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	70RM	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVERSICARE OF RIPLEY	101 CUNNINGHAM DR RIPLEY, MS 38663

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M 000	Initial Comments The State Agency (SA) determined during an annual recertification survey and complaint investigation (CI) MS # 22574, conducted on 08/29/23 through 08/31/23 that the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm with deficiencies cited at M 610, M 640, M 715, M 815 and M1020. CI MS #22574 was investigated related to Quality of Care and Resident verbal abuse and the facility was found to be in compliance. Census at the time of the survey was 121 and the facility had a license for 131 residents.	M 000		
M 610	45.21.2 Activities of daily living 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, resident and staff interviews, record review and facility policy review the facility failed to provide the necessary nail care for a resident as evidenced by long, thick, overgrown toe nails for two (2) of 30 residents on sample. Resident #61 and Resident #68.	M 610	M610 – Activities of daily living • The center addressed the corrective action for the resident that could have been affected by the deficient practice of providing necessary nail care for a resident. Concerning resident #61, nail care was performed at the time of the finding by Registered Treatment Nurse. A	9/29/23

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M 610	Continued From page 1 Findings Include: Record review of a typed statement on facility letterhead, undated, and signed by the Administrator revealed, "(Formal Name of Facility) does not have a general ADL (Activities of Daily Living) Policy." Record review of a typed statement on facility letterhead and signed by the facility Administrator revealed, "(Formal Name of Facility) adopted Clinical Nursing Skills and Techniques, Perry and Potter as a supplementary policy and procedure care guide. Category: Clinical. Effective Date: Jan (January) 2023" Resident #61 An observation and interview on 08/29/23 at 10:29 AM, revealed Resident #61 toenails were long and thick, approximately 1/2 inch past the end of the resident's toes. An interview with the resident stated that he needs his toenails trimmed. An interview and observation on 8/30/23 at 1:15 PM, with Certified Nurse Assistant (CNA) #5 confirmed that Resident #61's toenails were too long and needed to be trimmed. She stated the resident is a diabetic and an Registered Nurse (RN) would be responsible for doing this resident's nails. An interview and observation on 8/30/23 at 1:35 PM, with the Treatment Nurse revealed someone just came and got her to go look at Resident #61's toenails and see if she could trim them. She stated that she had not been told about the resident's toenails needing trimmed before today.	M 610	follow up visit by the in-house podiatrist was scheduled for 9/11/23. Residents refused to be seen by the Podiatrist. Concerning resident #68, nail care was performed at the time of the finding by Registered Nurse Unit Manager. A follow up visit was also made by the in-house podiatrist on 9/11/23. • All resident's dependent on staff for nail care have the potential to be affected. • Audit completed per Director of Nursing on 09/04/2023 to identify all resident's dependent on staff for nail care. Those residents identified were offered nail care and an appointment with in-house podiatrist on next scheduled visit. All Nursing staff in-serviced by Director of Nursing and Director of Clinical Education on the process of weekly nail audits to be included in the weekly nursing note documentation. Nail care performed at the time of assessment or documented refusal. All Certified Nursing Assistants staff were in-serviced per Director of Nursing and Director of Clinical Education to document condition of nails on shower sheets, nail care performed and/or refusal of nail care. This in-servicing was completed on 09/28/2023. • The center plans to monitor the effect of systemic changes to ensure solutions are sustained. All resident's dependent for Activities of Daily Living will be monitored by the Director of Nursing and Assistant Director of Nursing to ensure appropriate nail care is completed and without thick, dirty or overgrown nails. This monitoring will be completed twice weekly for four weeks, weekly for eight weeks beginning on 08/31/2023 to ensure compliance. Any	

