

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/05/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/03/2023
NAME OF PROVIDER OR SUPPLIER HILLTOP MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 KIRKLAND STREET UNION, MS 39365		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS An annual recertification survey and a complaint investigations (CI) MS #21902, CI MS #22052, and CI MS #22205 were conducted from 7/31/23 through 8/3/23 at the facility. During the survey, the facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The SA determined the facility was not in compliance for CI MS #21902 related to staffing and call bells not being answered but was in compliance with the complaint of residents left soiled. The SA found the facility to not be in compliance with CI MS #22205 related to not being groomed, odors in the facility, staffing and call bells not answered. The SA determined the facility was in compliance related to falls and insufficient food. The SA determined the facility was not in compliance with CI MS #22052 regarding call bells not being answered. The SA determined the facility was in compliance regarding residents not being repositioned and left wet. The SA cited noncompliance at F561, F584, F585, F641, F656, F677, F688, F695, F725, F880, and F925.	F 000			
F 561 SS=D	At the time of the survey, the facility held a license for 60 beds and had a census of 59. Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose	F 561		9/14/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/25/2023

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

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F 561	Continued From page 1 activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review and facility policy review the facility failed to honor the choice of a resident to get up early for one (1) of 23 residents in the sample. Resident #36 Findings Include: Record review of the facility policy titled, "Policies and Procedures: Resident and Patient Rights" with a revision date of 09/01/2017 revealed, "Policy...It is the policy of the company that all employees will conduct themselves in a professional manner at all times, respecting the rights of each resident or patient to privacy, personal care, self-respect and confidentiality..."	F 561	Root Cause Analysis was conducted by the Quality Assurance Performance Improvement (QAPI) Committee on 8/10/23 and based on findings, the facility failed to honor the choice of resident # 36 to get up early. On 7/31/23, resident # 36 was gotten up by 7-3 shift. On 8/3/23 resident #36 care plan was updated by Minimum Data Set(MDS) Nurse to reflect resident's choice. Quality Review of current residents with preference to get up early was conducted on 8/3/23 by Director of Clinical Services (DCS) to ensure all residents with preference to get up early are up per their preference. All residents with preference to get up		

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F 561	Continued From page 2 An observation and interview on 07/31/23 at 12:43 PM, with Resident #36 revealed he was sitting up in his wheelchair in his room and the resident revealed that this facility needs staff bad. Resident #36 stated they do not have enough people to take care of us. He stated that he is supposed to get up every morning around 5:00 AM but he rarely does, and it is usually because they do not have enough staff. He revealed it was 10 AM before a staff member was able to get him up this morning. He stated, "I cannot get myself out of bed and don't have use of my left arm." An interview and review of the bath schedule on 8/1/23 at 1:06 PM with Licensed Practical Nurse (LPN) #1 confirmed that Resident #36 likes to get up early and his bath is scheduled on the 11 PM-7 AM shift. A review of the bath schedule with LPN #1 confirmed the resident was scheduled for a bath on the 11 PM-7 AM shift. An interview, on 8/1/23 at 1:10 PM with Certified Nurse Assistant (CNA) #1 confirmed that Resident #36 likes to have his baths early in the morning and likes to stay up after that, so he is scheduled for his bath on the 11 PM-7 AM shift. She revealed about 2-3 times a week that does not happen, and they must do his bath and get him up on the 7 AM-3 PM shift because they don't have the staff to bath him at that time and get him up. An interview, on 8/3/23 at 8:20 AM with the Director of Nurses (DON) confirmed that Resident #36 has made the request to be gotten up and his bath to be given on the 11 PM-7 AM shift. She confirmed there are times that he is not able to be gotten up on the 11 PM-7 AM shift and it is usually due to staffing. She confirmed	F 561	early have the potential to be affected. Education initiated on 8/3/23 by Director of Clinical Services (DCS) with current Certified Nurse Assistant and Licensed Nurses to ensure resident with preference to get up early are accommodated. New hires will receive education upon hire. Beginning on 8/3/23 Quality Monitoring of 4 residents with preference to get up early to be conducted by Director of Clinical Services (DCS) weekly x 4 weeks, then monthly x 4 months. Findings will be reported by the Director of Clinical Services (DCS) monthly x 6 months to Quality Assurance Performance Improvement (QAPI) Committee Meeting. On 9/8/23 will conduct a QAPI to review of findings from Quality Monitoring to ensure our solution is sustained. Review all findings from our Quality Monitoring on the first Friday of each month during the QAPI meeting by the QAPI committee in the monthly meeting for 6 months to ensure our solutions are sustained.		

