MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09SR	A. BUILDING: _____ B. WING _____	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEARER-RICHARDSON MEMORIAL NURSING HOMI	512 ROCKWELL DRIVE OKOLONA, MS 38860

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 08/08/23 through 08/10/23. The facility was found to not be in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm with deficiencies cited at M500, M610 and M640. Census at the time of the survey was 68 and the facility had a license for 73 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his	M 500		9/2/23

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M 500	Continued From page 1	M 500		

medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;

4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record;

5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the

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M 500	Continued From page 2 facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail	M 500		

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M 500	Continued From page 3 unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to prevent neglect by failing to provide goods and services to a resident	M 500	Resident #34 was provided with Activity of Daily Living (ADL) that included oral care, nail care and the removal of facial hair during a "Teachable Moment" with NA#1 by the Quality Assurance Nurse (QA Nurse) on the day of discovery 8/8/23. On	

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M 500	Continued From page 4 to ensure that the resident received the necessary Activities of Daily Living (ADL) and oral care for one (1) of 17 residents sampled. Resident #34. Findings Include: Record review of the facility policy titled Abuse, Neglect and Exploitation undated revealed, "Policy: Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation..."Policy Explanation and Compliance Guidelines: ... 2. ... Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being... 6. "Neglect" means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress..." An observation on 8/08/23 at 2:18 PM, of Resident # 34's room revealed the door was closed. The Survey Agent (SA) knocked and entered the resident's room, where he was observed lying in bed with his mouth open and eyes closed. An overpowering putrid (rotten) odor was present inside the room. The resident's tongue was observed with raised brown patches. The resident's teeth were observed to be in bad condition, with dark brown/black color to all teeth and red, inflamed gums. The resident's lower lip was raw, dry, and cracked with dried bloody patches. Long facial hair measured approximately 1/4 inch in length. The resident's nails were long, measuring approximately 3/8 inch in length from the tip of the fingers, with a brown substance underneath all the nails. The resident aroused to	M 500	8/10/23 a dental consult was scheduled for 8/28/23 for Resident #34. The RN Charge Nurse completed an assessment on this resident dated 8/12/23, which included his current dental status of abnormal mouth tissue, cavities/broken teeth and an inflamed gum. As part of Resident #34's routine dental care Peridex has been added as of 8/23/23 in conjunction with the use of a Water Pick system 8/28/23 and that a licensed nurse will be required to perform his oral care daily as evident per documentation within the Medication Administration Record. The dietary manager completed an observation round on 8/15/23 to identify residents with PEG tubes who could possibly be affected by the stated deficient practice. There were 3 of 25 residents identified that could have been been affected within this unit. The Director of Nurses completed a oral/dental evaluation on the three residents identified, with the findings of one resident already having a dental appointment, and the other two had no reason for a dental consult. On 8/1/23 the facility has acquired a new nursing documentation module titled "Nursing Advantage" which should assist with licensed personnel in completing a more detailed comprehensive assessment related to dental/oral evaluation. With every required comprehensive assessment which includes the admission assessment, an annual comprehensive assessment and upon a significant change assessment, beginning 8/23/23, the dental/oral section of any required	

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M 500	Continued From page 5 verbal stimuli and tried to communicate, but speech was low, unclear, and garbled. An observation and interview on 8/08/23 at 2:55 PM, with Nurse Assistant (NA) # 2 revealed she was working along with Certified Nurse Aide (CNA) # 1 to care for Resident #34. NA # 2 confirmed that she smelled an odor when she entered the resident's room and stated, "Mm-hmm, it smells like body odor." She revealed that she had washed the resident up today and had put on deodorant but did not give him a complete bath. She confirmed that she had not shaved him and stated, "I was scared to do that." She revealed that Resident # 34 had a bad odor coming from his mouth since he was admitted to the facility a couple of months ago. She revealed that when he came to the facility, he had old food (debris) that was caked on his teeth and stated, "His lips have been chapped like that since he came from the other place." She revealed that she had been applying baby oil to the resident's lips because his family had requested her to do that, but she had not applied anything on his lips today. An observation and interview on 8/08/23 at 3:06 PM, with Certified Nurse Aide (CNA) # 1 revealed that the aides do not perform oral care for the residents with tube feedings and revealed that the nurses do it. She confirmed that they had not performed oral hygiene for Resident #34 today. An observation and interview on 8/08/23 at 3:10 PM, with Registered Nurse (RN) #1 confirmed that there was a foul odor in Resident # 34's room and stated, "It's coming from his teeth." She revealed that they have worked on getting his teeth cleaner. She revealed that the resident came from another facility and had an excessive	M 500	comprehensive assessment will be reviewed by the will be reviewed by the Director of Nurses and/or the RN House Supervisor to ensure completion of dental evaluation, triggers are identified, interventions are appropriate and placed within the resident care-plan within 72 hours of admission. The DON will randomly observe 2 residents a day for at least 5 days a week to ensure adl assistance was provided as documented per care-plan. The RN Nursing Supervisor will be responsible to provide in-services to all nursing staff of the need and requirement to provide goods and/or services regarding ADL Care, with emphasis on oral care, fingernail care, and facial hair removal. As of 8/23/23, the RN Supervisor has in-serviced 46 of 54 nursing staff members, with the expectation of 100% compliance with the remaining nursing staff to be completed by 9/1/23. As of 8/22/23, systematic changes have been implemented regarding documentation of daily adl care by both the bath tech and the direct care giver for accountability of staff to attain, maintain services to a resident that are necessary. As of 8/23/23, the facility has developed a one-on-one mentor program that will be overseen by the Director of Nursing Services, which will assign a certified nursing assistant mentor to be assigned to all newly trained nursing assistants after completion of their certification program times 2 weeks to enhance their core knowledge, skills, comfort level, and competency. At the end of the two weeks the new hire will be checked-off on performance/competency level by the QA	