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M 610	Continued From page 2 She confirmed that Resident #61 toenails were long and needed to be trimmed. An observation revealed the Treatment nurse trimmed the resident's toenails. An interview on 8/30/23 at 1:46 PM, with the Director of Nurses (DON) confirmed that Resident #61 was a diabetic and needed his toenails trimmed. She confirmed that the nurse doing the weekly skin audits should have notified the treatment nurse about the need for nail care. She revealed the treatment nurse, or the RN can trim their nails if they are not too thick, and it should have been done. An interview on 8/31/23 at 12:30 PM, with RN #1 confirmed that Resident #61's toenails were thick and long and that should have been communicated to the treatment nurse to do nail care or she should have done it herself. She stated that any staff member that noticed the resident's toenails are long should notify the RN for nail care on a diabetic resident. She revealed the purpose of nail care is to prevent infection and to prevent them from scratching themselves and diabetics have slow wound healing. Record review of Resident # 61's "Admission Record" revealed the resident was admitted to the facility on 11/6/20 with medical diagnoses that included Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified Record review of Resident #61's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/3/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15 which indicates the resident is cognitively intact and in Section G that the resident was totally dependent for bathing.	M 610	negative findings will be corrected immediately and addressed with one-on-one education or the center's progressive discipline policy. Findings will be addressed monthly with the Quality Assurance Committee scheduled for September 29th, 2023, with the interdisciplinary team until such time compliance is achieved. Date of completion: 9/29/23	

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M 610	Continued From page 3 Resident #68 An observation and interview with Resident # 68 on 08/29/23 at 10:55 AM, revealed excessively long toenails that measured one-half (1/2) inch in length from the tip of the toes on both feet. The resident stated, "The doctor was here a couple of months ago, but didn't cut mine." The resident revealed he was unable to wear socks and was afraid that he may cut himself or someone else. An observation and interview on 8/30/23 at 11:05 AM, with RN # 1 confirmed that Resident # 68 had long toenails on both feet. She revealed that the treatment nurse was responsible for cutting the resident's toenails because he was a diabetic. She revealed that the Podiatrist just came to the facility a couple of weeks ago, but was unable to see the resident because he had too many residents on the list to be seen. RN #1 confirmed that the resident could scratch or injure himself due to the length of his nails. An observation and interview with the Director of Nursing (DON) on 8/30/23 at 11:15 AM, confirmed that Resident # 68 had long toenails. She acknowledged that he could potentially scratch or cut himself. Record review of the Admission Record revealed Resident # 68 was admitted to the facility on 5/16/22 with medical diagnoses that included Type 2 Diabetes Mellitus and Peripheral Vascular Disease. Record review of the MDS with an ARD of 7/25/23 revealed under section C a BIMS of 15 which indicated Resident # 68 was cognitively intact.	M 610		

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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 II Based on observation, staff and resident interview and facility policy review, the facility failed to supervise and complete a smoking assessment for one (1) of three (3) residents who smoked. Resident #77. Findings Include: Record review of facility policy titled, "Safe Smoking," dated 11/01/16, revealed, " Purpose ...2. To assess the ability to smoke and determine any measures needed to protect residents from possible self-inflicted injury during smoking. Procedure 1. Any resident who identified themselves as desiring to smoke will be assessed for safety related to smoking. This assessment will be reviewed and updated with any change of condition ..." On 08/30/23 at 9:33 AM, during an observation and interview, observed Resident #77 awake, lying in his bed. Observed a pack of cigarettes and a lighter laying on the bed side table in his room. Resident #77 stated his name and confirmed that those are his cigarettes and lighter and that he goes outside to smoke.	M 640	M640 – Accidents • The center addressed the corrective action for the resident that could have been affected by the deficient practice of completing a smoking assessment of a resident. A smoking assessment was performed on resident #77 on 08/30/2023 by Unit Manager. Resident deemed safe to smoke without supervision and has a Brief Interview for Mental Status (BIMS) score of 15. A comprehensive smoking care plan was implemented for resident #77 on 08/30/2023 by Director of Nursing. The resident was educated by the Director of Nursing on 08/30/2023 regarding signing himself in and out of the facility and returning smoking materials to the nursing staff to be placed in locked storage and staff signing with resident. All nursing staff in serviced on the process of resident #77 signing himself and smoking materials in and out of the facility by the Director of Nursing and Clinical Educator on 8/30/2023. • All residents have the potential to be affected by this deficient practice. • To avoid recurrence of the deficient practice, residents who smoke had their care plans and smoking assessment	9/29/23

