI MS #22028, CI MS #22029, CI MS #22030, and CI MS #22031) at the facility from 07/17/23 through 07/19/23. During the survey the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F812 for CI MS #21948 for failure to clean kitchen equipment used to prepare food. The SA investigated CI MS #22024, CI MS #22026, and CI MS #22028 for leaving medications in residents room and not administering medications according to plan of care and there were no deficiencies cited. The SA investigated CI MS #22030 and CI MS #22031 for Staff to Resident Altercation, investigated CI MS #22027 related to injury of unknown origin and there were no deficiencies cited. The SA also investigated CI MS # 22026 and CI MS #22029 for resident not groomed adequately and cited F677, along with F656, F725 and F726 related to not implementing comprehensive care plan and for insufficient staffing competencies. At the time of survey the facility had a census of 81 and held a license for 95 beds.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		8/25/23

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

Electronically Signed | 08/03/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 656		

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F 656	Continued From page 2 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure that a comprehensive care plan for a resident requiring two-person assistance with bathing and personal hygiene was followed for one (1) of six (6) residents sampled. Resident #2. Findings include: A review of the facility's policy entitled, "Care Plans, Comprehensive Person-Centered" dated 10/2022 with a reviewed date of January 2023, revealed under "Policy Statement: A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." Record review of Resident #2's Comprehensive Care Plan initiated on 04/27/22 documented the following: Focus: The resident has an Activities of Daily Living (ADL) self-care performance deficit related to anoxic brain damage. Interventions/Tasks: BATHING/SHOWERING: The resident is (dependent) on two (2) staff to provide bath/shower) and as necessary. BED MOBILITY: The resident is (extensive assistance) of two (2) staff for repositioning and turning in bed. On 07/18/23 at 10:25 AM, an interview with Nursing Aide (NA), revealed that she gave baths/showers on A- plus hall to all residents in	F 656	F656 Preparation and submission of this plan of correction by Cornerstone Rehabilitation and Healthcare Center, Corinth, MS does not constitute an admission of agreement by the provider of the truth, or facts alleged, or the correctness of the conclusions set forth on the statement of deficiencies. They are prepared solely pursuant to the requirements under the federal and state laws. F656 Development/Implement Comprehensive Care Plan 1. Resident # 2 is dependent on two staff members to provide bathing, showering, repositioning in bed and turning in bed according to Care Plan initiated on 4/27/2022. The Nursing Assistant revealed that she gave Resident #2 a bed bath by herself, with no one present in the room with her. The Nursing Assistant was educated on 7/19/2023 that she is not to provide care independently by the Director of Nurses. 2. The facility determined that each of the 81 residents could be affected. 3. Nursing staff members including Director of Nurses, Assistant Director of Nurses, Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants, and Nursing Assistants were immediately in-serviced by the Nurse Educator the use of the Kardex on the Point of Care charting in Point Click Care	

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F 656	Continued From page 3 even numbered rooms yesterday which was Monday, July 17, 2023. This NA revealed that she gave the showers first and when all were completed, she did the bed baths. NA stated, "I do bed baths and showers by myself." NA also confirmed that she had given Resident #2 a full bed bath the day before by herself with no one else present in the room with her. On 07/18/23 at 10:30 AM, an observation and interview with Certified Nursing Assistant (CNA) #1, revealed that there was supposed to be a CNA working alongside Nursing Aides. CNA #1 confirmed that Resident #2 had a mild body odor and that her hair was matted and unbrushed. CNA also revealed that Resident #2 required significant assistance and that there should always be 2 people bathing Resident #2. During an interview on 07/19/23 at 9:45 AM, with Director of Nursing (DON), confirmed that Resident #2 required extensive assistance of two staff members to provide bathing and shower needs and she confirmed that it was documented in Resident's Care Plan. DON revealed that the Nursing Aide (NA) was not supposed to be giving Resident #2 a bed bath by herself since her care plan was documented for two persons assist. She confirmed that there was no way the resident could be thoroughly cleaned if the NA completed the bed-bath by herself. DON revealed that this resident would require two people to turn and bathe to really get her clean. An interview on 07/19/23 at 10:05 AM, Minimum Data Set (MDS) Nurse revealed that she was responsible for developing the comprehensive care plan. She revealed the care plan was developed to make sure the staff knew how to	F 656	on 7/19/2023. On 7/21/2023, the Certified Nursing Staff and Nursing Assistants were trained one on one per Nurse Educator on accessing the Kardex on Point of Care Charting. On 7/21/2023, Nursing staff were in-serviced that each Resident has a person-centered Care Plan, which is followed to care for the Resident. If any changes are noted to the Resident Care Plan report it immediately to the Supervisor so the Care Plan can be updated. 4. On 7/24/2023, Audits will be conducted by Nurse Educator, on five residents weekly for four (4) weeks and then monthly for three (3) months to assure substantial compliance that Activity of Daily Living on resident of being followed according to Care Plan by staff observation. Audits will be taken to Quality Assurance beginning 8/15/2023 for review for three (3) months to identify Care Plans are being followed accordingly.	