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M 500	Continued From page 6 amount of buildup on his teeth. She revealed that the nurses and aides are both responsible for oral care on the resident and that oral care was part of the daily care that was supposed to be provided for the resident. RN #1 confirmed that the resident had raised brown patches on his tongue and a cracked lower lip with patchy areas of dried blood. She revealed that the aides should be using a lip moisturizer instead of baby oil to hydrate the lips. She confirmed that the resident's nails were long and dirty and stated, "The aides can cut and clean the nails as long as the resident is not a diabetic, and he is not." She confirmed that the resident had long facial hair and stated, "Yes, he is supposed to be shaved with his bath." The Survey Agent (SA) inquired who would be responsible for ensuring that all the needed care was provided for Resident #34, and she replied, "Well, I guess that would be me." An observation and interview with the Director of Nursing (DON) on 8/08/23 at 3:20 PM, confirmed that Resident #34 had not been shaved, had long dirty fingers nails, and had a cracked lower lip with patchy areas of dried blood and raised brown patches to his tongue. She revealed that the aides and nurses are both responsible for the oral care and that the aides should be using a lip moisturizer on his lips, and he should be shaved daily. She revealed that the aides are responsible for cleaning the resident's nails and can cut them if the resident was not a diabetic. The DON revealed that the resident had come to the facility with his teeth and mouth in that condition and stated the odor was coming from his teeth. She confirmed that the resident had an excessive amount of "buildup" on his teeth. An interview on 8/09/23 at 8:35 AM, with Registered Nurse (RN) # 1 revealed that the aide	M 500	Nurse and reviewed by the Director of Nurses to ensure compliance and continuation of employment. An in-service for all staff members on Resident Rights including the right to be free from Abuse & Neglect is scheduled for 8/29/23 by the local Ombudsman. Written material from the Attorney General's Office regarding Abuse and Neglect will be distributed to all staff as well with all staff members being in-serviced no later than 9/8/23. No staff member will be allowed to work after 9/8/23 till they receive the mandatory in-service regarding Abuse & Neglect. Social services was in-serviced by the Administrator on 8/16/23 on regarding her role as an advocate for the residents to ensure they receive necessary treatments as per resident rights, federal regulations, and dental services regarding benefits available to each resident. A Performance Improvement Plan was developed on 8/14/23 by the Quality Assurance Nurse and the Interdisciplinary Team consisting of the MDS Nurse, Social Services, Administration, Dietary, and Nursing Staff. The Focus Review will be to provide dental/oral services as needed and required as determined from a comprehensive assessment completed by licensed nurses, reviewed by the Director of Nurses, and referred to social services for scheduling of dental appointments as needed. Social services will be responsible to conduct interviews with resident and/or family member (if resident is not interview-able) regarding resident/family Satisfaction with services provided regarding dental status and	

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M 500	Continued From page 7	M 500		

had tried to brush Resident # 34's teeth this morning and his gums began bleeding, and the resident became agitated and upset.

An interview with the Director of Nursing (DON) on 8/09/23 at 4:00 PM, revealed that the facility had not attempted to make Resident # 34 a dental appointment. She stated, "No, we have not." She revealed that the resident came to the facility with his teeth in bad condition and stated that the facility used to have a dentist who came out to the facility, but no longer does.

An interview with the Administrator (ADM) on 8/09/23 at 4:30 PM, revealed that it was the responsibility of the aides and the nurses to do oral care for Resident #34. She confirmed that the resident should be shaved, nails should be cleaned and trimmed, and the nurse should ensure that all the care was done. She stated, "It is a concern." She revealed that they have not made the resident a dental appointment and revealed she was made aware of the situation yesterday with his teeth and the odor.

An interview with Resident #34's Resident Representative (RR) on 8/09/23 at 8:30 PM, via telephone, revealed that she visited Resident #34 a couple of times a week. She revealed that she had witnessed a lack of oral hygiene and that she had discussed with the staff about getting some dental help for him. She stated, "I told them to get his teeth extracted, if that's what it took." She revealed that she had a conversation with the Social Worker (SW) on admission and was assured that he would get the dental care needed.

