STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255182	A. BUILDING _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW NURSING CENTER	16411 ROBINSON ROAD GULFPORT, MS 39503

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 7/17/23 through 7/20/23. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550, F584, F623, F640, F656, F677, F684, F695, F761, and F865. The facility was licensed for 105 beds and had a census of 84 at the time of survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		8/15/23

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

Electronically Signed | 08/08/2023

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review the facility failed to provide a privacy bag for a resident with an indwelling catheter for one (1) of five (5) residents with urinary catheters. Resident #235. Findings Include: Record review of the facility's policy titled " Catheter Care", undated, revealed "Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Policy Explanation ...2. Privacy bags will be available and catheter drainage bag will be covered at all times while in use ..." On 07/17/2023 at 11:00 AM, during an observation, Resident #235 was lying in bed and had an indwelling catheter drainage bag that had yellow urine visible from the doorway and hallway.	F 550	*On 7/17/23, Resident #235 was lying in bed with no privacy cover over resident□s indwelling foley catheter drainage bag and urine in the bag was visible. A privacy bag for indwelling foley catheter was provided on 7/17/23. **All residents with indwelling foley catheter bags are at risk for this deficient practice. ***An inservice on Resident□s Rights/Dignity and Privacy was completed by the Director of Nursing (DON) on 7/21/23. The nursing staff beginning 7/21/23 will identify residents with indwelling foley catheters and ensure that privacy bags are placed on admission, hospital returns and upon written orders while in facility. The cart nurses are responsible for ensuring the quality of privacy bags are not torn or worn and will	

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F 550	Continued From page 2 On 07/19/2023 at 01:15 PM, during an observation, Resident #235 was lying in bed talking to a visitor. The visitor was at the bedside of the resident and the indwelling catheter drainage bag was not covered and urine was visible in his room and hallway. On 07/20/2023 at 08:55 AM, an observation and interview with the Director of Nursing (DON) in Resident #235's room, she confirmed there was no privacy cover on his catheter drainage bag and the urine in the bag was visible. She stated that the drainage bag was not the kind of bag that the facility used, and it should have had a dignity cover over the bag to keep the urine from being seen. She explained that it was the facility policy for the drainage bag to be covered. Record review of the "Physician Order Sheet for Foley Catheter" dated 7/11/2023, revealed "Foley catheter 16 French 10 cc (cubic centimeter) bulb to gravity ..." Record review of the "Face Sheet" revealed the facility admitted Resident # 235 on 7/10/23 with diagnoses including Retention of Urine and Acute Kidney Failure.	F 550	replace privacy bags as needed. ****Quality Assurance (QA) nurses will monitor that resident□s with indwelling foley catheters have privacy bags beginning 7/24/23 weekly X four weeks. Then monthly X three months. Results will be brought to monthly QA meeting starting 8/14/23 monthly X 3.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-	F 584		8/15/23

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F 584	Continued From page 3 §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review the facility failed to maintain a clean environment for two (2) of 20 resident rooms. Resident #54 and Resident #76	F 584	*On 7/17/23, Resident #54 was observed in room with privacy curtain with large visible stains and soiled. Resident #76 room was observed with the wall behind the bed with large pieces of missing paint	