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F 656	Continued From page 4 take care of the residents and that this resident required a two person assist for proper care. On 07/19/23 at 3:35 PM, an interview with Licensed Practical Nurse (LPN) # 3 revealed that the CNAs had I-Pads to chart on. She revealed that they would log in to (Proper name of computer software), and could see Resident's Care Plans, including any updates and new orders. She revealed that the CNAs should always know exactly how to take care of each resident here in the facility. On 07/19/23 at 4:15 PM, Administrator confirmed that if the NA had given a bed bath to Resident #2 without assistance, then the Care Plan was not followed. She also revealed that the Nursing Aides were supposed to be teamed up with a Certified Nursing Assistant and that bed baths and showers should never be completed by a Nursing Aide alone. Record review of Resident #2's "Admission Record" documented Admission Date of 04/27/2022. Resident #2 was admitted with the following diagnoses to include: Anoxic Brain Damage, Seizures, Type II Diabetes Mellitus, Dysphagia, Bipolar Disorder, Muscle Weakness, and Need for Assistance with Personal Care.	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:	F 677		8/25/23

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F 677	Continued From page 5 Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure that a resident who was unable to carry out activities of daily living (ADLs) received services by qualified staff to maintain good grooming, bathing and personal hygiene needs for one (1) of six (6) residents sampled. Resident #2. Findings include: Record review of the facility policy with revision date of March 2018 entitled, "Activities of Daily Living (ADLs), Supporting", revealed, "Policy Statement... Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene." On 07/18/23 at 10:05 AM, observed Resident #2 lying in bed with eyes open. She was non-verbal and unable to make her needs known. State Agent (SA) observed a white crusty substance to the right side of her mouth and right chin area and a mild body odor was noted. Resident's hair was observed as disheveled and matted. On 07/18/23 at 10:20 AM, an interview with Certified Nursing Assistant (CNA) #1, revealed that residents in even numbered rooms received baths every Monday, Wednesday, and Friday and residents in odd numbered rooms received their baths on Tuesday, Thursday, and Saturday. On 07/18/23 at 10:25 AM, an interview with Nursing Aide (NA), revealed that she had completed the Certified Nursing Assistant Program, had passed her written Certification	F 677	F677 Activity Daily Living Care Provided for Dependent Resident 1. Resident # 2 received a shower from a Certified Nursing Assistant and Nursing Assistant on 7/19/2023. On observation after care by Director of Nurses and Staff Development Coordinator resident #2 had no odor and hair was not matted. On 7/19/2023, the Nursing Assistant was verbally counseled that she could not provide care to residents independently by Director of Nurses. 2. The facility determined that each of the 81 residents could be affected. 3. On 7/21/2023, Nursing Staff were educated by Nurse Educator on providing personal hygiene, activities of daily living according to the Care Plan and documentation of care to include any refusals. On 7/19/2023, the Licensed Nursing Staff and Interdisciplinary Team began visual observation to assure the Nursing Assistants do not work independently. 4. Beginning 7/24/2023, audits will be conducted by Assistant Director of Nurses on five (5) residents for completion of care for Activities of Daily Living by observation weekly to ensure compliance for four (4) weeks and monthly for three (3) months. On 7/20/2023, Audits began for visual observation that Nursing Assistants are not working independently for four (4) weeks and monthly for three (3) months. Audits will be taken to Quality Assurance monthly beginning 8/15/2023 for three (3) months to identify that Activities of Daily Living are being performed without any	