An observation of Resident #34's teeth with the Director of Nursing (DON) on 8/10/23 at 8:39 AM,

services beginning 9/1/23 and ending no later than 9/8/23 with all 6 individuals who was or could have been affected by deficient practice. Beginning 8/23/23 all new admissions with a Peg tube will have the same resident/family survey conducted within 14 days of admission by social services to ensure that deficient practice does not recur. Any negative remarks made by either party will be reported immediately to the administrator for further review and corrective measures if needed. The Quality Assurance Nurse, Director of Nurses and the RN House Supervisor will observe Residents for oral care being provided as evident of no mouth odor, no cracked/dry lips and no debris within mouth cavity on all Peg tube feeder at least weekly from 8/18/23-9/15/23, and then monthly for 2 months thru 11/10/23. The Quality Assurance Nurse will utilize the Dental Status and Services Critical Element Pathway to conduct staff interviews(nursing aides, nurse, DON, MDS Nurse and social services) with at least 35% of noted staff per month till 100% compliance is met beginning 8/15/23 and ending 11/15/23, with any negative findings to be reported immediately to the administrator and/or the DON for further corrective measures to be taken. The Quality Assurance Nurse will present at the weekly QAPI meeting times 4 weeks beginning 08/23/2023 thru 09/13/2023 then monthly for two months beginning 09/20/2023 endign on 11/15/2023. The QA Committee met on 8/23/23 with the Medical Director attending and discussed survey results

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M 500	Continued From page 8 confirmed the only actions taken by the facility since the resident was admitted was mouth care. She revealed that the facility was unable to look and determine what was going on with his teeth and revealed that the resident was a mouth breather and had an order for nothing by mouth (NPO) which caused his mouth to be drier. The DON described the resident's teeth as, "Dark with dark buildup at the base of all his teeth" but stated she was unable to state that his teeth were decaying. She revealed that she did not see any broken or missing teeth. The DON described the resident's lower gums as "Raw" and stated, "They probably just cleaned them, so they are irritated." She revealed that they have not made the physician aware of the oral/dental condition and stated, "No, we have not made him aware, but he had assessed him." The Survey Agent (SA) inquired if she could provide documentation to support the resident's dental status, and she replied, "It should be there." The DON did not provide any documentation to support the residents' oral/dental status to the SA. An interview with the Social Worker (SW) on 8/10/23 at 8:50 AM, revealed that the resident was admitted from another facility and stated that during her admission assessment with the RR that dental care was never discussed. She revealed that the residents' Supplemental Security Income (SSI) does not pay for the dental company that the facility will be in contract with for dental care. Record review of the Order Summary Report revealed an order dated 6/21/23, "NPO (nothing by mouth) diet tube feeding texture related to Cerebral Infarction, Dysphagia." Also revealed an order dated 6/21/23, "Enteral Feed Order every day and night shift Clean mouth with swabs."	M 500	and Performance improvement Plan with next QAPI meeting scheduled for 9/1/23 and 9/8/23 and reviewed with the QA Committee on 9/01/23. The Administrator will be responsible for reporting to the Board of Trustees during their monthly scheduled Board meeting on the third Monday of each month and recorded within the documented minutes.	

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M 500	Continued From page 9 Record review of Resident # 34's Nurse Progress Notes dated 6/21/23 through 8/10/23 revealed no documentation regarding the residents' oral/dental status. Record review of Resident # 34's Nursing Admission Screening/History dated 6/21/23 revealed under, "6. MOUTH" none of the boxes were checked to describe the resident's oral condition or history. Record review of the Physician's Progress Notes dated 6/29/23 and 7/06/23 revealed no documentation regarding the condition of Resident #34's oral/dental status. Record review of the Admission Record revealed Resident # 34 was admitted to the facility on 06/21/23 with medical diagnoses that included Cerebral Infarction, Unspecified Dementia, Dysphagia, Hemiplegia and Hemiparesis Affecting Right Dominant Side and Gastrostomy Status. Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/27/23 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident is severely cognitively impaired. Also revealed under Section G, the resident requires total dependence for personal hygiene and revealed under Section L, "None of the above were present" which indicated Resident # 34 did not have any oral/dental status concerns.	M 500		
M 610	45.21.2 Activities of daily living	M 610		9/2/23

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M 610	Continued From page 10 Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, staff and resident interviews, record review, and facility policy review the facility failed to remove facial hair, bathe, shave, and perform nail and oral care for residents requiring assistance with their Activities of Daily Living (ADL) for five (5) of 19 sampled residents reviewed for ADLs. Resident #4, Resident #6, Resident #27, Resident #34, and Resident #35 Findings Include: Record review of the facility policy titled Activities of Daily Living (ADLs) with a revision date of 3/10/23 revealed under, "Policy: ... Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care." Also revealed under, "Policy Explanation and Compliance Guidelines: ... 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene." ...	M 610	On the day of discovery 8/8/23 Resident #6 had his ADL care addressed which included a shave, fingernails trimmed. Resident #6's care plan was updated on 8/9/23 to his preference of having his goatee and moustache but all other portions of his face to be clean-shaved, fingernails trimmed at least weekly by the bath aide and cna's as necessary. Care-plan revised on 8/23/23 regarding dental care by a licensed nurse with additional treatment plan. Resident #4 facial hair was removed on the day of discovery 8/8/23, with her care plan updated on 8/9/23 to include her need to have her facial hair removed at least weekly during bath time and on alternate days by floor staff if needed. Resident #27's care plan was updated on 8/9/23 by the MDS Nurse to include her transferring needs and her ability to get out of bed when she is compliant and noncombative, fingernail care to be performed at least weekly during bath time and by hall staff on alternate days if needed, staff to observe for dirty nails and clean as	