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F 584	Continued From page 4 Findings Include: Review of the facility's policy, "Routine Cleaning and Disinfection", dated 5/12/23, revealed, " Policy: It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment ...Policy Explanation and Compliance Guidelines ...13. Cleaning of walls ...will be conducted when visibly soiled. 14. Privacy curtains in resident rooms will be changed when visibly dirty ..." Resident #54 On 7/17/23 at 12:20 PM, in an observation and interview with Resident #54, the privacy curtain facing the resident had large visible stains and was soiled. The resident stated that the curtain had been in that condition for a while and no one had said anything to him about replacing it. He said he was sure staff had noticed it but had not done anything about it. On 07/18/23 at 01:53 PM, in an interview and observation with Certified Nurse Aide (CNA) #1, she confirmed that the privacy curtain for Resident #54 was soiled and stained and stated that the privacy curtain was not appropriate. CNA #1 explained that if she saw a privacy curtain that needed to be changed, she would tell housekeeping or maintenance. Then either herself or housekeeping would enter a request for the curtain to be changed in the maintenance log located at the nurse's station. CNA #1 reported that she had not placed a request in the log for the soiled privacy curtain for Resident #54. On 07/18/23 at 02:40 PM, in an interview and observation of the maintenance log with	F 584	and visible soiled stains. Housekeeping wiped the wall on 7/17/23. Maintenance replaced privacy curtain and repaired the wall on 7/21/23. **All residents are at risk for this same deficient practice. ***On 7/21/23, an in-service was completed by Quality Assurance (QA) nurse on Routine Cleaning and Disinfection with housekeeping staff to include cleaning visibly soiled walls. Housekeeping staff will identify during daily routine cleaning visibly soiled or tattered privacy curtains, chipped paint and stained walls and enter the information into the maintenance log located at each nurses station. ****Quality Assurance (QA) nurses will monitor two out of five hall(s) per week beginning 7/24/23 weekly X four weeks. Then monthly X three months. Results will be brought to monthly QA meeting beginning 8/14/23 X three months.	

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F 584	Continued From page 5	F 584		

Maintenance #2, he confirmed there had not been a request recorded in the log to change the privacy curtain for Resident #54. He stated that staff added items to the daily log and when the task was completed, it was signed or initialed by the maintenance staff. He confirmed that extra privacy curtains were available for use.

On 07/20/23 at 01:42 PM, in an interview with the Director of Nursing (DON) and the Administrator, the Administrator stated that she had been made aware of the soiled privacy curtain. She stated that the facility had ordered new privacy curtains and they were expected to be delivered soon.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/10/2023 revealed Resident #54 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated he was cognitively intact.

Resident #76

On 7/17/23 at 11:20 AM, in an observation of Resident #76's room revealed the wall behind the bed, facing the entrance to the room, had large pieces of missing paint. The wall was soiled and had visible stains.

During an interview on 07/19/23 at 10:35 AM, with Maintenance Staff #1, he confirmed that the wall on Resident #76's side of the room nearest the window had peeling paint and was visibly soiled. He said that the reason the wall was missing paint was because the bed was too close to the wall and when the resident raised the bed, it scraped the paint off the wall. He confirmed that though the paint was missing, it did not prevent housekeeping from cleaning the walls. He stated

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F 584	Continued From page 6 that he had previously repaired the wall, and that he would repair it again. On 07/19/23 at 11:00 AM, an observation and interview with the Director of Nurses (DON) and the Administrator revealed the wall in Resident #76's room had peeling paint and was soiled. She stated that the wall was damaged because the bed was too close to the wall and when staff would raise or lower the bed, it damaged the wall. The DON confirmed the wall was soiled and housekeeping should have cleaned the walls and the room was not conducive to a home-like environment.	F 584		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		8/15/23

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F 623	Continued From page 7	F 623		

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

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related

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F 623	Continued From page 8 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to provide written notification to the resident and the resident's representative, in a language they could understand, the reason a resident was	F 623	*Resident #12□s representative was not provided written notice about resident□s transfer to hospital in a language that could be understood. Discharge/Transfer notification form changed 7/24/23 to	

