STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255307	A. BUILDING _____ B. WING _____	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN AGE NURSING HOME	2901 HIGHWAY 82 EAST GREENWOOD, MS 38930

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification and complaint investigation (CI) MS #22129 at the facility from 7/24/23-7/27/23. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation related to F641, F656, F677, F684, F690, F757, and F812. The facility was found to be in compliance with CI MS #22129 regarding neglect and hydration. The census at the time of the survey was 74 and was licensed for 95 beds.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview ,record review, and facility policy review, the facility failed to accurately code antipsychotic medication for two (2) of 18 Minimum Data Set (MDS) assessments reviewed. Resident #61 and #62. Findings include: Review of the facility policy titled, "Resident Assessment Instrument," revised 12/2010, revealed, " ...Policy Interpretation and Implementation ...3. The purpose of the assessment is to describe the resident's capability to perform life functions and to identify significant impairments in in functional capacity. 4. Information derived from the comprehensive assessment helps the staff to plan care that	F 641	Residents #61 & #62 were reassessed on 7/26/23 to include the use of antipsychotic medications by the Minimum Data Set (MDS) Coordinator and assessments were corrected to reflect accurate coding. The facility has determined that all residents receiving antipsychotic medications have the potential to be affected. Director of Nursing (DON) conducted one on one education with the MDS Coordinator and Care Plan Nurse to ensure coding of Section N of the MDS assessment is accurate citing the RAI	8/25/23

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

Electronically Signed | 08/10/2023

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F 641	Continued From page 1 allows the resident to reach his/her highest practicable level of functioning ...7. All persons who have completed any portion of the MDS Resident Assessment Form MUST sign each document attesting to the accuracy of such information ..." Resident #61 A record review of Resident #61's Section N-Medications of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/10/2023, revealed N0410A: antipsychotic-number of days received seven (7) ...N0450A-Resident received antipsychotic medications coded zero (0)-antipsychotics were not administered...N0450B: (GDR) gradual dose reduction attempted , N0450C: Date of last attempted GDR, N0450D: physician documented GDR, N0450E: Date physician documented GDR ,N2001: Drug regimen review ,N2003: Medication follow-up, and N2005: Medication intervention were not answered. A record review of Resident # 61's Electronic Medication Administration Record (E-MAR) for May 2023 revealed that he received an antipsychotic medication, Haloperidol 5 mg (milligrams), for seven (7) days during the assessment reference period of 5/04/23 through 5/10/23. An interview with the MDS Coordinator on 7/26/23 at 3:45 PM, she revealed she coded N0450A under Section N of the MDS dated 5/10/23 incorrectly, revealing that because she coded section N0450A incorrectly she was not prompted to answer the questions regarding gradual dose reduction and drug regimen review	F 641	manual instructions on 7/26/23. 100% audit of residents receiving antipsychotic medication was conducted and those within the 90-day assessment window were corrected on 08/10/23 by MDS Coordinator. DON will conduct an audit of four (4) resident(s) MDS assessments per week receiving antipsychotic medications for four (4) consecutive weeks then monthly for three (3) months beginning 7/31/2023. Audited records will be reviewed at the monthly Quality Assurance Committee on 8/18/2023 and monthly for 3 months until such time consistent substantial compliance has been achieved as determined by the committee.	

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F 641	Continued From page 2	F 641		

and confirmed she should have answered all of the questions and confirmed Resident #61 did receive antipsychotic medications for seven days during the look back period.

Record review of Resident #61's Facesheet revealed that the resident was admitted to the facility on 10/21/19 with diagnoses of Major Depressive Disorder and Schizoaffective Disorder.

Record review of the Minimum Data Set (MDS) Section C with an ARD on 5/10/23, revealed that Resident # 61 had a Brief Interview of Mental Status (BIMS) score of 4 which indicated that he was severely cognitively impaired. Section N revealed Resident # 61 received antipsychotic medications seven days during the look back period.

Resident #62

A record review of Resident #62's quarterly MDS with an ARD of 6/26/2023, revealed in Section N, Item N0410A: medications received: Days: antipsychotic was coded as five (5), but N0450A: Resident received antipshychotic medications was coded zero (0) No-Antipsychotics were not received.