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M 610	Continued From page 11 Record review of the facility policy titled NAILS, CARE OF (FINGER AND TOE) undated revealed, "BASIC RESPONSIBILITY: LICENSED NURSE PERFORMS THE PROCEDURE ON HIGH-RISK RESIDENTS. NURSING ASSISTANTS MAY PERFORM THE PROCEDURE IF THE RESIDENT IS NOT AT RISK FOR COMPLICATIONS OF INFECTION...PURPOSE 1. To provide cleanliness 2. To prevent spread of infection. 3. For comfort. 4. To prevent skin problems..." Resident #6 An observation and interview with Resident #6 on 8/8/23 at 2:30 PM, revealed long and bushy facial hair on his face, chin, mustache area, under chin and jaws, on lower cheeks, and neck. He stated he liked having a mustache and a goatee, but he prefers to be clean-shaven on the rest of his face and neck. His fingernails were noted to be long, approximately 1/3 inch from nailbed and he stated he would like for his fingernails and toenails to be trimmed since they were too long. During an interview on 8/8/23 at 3:00 PM, Certified Nursing Assistant (CNA) #10 revealed the resident had excess facial hair on his lower jawbone, under his chin, and on his neck. She stated this resident had been in the hospital and had moved from another hall of the facility and has been back from the hospital for a few days. She stated it was the CNA's responsibility to ask what the resident prefers and to shave the residents and to trim the fingernails as the resident desired and she had failed to ask this resident. During an interview and observation on 8/8/23 at 3:15 PM, Registered Nurse (RN) #2 revealed that	M 610	necessary due to her eating snacks through out the day and is not able to identify the need for cleanliness. On 8/9/23 Resident #34 had ADL care provided for him on the day of discovery by the QA Nurse and nursing assistant which included shaving, mouth care, and cleaned and trimmed fingernails. Resident #35 was given a shower on the day of discovery 8/9/23 by a certified nursing assistant with his care plan updated on 8/9/23 to include his preference on bath time of three days a week and fingernail care to be given at least weekly during bath time and on alternate by staff as needed. The MDS Nurse audited 68 of 68 charts on 8/15/23 to identify residents who are dependent on staff for Adl assisstance. Upon review of the Resident Matrix by the MDS Nurse it was determined that 58 of 68 residents were dependent on staff for assistance with Adl care. An in-service is scheduled for 8/29/23 by the Director of Nurses for all licensed nurses, certified nurse aids and nurse aides regarding the need and requirement for staff to provide care and assistance to residents who are unable to carry out Activity of Daily Living, any updated facility practices regarding nail care, removal of facial hair, lift program, and required documentation. A Performance Improvement Plan was developed on 8/14/23 by the Quality Assurance Nurse and the Interdisciplinary Team consisting of the MDS Nurse, Social	

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M 610	Continued From page 12 it is the nurses' responsibility to trim the toenails, unless a podiatrist is needed. She removed the resident's socks and revealed the toenails on the left foot are slightly long (less than 1/4 inch from nailbed to tip of nail). The toenails on the right foot were noted to be long with the big toenail being approximately 1/4 - 1/3 inch long and very jagged with part of nail being close to 1/3 inch long, then the other half of the big toenail about 1/4 inch long. Rough and jagged area between these two lengths of the big toenail were observed. She confirmed that the toenails should be kept smooth and short to maintain good nail care and prevent damage to skin and that his nails were too long and jagged to be safe or comfortable. She confirmed the resident prefers to be clean shaven and that he currently is not. She also confirmed that the resident's fingernails needed to be trimmed since the resident prefers them to be short. She stated that from his appearance, it had been several days since he had these things done. Record review of Resident #6's "Admission Record" revealed the resident was admitted to the facility on 5/18/23 with diagnoses included Hemiplegia, Personal History of Traumatic Brain Injury, Lesion of Ulnar Nerve Left Upper Limb, Chronic Pain, Unilateral Primary Osteoarthritis of Left Knee. Record review of Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 5/25/23, revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating resident was cognitively intact. Resident #4	M 610	Services, Administration, Dietary, Nursing Staff, and the Quality Assurance Nurse. The Focus Review will be to ensure assistance is provided per the individual resident care plan as evident by documentation and general rounds made by the Director of Nurses, RN House Supervisor and the Quality assurance Nurse at least 2 times a week for 12 weeks beginning 8/18/23 to observe at least 12 residents per round. The Quality Assurance Nurse, will audit Adl performance as outlined in the ADL Critical Element Pathway and presented weekly at the scheduled QAPI meeting beginning 8/23/23 times 4 weeks thru 9/13/23, and then monthly times two months beginning 9/20/23 and ending on 11/15/23.The Quality Assurance Nurse will audit weekly observation rounds and present weekly at the scheduled QAPI meeting beginning 08/23/23 times 4 weeks thru 09/13/23 and then monthly times two months beginning 09/20/23 and ending 11/15/223. The Quality Assurance Nurse will report any negative findings to the Quality Assurance Committee during the facility's Quality Assurance meeting scheduled the third week of each month with the attendance of the Medical Director. The next scheduled Quality Assurance meeting is scheduled for 09/01/2023 with the Medical Director. The Administrator will be responsible for reporting to the Board of Trustees during their monthly scheduled Board meeting on the third Monday of each month and recorded in the documented minutes.	