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F 677	Continued From page 6 Test on 06/13/23, had failed her skills test and was scheduled to retake her skills test in August to get her certification. She revealed that she gave baths/showers on A plus hall to all residents in even numbered rooms yesterday which was Monday, July 17, 2023. This NA revealed that she gave the showers first and when this was completed, she completed the bed baths. NA stated, "I do bed baths and showers all by myself." She also revealed that someone was supposed to always be with her when taking care of residents, but they were not. This NA confirmed that Resident #2's hair was unbrushed and matted up and confirmed that Resident #2 had a mild body odor. NA also confirmed that she had given Resident #2 a full bed bath the day before by herself with no one else present in the room with her. On 07/18/23 at 10:30 AM, an interview with CNA #1, revealed that there was supposed to be a Certified Nursing Assistant working alongside Nursing Assistants until they received their certification. CNA #1 confirmed that Resident #2 had a mild body odor and that her hair was matted and unbrushed. CNA #1 revealed that Resident #2 was frequently resistant to care and often slapped them back with her hands blocking them from giving the care she needed. CNA #1 also revealed that the NA should always ask for help with residents. On 07/18/23 at 10:35 AM, an interview with the NA revealed that this resident was often resistant to care. She confirmed that her hair was messy but when they tried to brush it, resident would lift her hands up to stop them from brushing it. This NA revealed that she should have asked for help with Resident #2 and not given her a bed bath	F 677	issues.	

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F 677	Continued From page 7	F 677		

without a Certified Nursing Assistant present.

On 07/18/23 at 10:45 AM, an interview with Administrator (ADM), revealed that the Nursing Assistants who had not received their certification were required to be overseen by Certified Nursing Assistants (CNAs) or Licensed Practical Nurses (LPNs). ADM stated, "They were supposed to work together." Administrator revealed that Nursing Assistant (NA) had passed the written certification test; but had failed her first skills test and was rescheduled to take it again.

On 07/18/23 at 11:15 AM, an interview with Registered Nurse (RN) #1 in Resident #2's room, revealed that she was working on A-Hall this shift. She confirmed that Resident #2 had disheveled, matted hair, and a mild body odor. RN #1 stated, "It doesn't appear that she had a bath yesterday based on the smell."

An interview on 07/19/23 at 9:45 AM, with Director of Nursing (DON), revealed that the Nursing Assistants (NAs) were supposed to be supervised by Certified Nursing Assistants (CNAs) and she confirmed that the NA was not supposed to be giving Resident #2 a bed bath by herself since her needs were documented for two persons assist. She confirmed that there was no way the resident could be thoroughly cleaned if she completed the bed-bath by herself. The DON revealed that this would require two people to turn and really get her clean.

On 07/20/23 at 4:15 PM, an interview with Licensed Practical Nurse (LPN) #3, revealed that the Nursing Aides who have not passed the CNA program could pass out ice, change bed linens, make beds; but were not supposed to give baths

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F 677	Continued From page 8 or showers to residents without a CNA or Nurse present. Record review of Resident #2's "Documentation Survey Report" under "Tasks: Interventions and Tasks" in Electronic Medical Record (EMR) documented that she received a bed bath on 07/17/23 completed by Nursing Assistant. It was also documented under Activities of Daily Living (ADL)-Bathing the numbers four (4) and two (2) which represented the following: 4-Total Dependence and 2-Two-person physical assist. Record review of Resident #2's "Admission Record" documented Admission Date of 04/27/2022. Resident #2 was admitted with the following diagnoses to include: Anoxic Brain Damage, Seizures, Type II Diabetes Mellitus, Dysphagia, Bipolar Disorder, Muscle Weakness, and Need for Assistance with Personal Care. Record review of Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/23/2023 under Section C documented a Brief Interview for Mental Status (BIMS) Score of 99 which indicated resident was unable to complete the interview.	F 677		
F 725 SS=D	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	F 725		8/25/23

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F 725	Continued From page 9 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 observations, staff interviews, record review, and facility policy review, the facility failed to maintain adequate staffing numbers to assist the residents in getting the care they needed to maintain good grooming, bathing and personal hygiene needs for one (1) of three (3) days of survey. Findings include: The Administrator revealed that they had no policy on Nursing Assistant staffing; but provided the following typed statement on Company Letterhead: "After completing the Certified Nursing Assistant (CNA) class, The Nurse Assistant is scheduled on the unit teamed with a Certified Nursing Assistant. They are overseen by the Nurse working the cart and Registered Nurse	F 725	F725 Sufficient Nursing Staff 1. On 7/21/2023, Facility will ensure sufficient staffing to ensure provision of resident care. The Director of Nurses, Assistant Director of Nurses, and Staff Development Coordinator will ensure that the Nurses Assistants working on the floor provide care with the supervision of a Certified Nursing Assistant or Licensed Nurse. 2. The facility determined that each of the 81 residents could be affected. 3. On 7/20/2023, the Nursing Assistants and Certified Nursing Assistant were in-serviced by Director of Nurses and Nurse Educator that they must work together to provide care for residents.	