A record review of Resident # 62's "E-MAR Administration Record" revealed that she received an antipsychotic medication, Risperdal 0.5 mg, for six (6) days during the assessment reference period of 6/20/23 through 6/26/23.

An interview with Minimum Data Set Nurse (MDS) on 7/26/23 at 3:50 PM, she verified that

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F 641	Continued From page 3 failure to code the Antipsychotic Medication Review correctly could lead to residents missing gradual dose reductions and increase risk for side effects that can affect their health. Review of Resident # 62's Facesheet revealed that she was admitted to the facility on 12/5/2019, with diagnoses that include Unspecified dementia, Unspecified severity, with agitation, Personal history of other mental and behavioral disorders, Dementia...with psychotic disturbance, and Alzheimer's Disease.	F 641		
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	F 656		8/25/23

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F 656	Continued From page 4 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 observations, resident and staff interview, record review and facility policy review the facility failed to implement a care plan for removing facial hair on a resident that was dependent on staff for Activities of Daily Living (ADL) [Resident #28], and failed to develop a care plan for positioning of right arm and positioning of a urine catheter bag [Resident #228] for three (3) of 18 care plans reviewed. Findings include: Review of the facility policy titled, " Comprehensive Care Plans", revised 2/2017, revealed, "Policy: It is the policy of this facility to develop and implement a comprehensive	F 656	On 7/25/2023, Care plan(s) of the resident identifier(s) RI#(s) #28 & #228 were reviewed and updated by the Care Plan Nurse. The facility has determined that all residents have the potential to be affected. On 7/25/2023, all interdisciplinary care plan team members responsible for writing care plans were educated on the facility□s policy and procedure for developing Comprehensive Care Plans by Director of Nursing. Inservice education conducted by DON and Unit Managers for	

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F 656	Continued From page 5 person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment ..." Resident #28 Record review of Resident #28's care plans revealed a care plan with a problem onset date of 04/26/2019 that indicated that Resident #28 requires assistance with ADL's (Activities of Daily Living). Approaches include "Provide assist with all ADLs ...Wax or pluck facial hair - do not shave ..." An observation on 07/24/23 at 03:53 PM revealed that Resident #28 had dark hair approximately 1/8 of an inch long above her lip with a patch of black hair 1/8 of an inch wide and long on either side of her mouth and black hair stubble approximately 1/8 inch long covering her chin. An observation on 07/25/23 at 09:13 AM, revealed that the hair above Resident #28's lips and on her chin remained as it was yesterday. An interview on 7/25/23 at 4:00 PM with the Administrator and the Director of Nurses (DON), they confirmed that her care plan said do not shave, but the resident had agreed to being shaved in the past and while they were waiting on the wax strips to come in, they should have at least shaved in order to remove the hair from the resident's face. Record review of Resident #28's Facesheet revealed the resident was admitted to the facility	F 656	all clinical staff on removal of facial hair per individualized care plan initiated 7/27/23. Inservice education conducted by DON and Unit Managers for all clinical staff on Foley catheter care including proper positioning of drainage bag per individualized care plan initiated 7/27/23. Inservice education conducted by DON and Unit Managers for all clinical staff on proper positioning and body alignment per individualized care plan initiated 7/27/23.Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator(s) starting 7/31/2023. All care plans will be updated as indicated. The Director of Nursing (DON) will complete weekly audits of four (4) resident□s care plans for four (4) consecutive weeks then monthly for three (3) months beginning 7/31/2023. Audits will be completed to ensure that comprehensive care plans are developed for residents. Audit records will be reviewed at the monthly Quality Assurance Committee on 8/18/2023 and monthly for 3 months.	

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on 4/2619 with medical diagnoses that included Hemiplegia, unspecified affecting right dominant side and Dysphagia, oropharyngeal phase.

Record review of Resident #28's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/25/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident is moderately cognitively impaired and in Section G that the resident needed extensive assistance with personal hygiene and total dependence with bathing.

Resident #228 Urinary Catheter

An observation, on 07/25/23 at 03:25 PM revealed Resident #228 lying in bed positioned on his back. The State Agency (SA) was unable to locate the resident's Foley (urinary) catheter on either side of the bed.