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M 610	Continued From page 13 An observation on 08/08/23 at 11:25 AM revealed that Resident #4 was sitting up in her wheelchair in the dining area with approximately 10 gray hairs in random areas of the chin and cheeks that were approximately 1 inch long. An attempted interview with the resident revealed she was confused. An observation and interview on 8/8/23 at 4:30 PM with CNA #11 confirmed that Resident #4 had several long hairs on her chin and cheeks that needed to be removed. She revealed she is unsure if she is supposed to shave the resident or use a tweezer to remove the hairs. An interview on 8/8/23 at 4:38 PM, with CNA #12 confirmed that shaving is a part of bathing and stated, "But I am not sure about female shaving, because I don't want to embarrass them by asking." CNA #12 was asked if a resident cannot determine if they need facial hair removed then how would she know if they need shaved, she revealed she is not sure about females but admitted that she would not want facial hair. An interview on 8/8/23 at 4:40 PM, with Registered Nurse (RN) #2 and RN #3 confirmed that female facial hair removal should occur when the resident is bathed unless they refuse. Record review of Resident #4's ADL care at this time with RN #3 revealed there was no documentation that the resident had refused any care. An interview on 8/9/23 at 4:20 PM, with the Director of Nurses (DON) confirmed that females should have facial hair removed during their bath time. Record review of Resident #4's "Admission Record" revealed the resident was admitted to	M 610		

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the facility on 02/10/23 with medical diagnoses that included Dementia and Need for Assistance with Personal Care.

Record review of Resident #4's MDS with an ARD of 5/17/23 revealed in Section C a BIMS score of 04, which indicated the resident is severely cognitively impaired. This review revealed in Section G that the resident needed assistance from staff to complete "Personal Hygiene" and 'Bathing."

Resident #27

An observation on 08/08/23 at 10:50 AM of Resident #27 lying in bed with fingernails on bilateral hands approximately one-half (1/2) inch long and jagged past the fingertips and a brown substance was under the nails.

An observation and interview on 08/08/23 at 2:55 PM with CNA #1 revealed, Resident #27 gets a bed bath daily and we do her nail care but today she was combative, and I didn't do her nails. She revealed we try and go back when she is calmer and see if she will let us do her nails. If she doesn't then we get the nurse to do them. CNA #1 confirmed her nails were long, jagged, and had a brown substance underneath them.

An observation and interview on 08/08/23 at 3:10 PM with the DON revealed the aides are responsible for fingernail care which included trimming and keeping them washed and cleaned out. She revealed Resident #27 eats with her fingers and that her nails would require cleaning more frequently because of that. The DON confirmed that the nails were long and jagged and had a brown substance under her nails.

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M 610	Continued From page 15 A record review of Resident #27's "Admission Record" revealed the resident was admitted to the facility on 03/17/2022 with diagnoses that include Metabolic Encephalopathy, Unspecified Dementia, Peripheral Vascular Disease, and Generalized Anxiety Disorder. A record review of the MDS with an ARD of 07/20/23, revealed the resident is rarely/never understood which indicated Resident #27 has severe cognitive impairment. Resident #34 An observation on 8/08/23 at 2:18 PM, of Resident # 34 revealed his tongue was observed with raised brown patches, lips were dry with dried bloody spots on the bottom lip and his teeth were observed to be in bad condition, with dark brown/black color to all teeth. Long facial hair measured approximately 1/4 inch in length and his nails were long, measuring approximately 3/8 inch in length from the tip of the fingers, with a brown substance underneath all nails. An observation and interview on 8/08/23 at 2:55 PM, with Nurse Assistant (NA) # 2 confirmed that she smelled an odor when she entered the resident's room and stated, "Mm-hmm, it smells like body odor," and that she had washed the resident up today and had put on deodorant but did not give him a complete bath. She confirmed that she had not shaved him and stated, "I was scared to do that." She revealed that when he came to the facility, he had old food (debris) that was caked on his teeth. She stated, "His lips have been chapped like that since he came from the other place." She revealed that she had been applying baby oil to the resident's lips because his family had requested her to do that, but she had	M 610		

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M 610	Continued From page 16	M 610		

not applied anything on his lips today.