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F 725	Continued From page 10 (RN) Supervisor." This letter was typed up, dated 7/18/2023 and signed by Administrator. On 07/18/23 at 10:05 AM, observed Resident #2 lying in bed with eyes open. She was non-verbal and unable to make her needs known. State Agent (SA) observed a white crusty substance to the right side of her mouth and right chin area and a mild body odor was noted. Resident's hair was observed as disheveled and matted. On 07/18/23 at 10:25 AM, an interview with Nursing Aide (NA), revealed that she had completed the Certified Nursing Assistant Program, had passed her written Certification Test on 06/13/23, had failed her skills test and was scheduled to retake her skills test in August to get her certification. She revealed that she gave baths/showers on A plus hall to all residents in even numbered rooms yesterday which was Monday, July 17, 2023. This NA revealed that she gave the showers first and when this was completed, she completed the bed baths. NA stated, "I do bed baths and showers all by myself." She also revealed that someone was supposed to always be with her when taking care of residents, but they were not because there wasn ' t enough staff. This NA confirmed that Resident #2's hair was unbrushed and matted up and confirmed that Resident #2 had a mild body odor. NA also confirmed that she had given Resident #2 a full bed bath the day before by herself with no one else present in the room with her. On 07/18/23 at 10:30 AM, an interview with CNA #1, revealed that there was supposed to be a Certified Nursing Assistant working alongside Nursing Assistants until they received their	F 725	Nursing Assistants must not be left unattended during care. Audit will be completed by 8/4/2023 on acuity of residents on A/A plus Hall by Medical Records. On August 7,2023, an extra slot will be added to the A and A plus Hall for a Certified Nursing Assistant or Licensed Nurse to provide compliance. 4. Beginning 7/24/2023, the Director of Nurses and Administrator will review for sufficient staffing daily to ensure compliance of provision of resident care. Sufficient staffing will be reviewed daily in the Morning Meeting to ensure Nursing Assistants are teamed with Certified Nursing Assistants to provide compliance according to Acuity of care. Beginning August 15, 2023, review, and recommendation at monthly Quality Assurance meeting for three (3) months.	

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certification. CNA #1 confirmed that Resident #2 had a mild body odor and that her hair was matted and unbrushed. CNA also revealed that there should always be two (2) people bathing Resident #2; and stated, "We don't always have enough staff." CNA #1 revealed that Resident #2 was frequently resistant to care and often slapped them back with her hands blocking them from giving the care she needed.

On 07/18/23 at 10:45 AM, an interview with Administrator (ADM), revealed that the Nursing Assistants who had not received their certification were required to be overseen by Certified Nursing Assistants (CNAs) or Licensed Practical Nurses (LPNs). ADM stated, "They were supposed to work together." Administrator revealed that Nursing Assistant (NA) had passed the written certification test; but had failed her first skills test and was rescheduled to take it again.

On 07/18/23 at 11:15 AM, an interview with Registered Nurse (RN) #1 in Resident #2's room, revealed that she was working on A-Hall this shift. She confirmed that Resident #2 had disheveled, matted hair, and a mild body odor. RN #1 stated, "It doesn't appear that she had a bath yesterday based on the smell."