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M 640	Continued From page 5 An interview with the Assistant Director of Nursing (ADON) on 08/30/23 at 9:40 AM, confirmed that the cigarettes and lighter should not be in the resident's room and stated, "He is our resident that goes out to the road to smoke and he left yesterday to go out to the store with someone and I bet he bought those cigarettes then. But he usually does keep his cigarettes in his room I think because he smokes independently and goes outside whenever he wants to." The ADON confirmed that she could see how that could be a safety issue with him keeping his lighter and cigarettes with him in his room and confirmed that the resident walks across the road to smoke. She stated they are a smoke free facility so he knew that when he was admitted and because he is cognitive she stated that the resident told them that he would just sign himself out on pass and go across the road to smoke, so that is what he does. The ADON revealed, "So, I guess when he does that he just keeps his cigarettes and lighter with him." An interview on 08/30/23 at 2:15 PM, with the Administrator stated, "We are considered a smoke free building, meaning that when new residents are admitted that they know they cannot smoke on the premises and this resident was admitted knowing that he couldn't smoke here on the facility premises so since he is cognitive and alert and signs himself out and walks across the street to be off the premises to smoke." Record review of the resident's medical record revealed there was not a smoking assessment completed for Resident #77. An interview with the Director of Nursing (DON) at 5:00 PM on 08/30/23, confirmed that she had	M 640	reviewed by Director of Nursing and Minimum Data Set Nurse on 08/30/2023. Smoking assessments are to be completed in the Clinical Health Evaluation on admission to identify those residents that smoke at home. Education will be provided to resident and family on the center's "Smoke Free" policy. All nursing staff in-serviced on smoking assessments and the center's "Smoke Free" policy by the Director of Nursing and Clinical Educator. Nursing staff education was completed on 09/28/2023. • On going compliance with corrective action will be monitored by the Director of Nursing and Interdisciplinary Team to ensure smoking assessments are completed on admission and included on the comprehensive care plan, beginning on 09/04/2023. Monitoring will be weekly for 4 weeks, 2 times a month for one month then monthly thereafter for a minimum of month. Any negative findings will be corrected immediately and addressed with one on one in-servicing and/or the center's progressive discipline policy. Findings will be addressed in the monthly Quality Assurance Performance Improvement Meeting beginning in the September 2023 Meeting scheduled on the 29th by the interdisciplinary team for review monthly for three months then as deemed necessary by the Quality Assurance committee or until such time compliance is reached as determined by the Quality Assurance Committee. Date of completion: 9/29/23	

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M 640	Continued From page 6 reviewed the residents medical record and that they had not completed a smoking assessment on the resident on admission to the facility. She stated, "When he first came here he was very sick and has improved, but honestly I didn't know he was a smoker until recently, probably in the last month, and we just missed doing a smoking assessment on him. He has a friend that comes by, and he goes out with him and he started bringing back cigarettes and smoking." Record review of the Admission Record revealed that the resident was admitted to the facility on 12/29/22 with diagnoses that included Paranoid Schizophrenia, Heart Failure and Need for Assistance with Personal Care. Record review of the Minimum Data Set with an Assessment Reference Date (ARD) of 06/29/23, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident is fully cognitively intact.	M 640		
M 715	45.24.4 Labeling of drugs Labeling of drugs. Each facility shall follow the Mississippi State Board of Pharmacy labeling requirements. This Statute is not met as evidenced by: Level II Based on observation, staff interview, and facility policy review the facility failed to label and date eye drops on one (1) of five (5) medication carts observed during medication administration for C Hall medication cart.	M 715	M715 – Labeling of drugs • The following corrective action was implemented by center to ensure residents were not negatively impacted by this deficient practice of an unlabeled bottle of eye drops, not containing an expiration date. Open bottle of eye drops	9/29/23