An observation and interview on 8/08/23 at 3:10 PM, with Registered Nurse (RN) #1 confirmed that the nurses and aides are both responsible for oral care on the resident. She stated that this was part of the daily care that was supposed to be provided for the resident. She confirmed that the resident's nails were long and dirty and stated, "The aides can cut and clean the nails as long as the resident is not a diabetic, and he is not."

An observation and interview with the Director of Nursing (DON) on 8/08/23 at 3:20 PM, confirmed that Resident #34 had not been shaved, had long dirty fingers nails, and had an extremely dry, cracked lower lip with patchy areas of dried blood and raised brown patches to his tongue. She revealed that the aides and nurses are both responsible for the oral care, nail care and hygiene.

An interview with the Administrator (ADM) on 8/09/23 at 4:30 PM, revealed that it was the responsibility of the aides and the nurses to do oral care for Resident #34 and stated, "It is a concern."

Record review of the "Admission Record" revealed Resident # 34 was admitted to the facility on 06/21/23 with medical diagnoses that included Cerebral Infarction, Unspecified Dementia, Dysphagia, Hemiplegia and Hemiparesis Affecting Right Dominant Side and Gastrostomy Status.

Record review of the MDS with an ARD date of 6/27/23 revealed under section C a BIMS score of 7, indicating Resident #34 is severely cognitively impaired. Also revealed under section

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M 610	Continued From page 17 G, Resident #34 requires total dependence for personal hygiene. Resident #35 An observation and interview on 08/08/23 at 11:07 AM, revealed Resident #35 revealed that the facility is only bathing him one time a week. lying in bed. The resident stated, "I want to be shaved, and have my nails cut." An observation revealed long nails on both hands that measured approximately 3/8 inch in length, and facial hair approximately 1/4 inch. An observation and interview on 8/8/23 at 3:25 PM, with RN #2 confirmed that Resident #35 had long nails and facial hair and she asked him if he received a shower yesterday and the resident replied, "No, I didn't." An interview with CNA # 6 on 8/09/23 at 11:10 AM, revealed the aides have a shower list that they keep at the nurse's station and that the resident was on the list for Monday, Wednesday, and Friday showers. An interview with RN #2 on 8/09/23 at 11:20 AM, confirmed that Resident # 35 did not get a shower on Monday and stated, "I'm not sure why he didn't; I wasn't here." An interview with the Director of Nursing (DON) on 8/09/23 at 11:30 AM, revealed she had spoken with the aide assigned to Resident #35 and she confirmed that she did not give him a shower on Monday because every time she went in his room he was asleep so she didn't wake him up. Record review of the ADL bathing task for Resident #35 revealed under Monday 8/07/23,	M 610		

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M 610	Continued From page 18 "Not Applicable" was checked. Record review of the "Admission Record" revealed that Resident #35 was admitted to the facility on 6/26/23 with medical diagnoses that included Type 2 Diabetes Mellitus, Major Depressive Disorder, Acquired Absence of Left Leg Below Knee and Acquired Absence of Right Leg Above Knee. Record review of the MDS with an ARD of 7/12/23 revealed under section C a BIMS score of 10, indicating Resident # 35 is moderately cognitively impaired. Record review revealed under section G, the resident requires one-person physical assist with personal hygiene and is totally dependent for bathing.	M 610		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level III Based on resident and staff interview, record review, and facility policy review, the facility failed to ensure a resident was free from accidents during a lift transfer by using the inappropriate lift for one (1) of 19 residents reviewed for investigations. Resident #53	M 640	An updated lift assessment was completed for Resident #53 by the RN Restorative Nurse on 8/15/23 in which it was reiterated that a full body sling was appropriate for this resident. Resident #53 care-plan was reviewed and found to be accurate as deemed with the current assessment. An audit was completed by the MDS	9/2/23

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M 640	Continued From page 19 Findings include: Record review of facility policy titled "Modified Lifting Policy" undated, revealed, "(Proper name of nursing home) will provide a safe work environment for patient care areas by providing and requiring the use of safety materials, equipment and training designed to prevent personnel and patient injury." The policy also revealed, "1. Staff will follow the documented lifting protocol deemed appropriate for each resident. ... 2. Staff will utilize proper transfer/lifting/assistance procedures for each resident to include use of mechanical transfer devices or other lifting equipment or devices and by applying proper body mechanics." Record review of Physician's Order dated 6/16/23, revealed an order for x-ray of left shoulder related to acute pain. Record review of "Patient Results" of left shoulder x-ray from local hospital dated 6/16/23, revealed, "Findings: Bone - There is a nondisplaced fracture involving the neck of the left humerus. There is no definite dislocation identified. There is mild angulation of the humeral head laterally. Intact AC joint". Record review of hospital records dated 6/16/23, revealed, "77-year-old female who presents from local nursing facility due to a humeral fracture. Patient says she was being helped to bed and she may have slipped somewhat but there is no significant fall or trauma. She has pain to her left shoulder with any attempts at movement. Denies any other complaints." Hospital records also revealed the aftercare instructions as "Humerus Fracture, treated with immobilization." An interview on 8/8/23 at 11:55 AM, with Resident #53 revealed the staff was assisting her from her	M 640	Nurse on 8/14/23, on 68 of 68 electronic health records to identify how many residents are in need of a mechanical lift, in which it was identified that there were 19 of 68 residents identified to have the need of a mechanical lift for transfers to assist in prevention of accidents occurring. Between the dates of 8/16/23-9/1/23, the restorative nurse will in-service all licensed personnel on the need and requirement for lift assessments to be accurate and completed on admission, annually with a comprehensive assessment and with a significant change in condition and as needed per professional judgement. It will also be discussed that the care-plan must coordinate and reflect the results of the lift assessment upon completion. On 8/15/23 the Director of Nursing reviewed 68 of 68 charts to make a comparison of the current lift assessment and compared it to the individuals care-plan, with no negative findings. On 8/22/23 the Quality Assurance Nurse and the MDS Nurses completed a comparison report for all 19 residents to ensure that the care-plan had an appropriate coordinating lift assessment to ensure completion of both an assessment and a coordinating care-plan. A Performance Improvement Plan was developed on 8/14/23 by the Quality Assurance Nurse and the Interdisciplinary Team consisting of the MDS Nurse, Social Services, Administration, Dietary, Nursing Staff, and the Quality Assurance Nurse. The Focus Review will be to review lift assessment for existing resident in need	