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F 623	Continued From page 9 transferred to the hospital for one (1) of one (1) resident records reviewed for hospitalizations. Resident #12 Findings include: Review of the facility's policy, "Transfer and Discharge (including AMA)," revised 6/23/23, revealed, " Policy: It is the policy of this facility to permit each resident to remain in the facility, and not initiate transfer or discharge for the resident from the facility, except in limited circumstances ... Policy Explanation and Compliance Guidelines: ... 4. The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include all the following at the time it is provided: a. The specific reason and basis for transfer or discharge. b. The effective date of transfer or discharge. c. The specific location ... to which the resident is to be transferred to or discharged ..." A record review of the facility's, "Notice of Resident Transfer or Discharge form," dated 5/28/23 and addressed to the Resident/Representative of Resident # 12, revealed ... "The reason for the transfer/discharge is for the following reason(s): The transfer is necessary for the resident's welfare and the resident's needs cannot be met by the facility (i.e. urgent medical need). Specify: Acute Care- Hospital ..." Record review of the facility's, "Departmental Notes," dated 5/28/23 at 7:15 PM revealed, " ... Res (Resident) complaining of chest pain ...I want to go to the hospital ... Notified MD (Medical Doctor) ... Res left facility at 13:30 (:30 PM), via	F 623	reflect resident□s reason(s) for transfer. **All residents who Discharge/Transfer are at risk for this same deficient practice. ***An in-service with office staff and Business Office Manager (BOM) was given by the administrator and completed on 7/24/23. BOM will mailout Discharge/Transfer letters beginning on 7/24/23 to resident□s representative(s) in a language that resident□s representative(s) can understand, the communication sheet will include reason why the resident is being discharged/transferred. ****Quality Assurance (QA) will monitor Discharge/Transfer letters beginning 7/24/23 for appropriate documentation in a language that can be understood. The BOM will put a copy of the Discharge/Transfer notice(s) in QA box beginning 7/24/23 weekly X four weeks. Then monthly X three months. Results will be brought to monthly QA meeting beginning 8/14/23 X three months.	

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F 623	Continued From page 10 (Proper name of local ambulance service ..." The Director of Nurses (DON), confirmed in an interview on 7/19/23 at 2:19 PM, Resident #12 was admitted to the local hospital because of chest pain. During an interview on 7/20/23 at 9:00 AM, Resident #12's son stated he doesn't remember how he was notified that his mother was sent to the hospital, but he thinks they told him when he called the facility asking about his mother. The son denied receiving written notification of his mother's transfer to the hospital. An interview on 7/20/23 at 12:33 PM, with the Supply Manager, revealed she receives copies of the orders (pink slips) for the residents transferred to the hospital or discharged and emails a copy of the order to the Billing Office Manager. The Supply Manager confirmed that the pink slips do not have the reason for the transfer or discharge. During an interview on 7/20/23 at 12:39 PM, the Billing Office Manager (BOM) confirmed she receives the emailed copy of the resident's transfer order and uses that information to notify the resident's family of the transfer. The BOM explained that the transfer orders (pink slips) do not include the reason for the transfer and therefore, she thought informing the family that the resident needed acute care was enough. During an interview on 7/20/23 at 1:00 PM, with the Administrator she revealed she wasn't aware that the pink slip does not have the reason the resident was transferred to the hospital.	F 623		

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F 656	Continued From page 11	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		8/15/23

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F 656	Continued From page 12 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 interview, record review, and facility policy review, the facility failed to develop a comprehensive care plan related to a medication for one (1) of (20) care plans reviewed. Resident #54 Findings Include: Review of the facility's policy, Comprehensive Care Plans, undated, revealed, " Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident ...Policy Explanation and Compliance Guidelines ...3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ..." In an observation and interview on 7/17/23 at 12:20 PM, with Resident #54 he was lying in the bed and there was a container of medication on his overbed table in front of him. The container of cream, which had a pharmacy label, was prescribed to Resident #54 and was labeled as Triamcinolone Acetonide. Resident #54 stated he had gotten the cream when he went to the doctor	F 656	*On 7/20/23, Resident #54 was observed not to have a comprehensive care plan developed related to his skin condition. Minimum Data Set (MDS) Coordinator reviewed resident #54□s care plan and developed a person-centered skin care plan on 7/21/23. **All residents are at risk for this deficient practice. *** All current nursing staff completed an in-service on 7/24/23 by the MDS coordinator and MDS assessment nurse on the importance of reviewing and following resident care plans to prevent potentially serious outcomes. ****Quality Assurance (QA) nurses will monitor all at risk for impaired skin care plans beginning on 7/24/23. Five care plans for residents at risk for impaired skin will be monitored beginning on 7/24/23 weekly x four weeks and monthly x three months and will be brought to standup for interdisciplinary team review. Findings will be brought to Quality Assurance (QA) meeting beginning on	