An observation and interview on 7/25/23 at 3:27 PM, with Licensed Practical Nurse (LPN)#1 revealed Resident #228's Foley catheter bag was laying on the bed beside the resident's right knee. LPN #1 confirmed the catheter bag should not be in the bed with the resident. LPN #1 stated that the catheter bag should be hanging on the bedside to prevent urine from backing up into the urethra and causing an infection.

An interview, on 7/26/23 at 10:20 PM with Licensed Practical Nurse (LPN) #2 revealed she develops care plans. She confirmed that she failed to care plan that Resident #228's Foley catheter should be kept below the level of the bladder. She stated that was important because if the catheter is not below the level of the bladder,

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F 656	Continued From page 7	F 656		

urine can back up and could cause pain or infection.

An interview, with the DON on 7/26/23 at 10:30 AM, revealed Resident #228's care plan should have included position of the catheter bag, it is in their policy.

Resident #228 Positioning

Record review of Resident #228's care plans revealed there was no care plan regarding the need to position the resident's right arm.

On 07/24/23 at 10:30 AM, observation revealed Resident #228 was sitting up in his geriatric chair with his right arm hanging down beside the chair.

On 07/24/23 at 11:30 AM, Resident # 228 was observed sitting up in his geriatric chair with his right arm hanging down beside his chair. The Speech Therapist walked up to his chair and picked up his arm and repositioned it.

On 07/26/23 at 1:26 PM, observation revealed Resident #228 sitting up in his geriatric chair with his right arm hanging down beside his chair.

On 07/26/23 at 01:45 PM, in an interview with Resident # 228 he stated that he can move his arm around and he can put his arm down but cannot pick it back up and doesn't want it to stay hanging down. Resident #228 stated that he would like them to find something to keep it from falling off the side of the chair.

An interview on 07/26/23 at 01:50 PM with LPN #2 confirmed that there was not a care plan for positioning for Resident #228. She stated that

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F 656	Continued From page 8 therapy has not talked to her about positioning for Resident #228 while up in the geriatric chair. . An interview on 07/27/23 at 09:07 AM with Director of Nursing (DON), confirmed that there was no care plan for positioning Resident #228's right arm and that there should be a care plan in place for this. Review of the facility Facesheet revealed Resident #228 was admitted to the facility on 7/14/23 with diagnoses that included Paraplegia, Fusion of spine cervical region, Benign Prostatic Hyperplasia, and Retention of Urine, unspecified. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/21/23 revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated Resident #228 was 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, staff and resident interview, record review and facility policy review the facility failed to remove facial hair on a resident that was dependent on staff for their Activities of Daily Living (ADL) for one (1) of 18 resident's reviewed for ADL's. Resident #28. Findings Include:	F 677	Facial hair was removed by Certified Nursing Aide for resident #28 on 7/25/23. The Director of Nursing and the treatment nurse completed an assessment of each resident□s facial hair on 7/27/23. Residents requiring specialized hair removal due to high-risk conditions will be appropriately documented on the care plan.	8/25/23

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F 677	Continued From page 9 Review of the facility policy titled, "ADL Basic Care" with a revision date of 4/25/17 revealed, "A. All residents are given or are assisted with their bathing, showering or bed bath..." An observation on 07/24/23 at 3:53 PM, revealed that Resident #28 had dark hair approximately 1/8 of an inch long above her lip with a patch of black hair 1/8 of an inch wide and long on either side of her mouth and black hair stubble approximately 1/8 inch long covering her chin. An observation on 07/25/23 at 09:13 AM, revealed that the hair above Resident #28's lips and on her chin remained as it was yesterday. An interview on 7/25/23 at 12:40 PM, with Certified Nurse Assistant (CNA) #2 revealed that female facial shaving is a part of the resident's bath and confirmed that Resident #28 had facial hair above her lip and on her chin. She stated that she thinks the resident goes to the beauty shop to get the facial hair waxed, but she is not sure the last time she went. An interview and observation on 7/25/23 at 1:10 PM, with Licensed Practical Nurse (LPN) #1 confirmed that female resident's facial hair should be removed unless they refuse. LPN #1 confirmed that Resident #28 had facial hair above her lip and on her chin. When the State Agent ask the resident if she wanted her facial hair removed by shaving the resident answered one finger for yes and agreed that 2 fingers would have meant no. An interview on 7/25/23 at 3:40 PM, with the facility Beautician revealed she does not like to use the hot wax on Resident #28, because it is so	F 677	The facility has determined that all residents have the potential to be affected. An in-service education program was initiated 7/27/23 by the Director of Nursing and the Unit Managers with all direct care staff addressing the proper facial hair removal including resident preferences and high-risk conditions. The Unit Managers will conduct an audit of four (4) residents per week for four (4) weeks and monthly for three (3) months beginning 7/31/2023. Audit records will be reviewed at the monthly Quality Assurance Committee on 8/18/2023 and monthly for 3 months.	