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M 715	Continued From page 7 Findings Include: Record review of Facility Policy, dated 04/22, titled "Medication Storage, revealed, "It is the policy ...that medication storage complies with state and federal laws and regulations... Expired, contaminated, or deteriorated medications are immediately removed from stock and disposed of according to procedures for medication destruction and reordered from the pharmacy if a current order exists." An observation on 08/30/23 at 8:40 AM, during medication pass with Licensed Practical Nurse (LPN) #5, revealed the eye drops for Resident #10 were not dated on the bottle or box. The date the eye drops were filled from the pharmacy was 05/12/2023. An interview on 08/30/23 at 8:44 AM, with LPN #5 stated that eye drops were good for 60 days before having to be discarded. LPN #5 confirmed that the eye drops had no open date on the box or the bottle and that if the eye drops were filled on 05/12/2023 that they should have been discarded on 07/12/2023. An interview on 08/30/23 at 9:00 AM, with the Director of Nursing (DON) confirmed that eye drops should be discarded 60 days after the fill date and that a date should be placed on the bottle when they are opened.	M 715	were immediately discarded and replaced with a new bottle and dated. Audit of all medication carts were completed by the Director of Nursing and Assistant Director to ensure all opened medications had the appropriate labeling of an expiration date. Any unlabeled medications were discarded at time of discovery. Medication cart audit was completed on 08/30/2023. • All residents have the potential to be affected by this deficient practice. • To avoid recurrence of the deficient practice, the facility implemented systemic changes that included in-servicing to the registered Nurses and Licensed Practical Nurses on proper labeling and storage for medications by the Director of Nursing initiated on 9/4/23 and completed on 9/8/23. • The center plans to monitor the performance of the systemic changes to make sure the solutions are sustained by the Director of Nursing, Assistant Director of Nursing, or Registered Nurse Supervisor conducting rounds ensuring all medications on medication carts are dated in accordance with policy daily will be done daily for two weeks beginning 8/31/23, three times weekly times two weeks, then monthly times two months. Any negative findings will be corrected immediately and addressed with one-on-one in-service and/or the center's progressive discipline policy. Findings will be addressed in the monthly Quality Assurance Performance Improvement Meeting beginning in the September 2023 meeting scheduled on the 29th by the interdisciplinary team for review monthly for three months then as deemed necessary by the Quality	

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M 715	Continued From page 8	M 715	Assurance committee until such time compliance is reached. Date of completion: 9/29/23	
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation, staff interviews and facility policy review, the facility failed to label food items in the refrigerator and freezer and failed to maintain a clean ice maker for one (1) of three (3) kitchen tours. Findings Include: Record review of the facility policy titled food storage with an effective date of 11/01/17 revealed under, "Policy: It is the policy of this center to store, prepare and serve food that is stored in accordance with federal, state, and local sanitary codes." Also revealed under, "Policy Interpretation and Implementation... 5. Foods will be labeled as to content and dated ..." Record review of the facility policy titled "Ice Machines" with an effective date of 9/01/14 revealed "Purpose: To maintain dietary refrigeration equipment to preserve food at safe regulated temperatures. The temperatures at which foods are stored can affect their appearance, taste, nutrient content and most	M 815	M815 – Safe Food Handling Procedures • Center addressed the corrective action for those residents found to have been affected by the deficient practice by discarding all food that was not labeled properly in the refrigerator and freezer, center maintenance staff also cleaned and sanitized ice maker located in the kitchen on 8/29/23. • Center identified that all residents have the potential to be affected by the same deficient practice. • To avoid recurrence of the deficient practice, the facility implemented systemic changes on 9/4/23 that included the Administrator, and Dietary Manager in servicing all dietary staff on the proper storage and labeling of food as well as changing the cleaning and sanitizing process for facility ice makers from quarterly to bi-monthly. • The center plans to monitor the effect of the systemic changes to make sure solutions are sustained by the Administrator and Director of Nursing,	9/29/23