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M 640	Continued From page 20 chair to her bed and their feet got twisted and she fell. Stated she was taken to the hospital due to a broken left arm but did not have to have surgery. She stated she wore a sling while it healed. An interview on 8/9/23 at 3:00 PM, with Resident #53 revealed she did not fall to the floor with this incident, but when she was on the stand-up lift, she "stumbled" when transferring to the bed. She stated she had pain in her arm, and she was given Tylenol. An interview with the Minimum Data Set (MDS) Registered Nurse (RN) on 8/10/23 at 8:45 AM, revealed the resident was care planned for a full body total lift for transfers and it was changed to a sit to stand lift, and after her shoulder incident, she was changed back to a total lift. She printed off the previous care plans and noted on the care plans, only the Vander Lift (full body lift) was listed for transfers. She stated that the Vera Lift (sit to stand lift) had to be on the care plan at some point since she could see a resolved date for the Vera Lift after the resident's incident. She stated she is unable to locate the care plan that listed the sit-to-stand lift in the system. An interview with the Director of Nursing (DON) on 8/10/23 at 9:10 AM, revealed the resident was being transferred from her chair to the bed in a sit-to-stand lift by two (2) staff members and when the resident was placed in bed, she complained of her left arm and stated she had pain. She confirmed she investigated the incident and sent the information into the State Agency (SA) and from what she was able to determine the resident had a diagnosis of osteoporosis and it could have been a spontaneous type fracture. She was unable to determine any other cause of the injury. She stated the full body lift was now	M 640	of a transferring device for appropriateness and that the appropriate interventions are included within the resident's care plan as deemed by the comprehensive assessment. Beginning 8/18/23, the Restorative Nurse is responsible for completion of the lift assessment within 48 hours of admission, annually with a comprehensive assessment or upon a significant change in a residents condition. An audit will be completed by the Quality Assurance Nurse weekly times 90 days beginning 8/23/23 to ensure compliance with the need and requirement that both the lift assessment and the resident's care-plan are one and the same. DON will observe at least 2 residents per week that require mechanical lift to ensure lift is appropriate per lift assessment, care-plan and observation of demonstration by assigned staff. The Quality assurance Nurse will report any negative findings to the Quality Assurance Committee during the facility's Quality Assurance meeting scheduled the third week of each month with the attendance of the Medical Director beginning 8/23/23 times 3 months. The next Quality Assurance meeting is scheduled for 09/01/2023. The Administrator will be responsible for reporting to the Board of Trustees during their monthly scheduled Board meeting on the third Monday of each month and recorded in the documented minutes.	

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being used, but at that time she had been assessed for a sit-to-stand lift. When asked about that the care plan indicated that the full body lift was to be used for transfers, she responded that she is uncertain why that one is listed since she had been using the sit-to-stand lift and was able to bear some weight and was doing well with transfers. She pulled the assessment dated 12/21/22 and it revealed the resident required a full body lift/Vander Lift or other full mechanical lift and not a sit to stand lift. She stated she looked for another assessment or documentation for the change in lift type, but she was unable to find where another assessment was done. She stated the residents are assessed annually for the type of lift required. She confirmed the most recent assessment determined the need for the total lift, and at the time of the resident's injury, the wrong lift was used for her transfer.