An interview on 07/19/23 at 9:45 AM, with Director of Nursing (DON), revealed that the Nursing Assistants (NAs) were supposed to be supervised by Certified Nursing Assistants (CNAs) and she confirmed that the NA was not supposed to be giving Resident #2 a bed bath by herself since her needs were documented for two persons assist. She confirmed that there was no way the resident could be thoroughly cleaned if she completed the bed-bath by herself. The DON

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F 725	Continued From page 12 revealed that this would require two people to turn and really get her clean. On 07/20/23 at 4:00 PM, an interview with CNA #2, revealed that when the NAs completed their classes, they were paired with a CNA. She revealed that the NAs who had not passed the CNA classes were not supposed to give baths or showers without a CNA or Nurse with them; but the NAs were providing care without supervision at this time due to staffing issues. CNA #2 revealed that if they were fully staffed for the day, then the NAs could be paired with a CNA. Record review of Resident #2's "Admission Record" documented Admission Date of 04/27/2022. Resident #2 was admitted with the following diagnoses to include: Anoxic Brain Damage, Seizures, Type II Diabetes Mellitus, Dysphagia, Bipolar Disorder, Muscle Weakness, Difficulty in Walking, and Need for Assistance with Personal Care.	F 725		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 726		8/25/23

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F 726	Continued From page 13 §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to ensure that the nursing assistants (NA) have the competencies and skill sets to provide care and respond to resident's individualized needs for one (1) of six (6) residents sampled. Resident #2. Findings include: Administrator revealed that they had no policy on Nursing Assistant Competencies; but provided the following typed statement on Company Letterhead: "After completing the Certified Nursing Assistant (CNA) class, The Nurse Assistant is scheduled on the unit teamed with a Certified Nursing Assistant. They are overseen by the Nurse working the cart and Registered Nurse (RN) Supervisor." This letter was typed up, dated 7/18/2023 and signed by Administrator.	F 726	F726 Competent Nursing Staff 1. On 7/21/2023, Nursing Assistant was in-serviced that she was not able to perform Resident Care without oversight of a Certified Nursing Assistant or Licensed Nurse. On 7/21/2023, Administrator counseled Registered Nurse of Certified Nursing Assistant class, that students should always be aware that they are unable to provide care independently. 2. The facility determined that each of the 81 residents could be affected. 3. On 7/20/2023, All Nursing staff were in-serviced by Nurse Educator that nursing assistants must not provide care to residents independently, they must be accompanied by a Certified Nursing Assistant or Licensed Nurse.	

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F 726	Continued From page 14 On 07/18/23 at 10:05 AM, observed Nursing Assistant (NA) enter unsampled resident's room by herself. An interview with Nursing Assistant (NA), on 07/18/23 at 10:25 AM, revealed that she had just finished giving a bed bath to this unsampled resident. NA revealed that she had completed the Certified Nursing Assistant Program, had passed her written Certification Test on 06/13/23, had failed her skills test and was scheduled to retake her skills test in August to get her certification. NA stated that she gave baths/showers on A plus hall to all residents in even numbered rooms yesterday which was Monday, 7/17/23. She was giving showers and bed baths to all residents in the odd numbered rooms today. This NA revealed that she did the showers first and when this was completed, she did the bed baths. NA stated, "I do bed baths and showers by myself." She also revealed that since she was not certified, someone was supposed to always be with her when taking care of residents, but they were not. This NA confirmed that Resident #2's hair was unbrushed and matted up and she confirmed that Resident #2 had a mild body odor. NA also confirmed that she had given Resident #2 a full bed bath the day before by herself with no one else present in the room with her and confirmed that she should have had another person with her to be able to give a complete bath due to the resident's extensive care needs. An interview with CNA #1 on 07/18/23 at 10:30 AM, revealed that there was supposed to be a Certified Nursing Assistant working alongside Nursing Assistants until they received their certification. CNA #1 confirmed that Resident #2 had a mild body odor and that her hair was	F 726	4. Audits/Observations of Nursing Assistants to assure compliance is met initiated on 7/24/2023 by Director of Nursing/Assistant Director of Nurses weekly for four (4) weeks, monthly for three (3) months. All findings beginning August 15, 2023, will be reviewed per Quality Assurance for three (3) months.	

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matted and unbrushed. CNA also revealed that there should always be two (2) people bathing Resident #2; and stated, "We don't always have enough staff." CNA #1 also revealed that the NA should always ask for help with residents.

In an interview and record review of the Nursing Assistant List provided by the Administrator on 7/18/23 at 10:45 AM, revealed that Nursing Assistant passed her written test following completion of the Certified Nursing Assistant Program. The Administrator revealed that Nursing Assistant failed the skills test on 06/13/23 and was rescheduled to take the skills test again on August 25, 2023. The Administrator confirmed that the Nursing Assistant was not certified at the time of the complaint survey.