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M 815	Continued From page 9 importantly their safety... Monthly Preventative Maintenance... Sanitize interior of ice machine per manufacturer's instructions. Clean out and sanitize the ice bin..." Record review of the kitchen ice machine manufacturer's guidelines for cleaning and maintenance revealed under, "1. Cleaning Procedure: 1) Dilute 16 fl. (fluid) oz. (ounce) (473 ml) (milliliters) of Hoshizaki "Scale Away" with 3 gal. (gallon) (11 l) (liters) of warm water." ... Also revealed under, "2. Sanitizing Procedure-Following Cleaning Procedure: 1) Dilute a 5.25% sodium hypochlorite solution (chlorine bleach) with warm water. (Add 1.5 fl. (fluid) oz. (ounce) (44 ml) (milliliters) of sanitizer to 3 gal. (gallons) (11 l)(liters) of water.)..." An observation of the kitchen ice machine with the Dietary Manager (DM) on 8/29/23 at 10:21 AM, revealed a black substance adhering to the inside of the entire ice machine door. The DM confirmed the black substance inside the ice maker door, and she revealed she was not sure what the black substance could be. She revealed that the ice machine was emptied routinely and cleaned by the maintenance department, but she was unsure how often or the last time it was cleaned. She revealed that the black substance could make the residents or staff sick. An observation of the kitchen stand-up refrigerator with the DM on 8/29/23 at 10:28 AM, confirmed four (4) unlabeled/undated sandwiches wrapped up in clear plastic wrap. The DM revealed the sandwiches were peanut butter, and she revealed she was unsure when they were placed in the refrigerator. An observation of a large clear bag with whitish colored meat that was unlabeled/undated. The DM identified the item in	M 815	Assistant Director of Nursing, rounding in center kitchen four times weekly for four weeks beginning on 9/4/23, two times weekly for four weeks, and weekly times four weeks, to ensure proper storage and labeling of food and cleanliness of ice maker, all negative findings will be corrected immediately and addressed with one-on-one in servicing and/or the center's progressive discipline policy. Findings will be addressed in the monthly Quality Assurance Performance Improvement Meeting beginning in the September 2023 meeting scheduled on the 29th by the interdisciplinary team for review monthly for three months then as deemed necessary by the Quality Assurance committee. Date of Completion 9/29/23	

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M 815	Continued From page 10	M 815		

the bag as turkey breast and revealed she was unsure how long it had been in the refrigerator. Observed 12 small burgundy bowls with a whitish/tan chunky substance inside and covered with clear plastic wrap that was unlabeled/undated. The DM revealed the substance was pineapple tidbits and confirmed that the staff should have dated it. The DM confirmed that by not dating the food inside the refrigerator, the staff would not know how long the food had been stored or when it should be thrown away. The DM revealed she was throwing away all the unlabeled foods for safety and acknowledged that the residents could possibly get sick.

An observation of the kitchen freezer with the DM on 8/29/23 at 10:40 AM, revealed an open 32-ounce bag of whole kernel corn with less than one-half (1/2) the bag remaining that was undated. The DM confirmed that the corn should have been labeled when it was opened. The DM also confirmed a clear plastic bag that was opened and undated with six (6) frozen chicken breasts. She confirmed that all things placed inside the freezer should be labeled and dated.

An interview with the DM on 8/30/23 at 1:30 PM, confirmed that the dietary staff had not been cleaning the ice machine and revealed the only cleaning the ice machine received was by the maintenance department.

An interview with the Maintenance Supervisor on 8/30/23 at 1:45 PM, revealed that he did routine cleaning on the ice machine every 3 months. He revealed he cleaned the coils, descaled, delimed, emptied the ice and flushed the ice machine with clean water. He confirmed that he did not clean the inside of the ice machine door as part of his