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F 656	Continued From page 13	F 656	8/14/23 X three months.	

several months ago for eczema and the cream had remained on his overbed table since he received the medication.

Record review of a "Physician's Order Sheet", dated 1/24/23, revealed a handwritten order "Triamcinolone Acetonide 0.1% topical cream. Apply to affected areas on face and scalp twice daily for one-two weeks then as needed for flares."

Review of the medical record revealed there was no comprehensive care plan developed for Resident #54 related to his skin condition of eczema or an approach developed for the Triamcinolone cream as ordered by the physician.

On 07/20/23 at 11:34 AM, in an interview with Registered Nurse (RN) #2 and Licensed Practical Nurse (LPN #3), RN #2 explained that the facility developed the comprehensive care plans based on the comprehensive Minimum Data Set (MDS) assessments and any other relevant information, including physician orders. RN #2 and LPN #3 stated that Resident #54 went to a dermatology appointment, had a biopsy procedure, and returned to the facility with multiple physician orders. RN #2 and LPN #3 confirmed that although there had been a care plan developed for the skin condition related to the biopsy and that care plan had been resolved, there was no care plan developed related to the eczema flare ups and the medication to be administered as needed.

On 07/20/23 at 12:20 PM, during an interview with the Director of Nursing (DON), she stated that care plans should be developed and are used to provide individualized care to residents

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F 656	Continued From page 14 and to ensure their needs are met according to the physician's order. Record review of the "Face Sheet" revealed the facility admitted Resident #54 on 11/15/2019 with a diagnosis of Hemiplegia. Record review of the MDS with an Assessment Reference Date (ARD) of 4/10/2023 revealed Resident #54 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated he 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 observation, interviews, record review and facility policy review the facility failed to provide nail care for a resident who was unable to carry out Activities of Daily Living (ADLs) for one (1) of (20) sampled residents. Resident #76. Findings include: Record review of the facility's policy, "Activities of Daily Living (ADLs)", dated 10/28/2021, revealed, " ...The staff will provide care on a timely basis to promote and prevent avoidable changes in care. This includes the residents ability to: 1. Bathe, dress, and groom ...Policy Explanation and Compliance Guidelines ...3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good	F 677	*On 7/18/23, Resident #76 was observed with finger nails curved beyond the nail bed. Resident #76 finger nails were cleaned, trimmed and filed by wound care Registered Nurse (RN) on 7/18/23. **All residents have the potential to be at risk for this deficient practice. ***On 7/24/23, all nursing staff was in-serviced by facility wound care RN on proper nail care, trimming, cleaning and filing, including when to refer to podiatry and reporting abnormal findings to the License Practical Nurse (LPN), RN and/or notifying the physician.	8/15/23