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F 677	Continued From page 10 harmful on her skin. She revealed it has been at least 2 months since she had waxed Resident #28's facial hair. An interview on 7/25/23 at 4:00 PM, with the Administrator and the Director of Nurses (DON) revealed they had been in the process of ordering some wax strips that were not so hot and hard on her skin. She confirmed the resident had agreed to being shaved in the past and while they were waiting on the wax strips to come in, we should have at least shaved in order to remove the hair from the resident's face. Record review of Resident #28's Facesheet revealed the resident was admitted to the facility on 4/26/19 with medical diagnoses that included Hemiplegia, unspecified affecting right dominant side and Dysphagia, oropharyngeal phase. Record review of Resident #28's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/25/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident is moderately cognitively impaired and in Section G that the resident needed extensive assistance with personal hygiene and total dependence with bathing.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in	F 684		8/25/23

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F 684	Continued From page 11 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interview, record review and facility policy review, the facility failed to provide treatment and care to address a resident's positioning needs that were in accordance with professional standards of practice for one (1) of (18) residents reviewed on sample. Findings include: A review of the facility policy titled, "Positioning in Chair ", undated, revealed, "STANDARD Residents are positioned to maintain correct body alignment when seated in a chair ...POLICY ...Special seating-positioning needs are provided ...Recliner ...2. Center head and shoulders against the backrest of chair, maintaining alignment with hips ..." An observation on 07/24/23 at 10:30 AM, revealed Resident #228 was sitting up in his geriatric chair with his right arm hanging down beside the chair. An observation on 07/24/23 at 11:30 AM, revealed Resident # 228 was sitting up in his geriatric chair with his right arm hanging down beside his chair. The Speech Therapist walked up to his chair and picked up his arm and repositioned it. An observation on 07/24/23 at 11:56 AM and again at 2:48 PM, revealed Resident #228 sitting up in his geriatric chair with his right arm hanging	F 684	Resident #228 was assessed to identify body alignment and positioning needs to prevent arm from hanging down beside his chair on 7/26/2023 by the Director of Nursing, Physical Therapy Assistant, and Certified Occupational Assistant. A resting hand arm trough was applied to resident□s chair to facilitate proper positioning 7/26/23 by the Certified Occupational Assistant. The facility has determined that all residents have the potential to be affected. All residents were assessed by DON, PTA, and COTA for proper positioning and body alignment needs on 7/28/2023. Inservice education conducted by Director of Nursing and Unit Managers for all clinical staff on proper positioning and body alignment per individualized care plan initiated 7/27/23. The Director of Nursing (DON) will observe four (4) resident□s body positioning weekly for four (4) consecutive weeks then monthly for three (3) months. Observations will be completed to ensure proper body alignment and positioning beginning 7/31/2023. Observations will be reviewed at the monthly Quality Assurance Committee on 8/18/2023 and monthly for 3 months.	

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down beside his chair.

An observation on 07/26/23 at 1:26 PM, revealed Resident #228 sitting up in his geriatric chair with his right arm hanging down beside his chair. Licensed Practical Nurse (LPN) #3 walked up and talked to Resident # 228 and did not pick his arm up and place it back in his geriatric chair.

An interview on 07/26/23 at 1:36 PM, with LPN #3, confirmed that she should have repositioned the resident's arm and that it should not be hanging down.

An interview on 07/26/23 at 1:38 PM, with Certified Occupational Therapy Assistant (COTA) revealed that they have been working with Resident #228 and his hand splints. She stated that they have been looking at his positioning in the chair but other than a sling they really aren't sure what they would use. She stated they didn't want to use a sling because he has use of the right elbow and can move his arm around, that he just can't lift it back up to put back in the chair if it falls to the side of the chair. She stated that they have worked on educating the resident to tell the staff when he needs his arm picked back up.