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 815	Continued From page 11 cleaning routine. He confirmed that the kitchen staff were responsible for cleaning the inside of the ice machine door, and he stated, "That should be wiped down daily." He confirmed that the black substance on the inside of the ice maker door could potentially make someone sick. Record review of the Ice Machine Quarterly Cleaning Schedule revealed the last date of cleaning was documented on 6/14/23. An interview with the Administrator (ADM) on 8/30/23 at 1:54 PM, with the DM in attendance, confirmed that the Dietary Department was not cleaning the ice machine. The ADM revealed that the black substance that had built up on the inside of the ice machine door could cause staff or residents to become sick. An interview with the Administrator on 8/30/23 at 2:04 PM, confirmed that all food items placed inside the refrigerator and freezer should be labeled with a date of opening and acknowledged that the residents could become sick from outdated food.	M 815		
M1020	45.35.3 Resident Bedrooms Resident Bedrooms. Resident bedrooms shall be cleaned and dusted as often as necessary to maintain a clean, attractive appearance. All sweeping should be damp sweeping, all dusting should be damp dusting with a good detergent or germicide. This Statute is not met as evidenced by: Based on observation, staff and resident interviews and facility policy review, the facility failed to ensure a resident resided in a clean	M1020	M1020 – Resident Bedrooms • Center addressed the corrective action for the resident found to have been	9/29/23

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	70RM	A. BUILDING: _____ B. WING _____	08/31/2023

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M1020	Continued From page 12 comfortable homelike environment for one (1) of thirty residents reviewed. Resident #99 Findings include: Record review of undated Facility Policy on "5-Step Daily Room Cleaning" revealed ".....the proper cleaning method to sanitize a patient room or any area in a healthcare facility." Under "5-Step Patient Room Cleaning Procedure", the facility policy revealed, "1. Empty Trash ... 2. Horizontal Surfaces ... 3. Spot Clean Walls ... 4. Dust Mop ... 5. Damp Mop ..." On 08/29/23 at 3:30 PM, an observation of Resident #99's room revealed sticky brown substance scattered on the floor of his private room, along with trash debris to include napkins, medication cups and gloves. There was also an empty pizza box on the floor lying next to the wall on the left side of his room. It was also observed that there were three urinals open and hanging on the top drawer of the nightstand to the left of Resident's bed. There was 750 milliliters (ml) of amber urine in the first urinal, 350 ml amber urine in the second urinal and the third urinal was empty. On 08/30/23 at 12:05 PM, an observation in Resident #99's room revealed three urinals hanging on the partially opened top drawer of the nightstand. The first urinal closest to the bed held 750 ml of amber urine inside and the second urinal held 350 ml amber urine. An interview at the same time with Certified Nursing Assistant (CNA) #4 as she entered Resident #99's room revealed that the resident was gone for a doctor's appointment. CNA#4 observed the urinals hanging on the nightstand and revealed that she needed to come back in and dispose of the urine.	M1020	affected by the deficient practice by the Administrator instructing the Housekeeping Manager to have resident #99's room deep cleaned following the Five Step Patient Room Cleaning Procedure on 8/30/23. On 8/30/23 Facility also completed facility wide audit to verify all residents have Safe/Clean/Comfortable/Homelike Environment with no negative findings. • The center identified that all residents have the potential to be affected by the same deficient practice. • To avoid recurrence of the deficient practice, the facility implemented systemic changes that included implementing in the care plan to clean Resident #99's Room two time daily using the Five Step Patient Room Cleaning Procedure. On 9/1/23, the Administrator, Housekeeping Regional Manager, Director of Clinical Education initiated an in-service to all housekeeping staff regarding the Five Step Patient Room Cleaning Procedure and initiated an in-service to all certified nursing assistants regarding the use of walking rounds to inspect all resident rooms and report any that need to be cleaned to the Administrator or the Director of Nursing. • The center plans to monitor the effect of the systemic changes to make sure solutions are sustained by the Administrator, Director of Nursing, Assistant Director of Nursing, and Registered Nurse Supervisors rounding in center four times weekly for four weeks beginning on 9/4/23, two times weekly for four weeks, and weekly times four weeks to ensure residents have a safe/clean/comfortable/homelike	