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F 677	Continued From page 15 nutrition, grooming and personal oral hygiene as documented in the resident's care plan ..." During an observation on 07/17/23 at 11:49 AM, Resident # 76 was in bed, and he had fingernails on both hands that were thick, jagged, and had a dark discoloration. The middle three fingernails on both hands were curved beyond the nail bed. During an interview on 7/18/23 at 4:15 PM, with Certified Nurse Aide (CNA) #2, she stated that she cleaned the resident's nails but did not cut his nails because they were thick and jagged. She explained that the nurse performed nail care for that type of nail. An observation and interview on 7/18/23 at 4:25 PM, with Licensed Practical Nurse (LPN) #1, the Director of Nursing (DON), and Registered Nurse (RN) #3, revealed Resident #76 had nails that were thick, discolored, and had been for an undetermined amount of time. LPN #1 explained that she had not provided any care for the nail herself. The DON stated that she was aware that Resident #76 had bilateral long, thick, and discolored nails and there was no Physician Order to perform nail care. Record review of the "Face Sheet" revealed Resident #76 was admitted by the facility on 10/12/22 with diagnoses that included Cerebral Infarction and Contracture, right hand. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/15/23 revealed Resident #76 was totally dependent upon staff for bathing and required extensive assistance with personal hygiene.	F 677	****Quality Assurance (QA) nurses will begin monitoring nail care 7/24/23, weekly X four weeks. Then monthly X three months. Results will be brought to monthly QA meeting 8/14/23 X three months.	

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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 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 observation, interviews, record review, and facility policy review, the facility failed to ensure a resident had been assessed for safe self-administration of medication and failed to ensure a physician's order was transcribed accurately for one (1) of (20) sampled residents. Resident #54 Findings Include: Record review of the facility's policy, "Resident Self-Administration of Medication" dated 6/23/2023, revealed, "Policy...A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely ..." Record review of the facility's policy, "Medication Orders", undated, revealed, "...Policy Explanation and Compliance Guidelines... 4. Documentation of Medication Orders ...f. Transcribe newly prescribed medications on the ...treatment record ..." During an observation on 7/17/23 at 12:20 PM, Resident #54, was lying in the bed and there was	F 684	*On 7/17/23, Resident #54 was observed with a tube of medication on the overbed table and the physician order for the tube of medication was not transcribed accurately. The tube of medication was removed by cart nurse from overbed table and stored in medication cart on 7/17/23. On 7/21/23, the physician order for tube of medication was clarified and discontinued. **All residents are at risk for this deficient practice. ***An in-service on self-administration of medication was given by Director of Nursing (DON) on 7/21/23 to all licensed nursing staff. Residents who request meds at bedside will have to score between 13-15 on Brief Interview for Mental Status (BIMS) in order to be screened and deemed appropriate for self-administration of medication, to include obtaining a physicians order and transcribing the order accurately. ****During Quality Assurance (QA)	8/15/23

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F 684	Continued From page 17 a container of medication on his overbed table in front of him. The container of cream, which had a pharmacy label, was prescribed to Resident #54 and was labeled as Triamcinolone Acetonide. Resident #54 stated he had gotten the cream when he went to the doctor several months ago for eczema and the cream had remained on his overbed table since he received the medication. He said that he used the cream whenever he needed it. Record review of "Departmental Notes", dated 1/24/23 at 11:55 PM, revealed "Late entry for 1/23/23 Resident returned to facility ...with new orders noted from Derm (Dermatology) clinic has bandage noted to left side of face ..." Record review of a "Physician's Order Sheet", dated 1/24/23, revealed a handwritten order "Triamcinolone Acetonide 0.1% topical cream. Apply to affected areas on face and scalp twice daily for one-two weeks then as needed for flares." Record review of the "Physician Orders" For the month of: February 2023, revealed a Physician's Order, with an order date and start date of 1/24/23 for "Triamcinolone 0.1% cream...apply to affected areas on face and scalp twice daily for 1-2 weeks then as needed for flares ...Stop date: 2/6/23." The interval code on the order was listed as "Daily". There was no entry for an interval code to apply the medication as needed. On 07/18/23 at 1:50 PM, during an observation and interview with Licensed Practical Nurse (LPN) #1 in the room of Resident #54, she asked Resident #54 if the nurses were applying the cream and he responded "No".He explained that	F 684	rounds, QA will survey two out of five hall(s) per week X four weeks for visible unauthorized medications in resident's rooms beginning 7/24/23, Then monthly X three months. Results will be brought to monthly QA meeting beginning on 8/14/23 X three months. All hand written physician orders will be reviewed and compared to transcribed orders in computer at daily morning meeting for accuracy beginning 7/24/23 by the charge nurse and Minimum Data Set (MDS) assessment nurses weekly X four weeks. Then monthly X three months. Results will be brought to monthly QA meeting 8/14/23 X three months.	