An interview on 07/26/23 at 01:45 PM, with Resident # 228 he stated that he can move his arm around and he can put his arm down but cannot pick it back up and doesn't want it to stay hanging down. Resident #228 stated that he would like them to find something to keep it from falling off the side of the chair.

An interview on 07/26/23 at 1:47 PM, with LPN #3 stated that she had not received any education from therapy on putting the residents' arm back

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F 684	Continued From page 13 up on the geriatric chair or positioning. An interview on 07/26/23 at 2:50 PM, with the Director of Nursing (DON) confirmed that Resident #228's arm should not be hanging down and that it could cause swelling. A record review of the facility Facesheet for Resident #228 revealed that he admitted to the facility on 07/14/23 with diagnoses that included Cervical disc disorder with myelopathy, unspecified cervical region, Paraplegia unspecified, and Fusion of spine cervical region. A record review of Resident #228's Minimal Data Set (MDS) with an Assessment Reference Date (ARD) of 07/21/23 revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact.	F 684		
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- (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;	F 690		8/25/23

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F 690	Continued From page 14 (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, staff interview, record review and facility policy review the facility failed to maintain a urinary catheter drainage bag below the bladder to prevent the potential of infection for one (1) of two (2) residents with a urinary catheter in the facility. Resident #228 Findings include: Review of the facility policy titled, "Catheterization", dated 11/2022, revealed, " ...Procedure ... Indwelling (FOLEY) Catheters ...#6 Drainage bag should hang below bladder level at all times." An observation on 07/25/23 at 3:25 PM, revealed Resident #228 lying in bed positioned on his back. The State Agency (SA) was unable to locate the resident's Foley (urinary) catheter on	F 690	The nursing assistant identified was immediately educated on the facility's Practice Guidelines for catheter care 7/25/23 by Unit Manager. The catheter bag was immediately hung below the bladder on the side of the bed when found on 7/25/2023. The facility has determined that all residents that have been identified as incontinent with indwelling catheters have the potential to be affected. All clinical staff including certified nursing assistants were in-serviced on the facility's Catheter Care policy 7/27/23 by Unit Manager. In-service training included demonstration of the catheter bag being hung below the level of the bladder.	

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F 690	Continued From page 15 either side of the bed. An observation and interview on 7/25/23 at 3:27 PM, with Licensed Practical Nurse (LPN) #1 revealed Resident #228's Foley catheter bag was laying on the bed beside the resident's right knee. LPN #1 confirmed the catheter bag should not be in the bed with the resident. LPN #1 stated that the catheter bag should be hanging on the bedside to prevent urine from backing up into the urethra and causing an infection. An interview on 7/26/23 at 9:35 AM, with the Director of Nursing (DON) revealed she was aware of the incident with Resident #228's catheter bag being left in the bed yesterday. She stated that she could not imagine why that happened. She stated that the staff knows to hang it on the bedside. The DON stated that leaving the catheter on the bed can cause urine to back up and lead to infection. An interview on 7/26/23 at 1:30 PM, with Certified Nursing Assistant (CNA) #1 revealed that she knows she is supposed to make sure the catheter bag is below the bladder. She stated that she usually does, but yesterday she was busy and just forgot. She stated the bag should be below the bladder, so urine won't flow back into the bladder and cause infection. Record review of the Physician Orders for the month of July 2023 revealed orders dated 7/14/23, Foley catheter 16 French (F) with 10 cubic centimeter (cc) bulb -- Change monthly and as needed (prn). Review of the facility Facesheet revealed Resident #228 was admitted to the facility on	F 690	The Director of Nursing (DON) will complete weekly audits of all residents with Foley catheters for four (4) consecutive weeks then monthly for three (3) months beginning 7/31/2023. Audited records will be reviewed at the monthly Quality Assurance Committee on 8/18/2023 and monthly for 3 months.	