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M1020	Continued From page 13 On 08/30/23 at 1:45 PM, an observation and interview with Resident #99 in his room revealed three urinals on the nightstand next to his bed. The first urinal had 900 ml of amber urine and the second had about 350 ml of amber urine inside. This SA also observed a sticky brown substance on the floor throughout resident's room and an empty pizza box on the floor lying next to the wall on the left side of his room. Trash and debris was also noted on the floor of the resident's room to include napkins, medication cups and gloves. The resident revealed that he feels like the staff don't come in very often because of the sign on the door (isolation sign) and that his room had not been cleaned today or yesterday (08/29/23 or 08/30/23). On 08/30/23 at 1:50 PM, the Director of Nursing (DON) entered Resident #99's room with the State Agency (SA) and stated, "This room is disgusting." She also revealed that this room didn't look like it had been cleaned yesterday and had not been cleaned yet today. She confirmed that the CNAs should be making frequent rounds and pouring the urine out of the urinals as soon as he used it. On 08/30/23 at 1:55 PM, an interview with CNA #4, revealed that she had not been in Resident #99's room this morning because he had been gone for a doctor's appointment and stated that the urinals must have been left from the night shift because he was gone this morning and she needed to get back in here and empty them. On 08/30/23 at 2:00 PM, an interview with Housekeeping, revealed that all rooms were cleaned every day and that she cleaned the isolation rooms at the end of the day to help	M1020	environment any negative findings will be corrected immediately and addressed with one-on-one in servicing and/or the center's progressive discipline policy. Findings will be addressed in the monthly Quality Assurance Performance Improvement Meeting beginning in the September 2023 meeting scheduled for the 29th by the interdisciplinary team for review monthly for three months then as deemed necessary by the Quality Assurance committee. Date of Completion 9/29/23	

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M1020	Continued From page 14	M1020		

prevent spread of infection. Housekeeping revealed that she normally worked 7:30 AM to 2:30 PM and that she left about 3:20 PM yesterday, 08/29/23. She also revealed that Resident #99's family was in his room visiting while she was trying to clean and sweep the room, so she wasn't in there long yesterday.

On 08/30/23 at 2:10 PM, an interview with the Housekeeping Supervisor, revealed that he teaches the housekeeping staff to clean the isolation rooms last and also revealed that maybe they needed to start getting Resident #99's room cleaned twice a day because stuff seemed to accumulate in his room.

Record review of "(Proper name of cleaning services) Daily Work Routine" form dated 08/29/23 documented that Housekeeper had cleaned Resident Rooms using 5 and 7 Step Method which included to Pull Trash, Horizontal Surfaces, Vertical Surfaces Dust Mop, and Damp Mop. Record review revealed that Housekeeper had marked that these tasks were completed for Resident #99's room on 8/29/23 at 12:00 PM.

Record review of Resident #99's "Admission Record" revealed admit date of 06/13/2023 with the following diagnoses to include: Encounter for Orthopedic Aftercare Following Surgical Amputation, Klebsiella Pneumoniae as The Cause Of Diseases Classified Elsewhere, Pain in Right Leg, Difficulty in Walking, Cognitive Communication Deficit, Need for Assistance with Personal Care, Acquired Absence of Right Leg Above Knee, Acquired Absence of Left Leg Above Knee.

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

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M1020	Continued From page 15 06/20/2023 revealed under "Section C", a Brief Interview for Mental Status (BIMS) score of 09 which indicated Resident #99 had moderate cognitive deficits. Level II Based on observation, staff and resident interviews and facility policy review, the facility failed to ensure a resident resided in a clean comfortable homelike environment for one (1) of thirty residents reviewed. Resident #99 Findings include: Record review of undated Facility Policy on "5-Step Daily Room Cleaning" revealed "".....the proper cleaning method to sanitize a patient room or any area in a healthcare facility." Under "5-Step Patient Room Cleaning Procedure", the facility policy revealed, "1. Empty Trash ... 2. Horizontal Surfaces ... 3. Spot Clean Walls ... 4. Dust Mop ... 5. Damp Mop ..." On 08/29/23 at 3:30 PM, an observation of Resident #99's room revealed sticky brown substance scattered on the floor of his private	M1020		

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M1020	Continued From page 16	M1020		

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