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he applied the cream himself. LPN #1 asked Resident #54 where he applied the cream and he stated that he used it on his face whenever he thought he needed it, and he did not tell the nurses whenever he used it.

On 07/18/23 at 02:00 PM, in an interview with Registered Nurse (RN) #1, she stated that Resident #54 was very particular and liked things a certain way in his room and on his overbed table. She stated he had a high Brief Inteview for Mental Status (BIMS) score and was able to follow directions, but he had not been assessed to determine if he could safely self-administer the medication. He had not been advised to tell the nurse when he administered the medication so that it could be recorded.

On 7/18/23 at 2:30 PM, in an interview with the Director of Nursing (DON), she confirmed there was no Physician's Order in the system for Triamcinolone to be administered as needed. She stated when the nurse entered the Physician's Order into the electronic health record, she should have entered two separate orders, one order for the daily administration of 1-2 weeks with a stop date, and one order to administer as needed without a stop date. She stated the nurse who entered the Physician's Order had not worked at the facility in several months.

On 07/20/23 at 08:49 AM, in an interview with the facility's Pharmacist, he confirmed that resident self-administration of medications should be consistent with the facility's policies and regulations for safety and that if a resident self-administers any medication, there should be documentation of the administration. He also

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F 684	Continued From page 19 confirmed that Physician Orders should be carried out per the facility's policy. On 07/20/23 at 12:20 PM, during an interview with the DON, she stated that it is her expectation that staff inputs Physician's Orders accurately into the electronic medical records. She stated that the nurses are trained upon hire and as needed to input orders. She also confirmed that a resident must be determined to be able to safely administer medications and the physician's order would need to be written for the resident to self-administer. She said that Resident #54 had not been assessed to self-administer medications. The DON explained that the process for ensuring accuracy of physician's orders is for the Quality Assurance (QA) nurse to check behind the nurses and use the yellow copies of the duplicate Physician's Order form to insure orders are entered correctly. She further explained that neither herself nor the current QA nurse was at the facility on 1/24/23 when the transcription error occurred. Record review of the "Face Sheet" revealed the facility admitted Resident #54 on 11/15/2019 with a diagnosis of Hemiplegia. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/10/2023 revealed Resident #54 had a BIMS score of 15 which indicated he was cognitively intact.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		8/15/23

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F 695	Continued From page 20 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure cautionary signage was posted related to oxygen usage for one (1) of one (1) resident reviewed for respiratory conditions. Resident #26 Findings Include: Review of the facility's policy, "Oxygen Administration", dated 6/23/23, revealed, " ...Policy Explanation and Compliance Guidelines ...6. Oxygen warning signs must be placed on the door of the resident's room where oxygen is in use ..." On 07/17/23 at 11:12 AM, Resident #26 was sitting in a wheelchair next to his bed. There was an oxygen (O2) concentrator in the corner of the room, with a nasal cannula stored on the back of the concentrator. Resident #26 was not wearing the nasal cannula and was unable to communicate if he had removed the cannula himself. There was no cautionary signage on the door of the room indicating that oxygen was being administered. Record review of the "Physician's Order Sheet' revealed a Physician's Order dated 7/9/23 for "Oxygen at 2L (liters) continuous r/t (related to) hypoxia."	F 695	*On 7/17/23, Resident #26 was observed in room with an oxygen concentrator not in use and no cautionary signage on door indicating that oxygen was being administered. Oxygen cautionary sign was placed on door by medication cart nurse 7/17/23. **All residents with oxygen are at risk for this deficient practice. ***On 7/24/23, The Director of Nursing (DON) gave an in-service with nursing staff on all oxygen orders scheduled and as needed, admission and readmit will receive a cautionary sign stating oxygen in use. ****Quality Assurance (QA) nurses will monitor all residents with oxygen beginning 7/20/23, scheduled and/or as needed for cautionary signage weekly X four weeks. Then monthly X three months. Results will be brought to QA meeting starting 8/14/23 X three months.	