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F 690	Continued From page 16 7/14/23 with diagnoses that included Paraplegia, Benign Prostatic Hyperplasia, and Retention of Urine, unspecified. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/21/23 revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated Resident #228 was cognitively intact.	F 690		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record and policy review the facility failed to ensure residents were	F 757	Special requirements for monitoring side effects for Resident #61 and #62 and	8/25/23

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F 757	Continued From page 17 free from unnecessary medications as evidenced by no documented monitoring for side effects of psychotropic medications for two (2) of five (5) residents reviewed for unnecessary medications. Resident #61 and Resident #62. Findings include Review of the facility policy titled, "Use of Psychotropic Drugs", with a revised date of 4/2017, revealed..."Procedure...13. The facility will monitor for general, cardiovascular, metabolic, and neurological adverse consequences of antipsychotic drug use..." Resident #61 A record review of the Physician Orders for July 2023 for Resident #61, revealed Haloperidol 5 mg (milligrams) give 1/2 tablet (2.5 mg) by mouth at bedtime for schizoaffective disorder and Seroquel 25 mg one tablet by mouth daily at 7 pm.. Record review of Resident # 61's E-MAR (Electronic Administration Record) Administration Record for July 2023, revealed there was no monitoring for side effects of psychotropic drugs documented. A review of Resident # 61's Progress Notes for July 2023 revealed no documentation of monitoring for side effects of psychotropic drugs. Record review of Resident #61's Facesheet revealed that the resident was admitted to the facility on 10/21/19 with diagnoses of Major Depressive Disorder and Schizoaffective Disorder.	F 757	every other resident receiving psychotropic medications were added to the Medication Administration Record special requirement charted at time of administration for each psychotropic medication 7/26/23 by the Director of Nursing. The facility has determined that all residents receiving psychotropic medications have the potential to be affected. All Licensed Nursing staff were in-serviced regarding the facility policy for monitoring for side effects of psychotropic medications and how to chart this within the MAR at time of administration on 7/26/23. The Director of Nursing (DON) or Unit Manager will complete weekly audits beginning 7/31/2023 for four (4) consecutive weeks then monthly for three (3) months of all new psychotropic medication orders to ensure that appropriate special requirements are added to the MAR to be documented at the time of administration. The Director of Nursing or Unit Manager will audit the MAR of four (4) residents receiving psychotropic medications for side effect documentation weekly for four (4) consecutive weeks and monthly for three (3) months beginning 7/31/2023. Audit records will be reviewed at the monthly Quality Assurance Committee on 8/18/2023 and monthly for 3 months.	

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Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) on 5/10/23, revealed Resident # 61 had a Brief Interview for Mental Status (BIMS) score of 4 which indicated he was severely cognitively impaired. Section N revealed Resident # 61 received antipsychotic medications seven days during the look back period.

Resident #62

A record review of Resident # 62's July 2023 Physician Orders revealed an order dated 6/27/23 "Risperdal 0.5 milligrams (mg) tablet. Give one tab (tablet) PO (by mouth) QD (daily) x (times) 1 week ... Rexulti 0.5 mg tablet. Give one tab PO QD x 1 week ...Rexulti 1 mg tablet. Give one tab PO QD x 1 week ...with a start date of 7/6/23, and Rexulti 2 mg tablet. Give one tab PO QD ...with a start date of 7/13/23..."

Record review of Resident # 62's E-MAR Administration Record for July 2023 revealed there was no documentation of monitoring for side effects for the use of psychotropic medications.

Review of Resident # 62's Facesheet revealed that she was admitted to the facility on 12/5/2019, with diagnoses that included Unspecified dementia, unspecified severity, with agitation, Personal history of other mental and behavioral disorders, and Dementia with psychotic disturbance and Alzheimer's Disease.

Record review of Resident # 62's MDS with an ARD of 6/26/2023 revealed a BIMS score of eight (8), which indicated the resident has moderate cognitive impairment.