An interview with Minimum Data Set (MDS) Registered Nurse (RN) and the DON on 8/10/23 at 10:30 AM, revealed that after reviewing the "Care Plan" and "Kardex" for this resident, she had determined that at some point between 4/15/23 and 5/15/23, the Vera Lift (sit to stand lift) was added to the care plan since it shows up on the Kardex. She stated the information on the Kardex comes from the Care Plan, so it had to be added to the Care Plan for it to trigger on the Kardex. She stated from what can be determined on the Kardex/Care Plan, it appears that the sit-to-stand lift was added on 5/5/23 and removed on 6/16/23 (after the incident), and the full lift was put in on 1/5/22 and was never removed. The MDS RN stated she does not know why she added this lift, and it could have been a system error or improperly entered information. The DON stated she is not sure how far back the use of the

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sit/stand lift was being used, but she knew it was being used for a while before the injury occurred. The DON confirmed the most recent assessment was for a total lift, so, the total lift should have been the one used. She stated when the lift was changed from the full lift to the sit-to-stand lift, no assessment was done to ensure safety for the resident. She confirmed that prior to changing a resident to a more independent type of transfer device, an assessment should have been done to ensure the resident would be safe using this for transfers and the facility failed to do this assessment.

An interview with Certified Nursing Assistant (CNA) #9 on 8/10/23 at 10:40 AM, revealed she had worked at the facility for about one and a half years and has worked with this resident often. She stated the staff use the Kardex to determine what lift to use, and this resident had the sit to stand lift listed. She stated that the resident was now using the full body lift for transfers.

A phone interview with CNA #8 on 8/10/23 at 10:45 AM, revealed she was working with the resident when this incident occurred. She stated this was the first time she had worked with this resident. She stated she and another CNA used the sit-to-stand lift to transfer the resident from the chair to the bed that evening. She stated she "wondered why the stand-up lift was being used since her left arm was weak." She stated they placed the resident in her bed and after she was lying down, the resident stated her left arm was hurting and would like some Tylenol. The nurse gave Tylenol, and her pain was eased. She stated she was unaware of anything that occurred during the transfer that would have caused an injury, but the next day an x-ray was done and showed a fracture. She stated the facility had

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trained her on lift use and she had done this job for 15 years. She confirmed that the resident's Kardex showed to use a sit-to-stand lift.

During an interview on 8/10/23 at 10:40 AM, the Administrator confirmed the facility failed to use the lift the resident was assessed for. She confirmed the resident had an injury but could not confirm it was from the lift.

Record review of "Transfer/Lift Assessment" dated 12/21/22, for Resident #53 revealed, "Instructions - An assessment should be made prior to each task if the resident has a varying level of ability due to medical reasons, fatigue, medications, etc. When in doubt, assume the patient cannot assist in the transfer/repositioning." Section A of assessment revealed, "Ability to assist with transfer/positioning - The resident's level of assistance can best be described as - Dependent: resident requires more than 50% assistance by staff or is unpredictable in the amount of assistance offered." Section B of assessment revealed, "Weight Bearing - Can the resident bear weight? No." Section C of the assessment revealed, "Upper Extremity Strength - Does the resident have upper extremity strength to support his/her weight during transfer? No." Section G of the assessment revealed, "Care Plan - After completing assessment, indicate transfer/repositioning needs below: How does the patient transfer to and from bed-chair, chair toilet, chair-chair, etc. - Vander Lift or other full mechanical lift - one or two person assist."

Record review of "Care Plan History" revealed on 1/5/22, the Vander (full body) lift was listed. On 5/5/23, the Vera (sit-to-stand lift) was listed. On 6/16/20, the Vera Lift was resolved.

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M 640	Continued From page 24 Record review of "Care Plan" with review start date of 3/27/23, revealed the resident needed assistance with Activities of Daily Living (ADL) care and for transfers she was listed as "Transfer: the resident is totally dependent on 2 staff for transferring" and, "the resident requires Mechanical Lift (Vander) with 2 staff assistance for transfers." Record review of "Kardex Report" for each month from 12/15/23 - 4/15/23, revealed, "Transfer: the resident is totally dependent on 2 staff for transferring" and "Transferring: the resident requires Mechanical Lift (Vander) with 2 staff assistance for transfers." Record review of "Kardex Report" dated 5/15/23 and 6/15/23 revealed, "Transfer: the resident is totally dependent on 2 staff for transferring" and "Transferring: the resident requires Mechanical Lift (Vera) with 1 or 2 staff assistance for transfers." Record review of "Care Plan" with review start date of 6/30/23, revealed the resident needed assistance with Activities of Daily Living (ADL) care and for transfers she was listed as "Transfer: the resident requires Mechanical Lift (Vander) with 2 staff assistance for transfers." Record review of Electronic Medication Administration Record for June 2023 revealed the resident received the nightly dose of Tylenol on 6/15/23. The resident received the as needed dose of Tylenol on 6/16/23 at 5:11 AM and on 6/17/23 at 2:36 AM. The resident received her night dose of Tylenol each night but did not receive the as needed Tylenol any other time during the month of June.	M 640		

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M 640	Continued From page 25 Record review of Resident #53's "Admission Record" revealed the resident was admitted to the facility on 12/21/21. Diagnoses included Wedge Compression Fracture of first and second Lumbar Vertebra, Hypertension, Cerebrovascular Disease, Muscle Weakness, Moderate Protein-Calorie Malnutrition, and Paroxysmal Atrial Fibrillation. Record review of Resident #53's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 6/20/23, revealed a Brief Interview for Mental Status (BIMS) score of nine (9) which indicated the resident is moderately cognitively impaired.	M 640		