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F 695	Continued From page 21 Record review of the "Departmental Notes" for Resident #26, dated 7/17/23 at 4:50 AM, revealed, " ... SPO2 (Saturation of peripheral oxygen) 94% on 2 lpm (liters per minute) via nasal cannula ..." On 07/18/23 at 02:00 PM, in an interview and observation with Licensed Practical Nurse (LPN) #2, she confirmed there was an O2 concentrator in the room for Resident #26. She also confirmed that there were no cautionary signs on the door indicating use of oxygen. On 07/20/23 at 12:27 PM, in an interview with the Director of Nursing (DON), she stated it was her expectation that all residents receiving oxygen therapy have cautionary signage for safety of the resident. Record review of the "Face Sheet" revealed the facility admitted Resident #26 on 3/14/23 and he had diagnoses including Obstructive Sleep Apnea and Diabetes Mellitus. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/14/2023 revealed Resident #26 had a Brief Interview of Mental Status (BIMS) score of 6 which indicated he had severe cognitive impairment.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		8/15/23

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F 761	Continued From page 22 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review, the facility failed to properly secure a medication for one (1) of (20) sampled residents. Resident #54 Findings Include: Review of the facility's policy, "Medication Storage", reviewed/revised 6/20/23, revealed, " ...It is the policy of this facility to ensure all medications housed on our premises will be stored in the ...medication rooms ...Policy Explanation and Compliance Guidelines 1. General Guidelines a. All drugs and biologicals will be stored in locked compartments ..."	F 761	*On 7/17/23, Resident #54 was observed with a tube of medication on the overbed table. The tube of medication was removed by cart nurse from overbed table and stored in medication cart on 7/17/23. **All residents are at risk for this deficient practice. ***An in-service on self-administration of medication was given by Director of Nursing (DON) on 7/21/23 to all licensed nursing staff. Residents who request meds at bedside will have to score between 13-15 on Brief Interview for Mental Status (BIMS) in order to be	

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F 761	Continued From page 23 Review of the facility's policy, "Resident Self-Administration of Medication", dated 6/23/23, revealed, " ...Policy Explanation and Compliance Guidelines ...7. All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage ..." On 7/17/23 at 12:20 PM, Resident #54 was observed lying in the bed. There was a container of medication on his overbed table in front of him. The container of cream, which had a pharmacy label, was prescribed to Resident #54, and was labeled as Triamcinolone Acetonide. Resident #54 stated he had gotten the cream when he went to the doctor several months ago for eczema and the cream had remained on his overbed table since he had received the medication. Record review of "Departmental Notes", dated 1/24/23 at 11:55 PM, revealed "Late entry for 1/23/23 Resident returned to facility ...with new orders noted from Derm (Dermatology) clinic has bandage noted to left side of face ..." Record review of a "Physician's Order Sheet", dated 1/24/23, revealed a handwritten order "Triamcinolone Acetonide 0.1% topical cream. Apply to affected areas on face and scalp twice daily for one-two weeks then as needed for flares." Record review of a handwritten Physician's Order, dated 1/24/23, revealed, "Triamcinolone 0.1% cream...apply to affected areas on face and scalp twice daily for 1-2 weeks then as needed for flares ..."	F 761	screened and deemed appropriate for self-administration of medication, to include obtaining a physician□s order and transcribing that order. ****During Quality Assurance (QA) rounds, QA will survey two out of five hall(s) per week X four weeks for visible unauthorized medications in resident's rooms beginning 7/24/23, Then monthly X three months. Results will be brought to monthly QA meeting beginning on 8/14/23 X three months.	