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F 757	Continued From page 19 An interview with the DON on 7/26/23 at 9:22 AM, confirmed that there was no documentation of monitoring for side effects of psychotropic medications and verified that neither Resident #61 or Resident #62 was monitored for side effects. The DON verified that failure to monitor for side effects could result in staff missing negative side effects in residents on psychotropic medications. The DON confirmed there should have been monitoring in place.	F 757		
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. 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, freezers, and	F 812	On 7/24/2023, the Assistant Dietary Manager removed all unlabeled and expired items from refrigerators, freezers,	8/25/23

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F 812	Continued From page 20 dry storage room were dated, labeled, and discarded by the expiration date for one (1) of two (2) kitchen tours. Findings include: Record review of the facility policy titled "Storing: Food and Equipment" with no revision date revealed under "Policy...Team members must store food in a manner that ensures quality, freshness and safeguards against foodborne illness..." This review revealed under "Label...Items to label...Ensure all food items are labeled. Be especially cautious to label all food items that are , not kept in their original containers, including condiments (e.g., salad dressing, ketchup, etc. Label information: Each label must contain the following information Product name (or a common name or identifying description), use-by-date, date the product was prepared or opened". And under "Storage; General Rule: Follow the Use-by-Date, generally, food should be discarded or used by the use-by date". That food should be discarded or used by the use-by date, which is the last date the manufacturer recommends use of the food. For foods that do not have a use-by date or do not have any identified quality issues, the Food Storage Chart can be used as a general suggestion for the average recommended length of storage time from the sell-by date to help preserve quality. An observation and interview on 7/24/2023 at 10:25 AM, of the walk-In refrigerator with the Assistant Dietary Manager revealed a large container of mustard with an opened date of 7/16/2023 and a best by 5/28/2022, four (4) large containers of sour cream with an open date of	F 812	and dry storage room on. On 7/24/2023, the dietary staff members were immediately in-serviced by the Certified Dietary Manager on the importance of labeling, first out rotation method, and disposing of expired items. The facility determined that all residents who consume the unlabeled or expired items have the potential to be affected. On 7/24/2023, all dietary staff were in-serviced by the Certified Dietary Manager on the facility□s policies and procedures for labeling and disposing of expired food items. A Supervisors Checklist was implemented on 7/25/2023 to check for proper storage including labeling and disposing of expired food items daily. A reference sheet was posted on 7/24/2023 for all dietary workers to reference the recommended time frame for storage. On 7/25/2023, the Certified Dietary Manager or Assistant Dietary Manager began completing weekly checks for 4 weeks then monthly for 3 months to ensure the policy and procedures are being followed. Findings will be discussed with the Administrator after each check. This plan of correction will be monitored by the Quality Assurance Committee on 8/18/2023 and monthly for 3 months.	

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6/9/2023 and best by date of 7/20/2023, an opened zip lock bag of bacon with no label. An interview at this time with the Assistant Dietary Manager confirmed that the large container of mustard and four (4) large containers of sour cream were expired, and the unlabeled and unzipped bag of bacon should be discarded and not used. She stated that the mustard, sour cream, and bacon would be served to all residents that receive food. She stated that she has no idea when the bacon was cooked. She revealed that all foods that are expired should be disposed of, and all opened food should be labeled with a date to prevent the resident's from getting sick.

An observation and interview with the Assistant Dietary Manager on 07/24/23 at 10:40 AM, of the walk-in freezer revealed a package of opened corn chowder. The Assistant Dietary Manager confirmed that the open corn chowder should be discarded since it had been opened.

An observation and interview on 7/24/23 at 10:50 AM, with the Assistant Dietary Manager of the dry food storage revealed an unopened package of tortilla shells with a best by date of 6/28/2023. An interview at this time with the Assistant Dietary Manager revealed the tortilla shells are used for soft shell tacos as an alternate food choice for residents, confirmed they were expired and should have been disposed of.

An interview with the Dietary Manager on 07/26/23 at 09:00 AM, revealed that food supply is received twice a week and kitchen staff are supposed to rotate items and dispose of expired items at that time with the Assistant Dietary Manager checking behind them to make sure this

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F 812	Continued From page 22 is completed. She stated that opened food is supposed to be labeled and the labels should include the open date. She confirmed that the mustard, sour cream, bacon, and corn chowder would have been used for all residents that receive food. She stated that the tortilla shells were used to make soft shell tacos and should have been disposed of when the food shipment came in and staff were rotating food according to dates. When the State Agent asked what the cooked bacon that was found in an unzipped bag and not labeled was used for, she revealed the staff use it to season vegetables and soups, but it should have been zipped and labeled. She confirmed that the mustard, sour cream, corn chowder, bacon and tortilla shells should have been disposed of. When asked what could happen if the expired or unlabeled foods were served to residents, she confirmed that it could have caused the residents to be sick.	F 812		