Record review of Resident #2's "Documentation Survey Report" under "Tasks: Interventions and Tasks" in Electronic Medical Record documented that she received a bed bath on 07/17/23 completed by Nursing Assistant. It was also documented under Activities of Daily Living (ADL)-Bathing the numbers four (4) and two (2) which represented the following: 4-Total Dependence and 2-Two-person physical assist.

Record review of Resident #2's "Admission Record" documented Admission Date of 04/27/2022. Resident #2 was admitted with the following diagnoses to include: Anoxic Brain Damage, Seizures, Type II Diabetes Mellitus, Dysphagia, Bipolar Disorder, Muscle Weakness, and Need for Assistance with Personal Care.

Record review of Resident #2's Minimum Data Set with an Assessment Reference Date of 06/23/2023 under Section C documented a Brief

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F 726	Continued From page 16 Interview for Mental Status (BIMS) Score of 99 which indicated resident was unable to complete the interview. Record review of Resident #2's Comprehensive Care Plan initiated on 04/27/22 documented the following: Focus: The resident has an ADL self-care performance deficit related to anoxic brain damage. Interventions/Tasks: BATHING/SHOWERING: The resident is (dependent) on two (2) staff to provide bath/shower) and as necessary. BED MOBILITY: The resident is (extensive assistance) of two (2) staff for repositioning and turning in bed.	F 726		
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 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.	F 812		8/25/23

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F 812	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review, the facility failed to ensure cooking equipment was clean as evidenced by the deep fryer and oven being dirty for one (1) of two (2) kitchen tours. Findings include: Review of the facility policy titled, "Equipment" revised 9/2017, revealed "Policy Statement: All foodservice equipment will be clean, sanitary, and in proper working order ...1. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials ... 2. All staff members will be properly trained in the cleaning and maintenance of all equipment... 3. All food contact equipment will be cleaned and sanitized after every use. State Agent (SA) entered the kitchen on 7/18/23 at 9:00 AM and toured with the District Manager in training and the Dietary Manager (DM) an observation of the deep fryer revealed black oil and a crumb-like substance floating on the oil and thick crumb build-up along the sides of the fryer. The District Manager in training revealed that's on the to-do list for tonight. The DM revealed the oil in the fryer is supposed to be changed weekly and the fryer is wiped down daily after each use. He confirmed that the fryer was dirty, and the oil hadn't been changed in a while. He confirmed that the outside of the fryer had not been wiped down after preparation of meals in a while due to the large buildup of food particles. An observation of the oven revealed a build-up of dark debris particles covering the bottom of the oven. The DM confirmed the oven was dirty and needed to	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary 1. On 7/20/2023, The fryer and oven were both cleaned per Dietary District Manager in Training. 2. The facility determined that each of the 81 residents could be affected. 3. In-service on 7/20/2023, per Dietary District Manager in training that cleaning is weekly on kitchen equipment and the appropriate steps to cleaning appliances. 4. Effective 7/24/2023, Dietary Manager and Infection Preventionist will conduct audits on kitchen sanitation weekly for four (4) weekly and monthly for three (3) months. On August 15, 2023, findings will be reviewed per Quality Assurance for three (3) months.	

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be cleaned and he wasn't sure when it was last cleaned. He confirmed we don't really use the oven much, but it still needs to be cleaned. The DM revealed the kitchen equipment is supposed to be clean to prevent any possible cross-contamination and confirmed the fryer and oven were not clean and that could be a fire hazard.

An interview on 7/18/23 at 9:15 AM Dietary Worker #1 revealed the fryer is supposed to be kept clean and wiped down and the oil is supposed to be changed on Friday, she revealed that she didn't do it this past Friday because she was off work, and she has been the only one changing it. She revealed that the oil was old and black and there were thick food particles in the oil and the insides of the fryer and the along the side of the fryer.

An interview on 7/18/23 at 9:25 AM the DM revealed he is responsible for ensuring the fryer and the oven is cleaned along with all kitchen equipment and he will make sure this gets cleaned right away.

An interview on 7/19/23 at 3:50 PM the District Manager in training revealed, I know what the problem was regarding the fryer being dirty, she revealed she asked the staff yesterday if they knew how to properly clean the fryer and no one knew. State Agent inquired if there were instructions on how to clean the fryer, the District Manager in training revealed, we don't have instructions, but every manager should know and train the employees and this had not been done.