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	255182	A. BUILDING _____ B. WING _____	07/20/2023

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F 761	Continued From page 24	F 761		

Record review of the "Physician Orders" for the month of February 2023, revealed a Physician's Order, with an order date and start date of 1/24/23 for "Triamcinolone 0.1% cream...apply to affected areas on face and scalp twice daily for 1-2 weeks then as needed for flares ...Stop date: 2/6/23." The interval code on the order was listed as "Daily". There was no interval code to apply the medication as needed.

During an interview and observation with Licensed Practical Nurse (LPN) #1, on 07/18/23 at 1:50 PM, revealed that LPN #1 was unaware that Resident #54 had the medication at his bedside. She stated she had not noticed the container of Triamcinolone was on his bedside table. She confirmed that the medication should not have been stored at his bedside and she removed it from the resident's room.

In an interview on 07/20/23 at 08:49 AM, with the facility's Pharmacist, he confirmed that the medications should be stored according to the facility's policies and regulations for safety.

During an interview with the Director of Nursing (DON) 07/20/23 at 12:20 PM, she stated that it is her expectation that medications be stored appropriately by being locked in the nurses cart or the medication rooms and she confirmed that medication should not be stored at the resident's bedside.

Record review of the "Face Sheet" revealed the facility admitted Resident #54 on 11/15/2019 with a diagnosis of Hemiplegia.

Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of

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F 761	Continued From page 25 4/10/2023 revealed Resident #54 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated he was cognitively intact.	F 761		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's	F 865		8/15/23

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implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained

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F 865	Continued From page 27 during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to ensure the program was sustained and interventions were monitored for effectiveness for one (1) repeated deficiency related to Physician Order transcription errors that was cited in May 2022 and October 2022. The facility's continued	F 865	*The Quality Assurance Performance Improvement (QAPI) Program was implemented and root cause analysis was conducted on 7/20/23 for three failure to ensure a physician□s order was transcribed accurately and failure to maintain an effective QAPI program in the facility.	

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F 865	Continued From page 28 failure during three surveys shows a pattern of the facility's inability to sustain an effective QAPI Committee for three (3) of (3) previous surveys reviewed. Findings Include: Record review of the facility's policy, "Quality Assurance Performance Improvement", dated 2/24/2021, revealed, "Policy: It is the policy of this facility to ...maintain an effective ...QAPI program ..." During this recertification survey, the facility was cited F684 (Quality of Care). The facility failed to ensure a physician's order was transcribed accurately. In May 2022, the facility was cited F684 for failure to ensure a physician's order was transcribed accurately. In October 2022, the facility was again cited F684 for failure to ensure a physician's order was transcribed accurately. On 07/20/23 at 01:42 PM, in an interview with the Director of Nursing (DON) and the Administrator, the Administrator stated that she expected the staff to be in compliance with the regulations regarding the accurate transcription of physician orders. She confirmed that the facility has QAPI meetings monthly and interventions are monitored for effectiveness and results of the monitoring is discussed in the QA and standup meetings. The Administrator stated that she was at the facility for the previous surveys and aware of the previous citations for the medication transcription errors.	F 865	**All residents are at risk for this deficient practice. ***Starting 7/24/23 Quality Assurance (QA) nurse will conduct and maintain QAPI meetings and direct performance and improvement plan. Starting 7/24/23 the administrator and the Director of Nursing (DON) will monitor the progress and completion of plans. A QAPI program book will be kept in the QA office; the book comprised of attendance report sheets, progress of performance improvement plans and implementation of programs set forth starting on 7/24/23. ****To ensure improvements are sustained starting on 7/24/23, the QA nurse will review QAPI plans with the administrator, DON and medical director during the monthly QA meeting on 8/14/23. QA committee will review findings and make recommendations and changes as needed, but no less than annually. The QAPI committee will meet beginning 7/24/23, once weekly X four weeks, then monthly X six months, then quarterly and as needed.	

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