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F 561	Continued From page 3 that a resident's choices should be honored though. Record review of Resident #36's "Admission Record" revealed the resident was admitted to the facility on 8/27/21 with medical diagnoses that included Cerebral Infarction, Unspecified. Record review of Resident #36's Documentation Survey Report v2 for July 2023 revealed under ADL (Activity of Daily Living) - for transferring there were five times in the last two weeks where the resident did not get out of bed on the 11PM-7AM shift for his bath. Record review of Resident #36's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/26/23 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicated that the resident was cognitively intact and under Section G that the resident needed extensive assistance for transferring.	F 561			
F 584 SS=E	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- §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	F 584		9/14/23	

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F 584	Continued From page 4 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 observations, resident and staff interviews, record review and facility policy review the facility failed to maintain a clean environment that was free of odors as evidenced by dirty walls and siderails and provide a sufficient supply of clean linen for two (2) of four (4) survey days. Findings include: Record review of the facility policy titled "Cleaning	F 584	On 8/1/23, housekeeping staff /laundry provided Certified Nurse Assistants (CNA) with clean wash clothes and towels to provide bathing for residents # 21, 41 and 28. Resident # 50 room was cleaned on 8/1/23 by housekeeping staff to remove brown substance from wall and side rails. On 8/1/23, North and South floors were mopped to remove urine odors.		

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F 584	Continued From page 5 and Disinfection of Environmental Surfaces" undated revealed, "Policy Statement: Environmental surfaces will be cleaned and disinfected according to current CDC (Centers for Disease Control) recommendations for disinfection of healthcare facilities and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogen Standard. Policy Interpretation and Implementation: 1 ... c. non-critical items are those that come in contact with intact skin but not mucous membranes. (1) Non-critical environmental surfaces include bed rails, some food utensils, bedside tables, furniture and floors." ... 9. Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. 10. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled ..." An observation on 7/31/23 at 11:05 AM, revealed a strong smell of urine as soon as you reach the nurses station that lingered between the North and South hallways and that smell extended all the way down the South hallway of the building. An observation on 7/31/23 at 3:00 PM, walking from the front door revealed a strong smell of urine as soon as you get to the nurse's station and continued down the South hallway. An interview on 8/1/23 at 8:51 AM, with Certified Nurse Assistant (CNA) #1 revealed that the facility only has one laundry staff member, and they are off on Tuesday's and Wednesday's, so they run out of towels and washcloths. She stated that when the staff came in this morning they were out of clean towels and wash cloths, so	F 584	Quality Review of housekeeping practices was conducted by the Executive Director on 8/1/23. All residents have the potential to be affected by this issue. Education of housekeeping staff conducted on 8/1/23 by the District Manager on routine cleaning schedules and ensuring Certified Nurses Assistants have adequate wash clothes and towels to complete baths. Beginning on 8/3/23 the Executive Director (ED) or Director of Clinical Services (DCS) conducted a quality review of 6 residents rooms and 2 common area 4x weekly x 4 weeks, then 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then weekly x 1 week. On 9/8/23 we will conduct a QAPI to review our findings from Quality Monitoring to ensure our solution is sustained. We will review all findings from our Quality Monitoring on the first Friday of each month, during the QAPI meeting by the QAPI committee in the monthly meeting for 6 months to ensure our solutions are sustained.		

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F 584	Continued From page 6 a CNA took it upon themselves to start a load of laundry. An observation and interview with Laundry & Housekeeping Supervisor on 8/1/23 at 9:25 AM in the laundry room revealed there were no clean towels or wash clothes available now. The Laundry & Housekeeping Supervisor stated that they have a laundry staff person that works 6AM-2PM every day except Tuesday and Wednesday, but on those days, he helps and does some washing. He revealed he was currently washing bath cloths and towels, but the staff come to the laundry room and stock their linen carts and take them to the halls. An observation on 8/1/23 at 9:40 AM, of the linen cart on the South Hall revealed there were only 3 wash cloths and no towels. CNA #1 confirmed this observation. An observation and interview with CNA #2 on 8/1/23 at 9:45 AM, confirmed the linen cart on the North Hall had no washcloths or towels and CNA #2 revealed that they still had about three baths to give and that they had given all the baths they could with the washcloths and towels that they had. During the resident council meeting on 8/1/23 at 2:00 PM, Residents #21, Resident #41 & Resident #28 complained that the facility runs out of towels and wash clothes often and all agreed that their baths had been postponed or delayed due to no clean washcloths or towels at that time. An interview on 8/1/23 at 3:30 PM, with the Activities Director and CNA #7 confirmed they run out of clean wash cloths and towels and revealed	F 584			

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F 584	Continued From page 7 that when they run out of towels and wash clothes, they tell housekeeping. An interview on 8/1/23 at 4:30 PM, with the Activities Director stated that since the facility stopped letting the staff use wet wipes, they have started running low on wash cloths and towels and that has been going on for the last couple of weeks. An interview on 8/2/23 at 2:15 PM, with the Director of Nurses (DON) and the Assistant Director of Nurses (ADON) stated that they knew about the issue with the staff running out of washcloths and towels, and knew there were extra in storage, but staff have been washing some at night and during the day to try and have enough to give baths. When the State Agent (SA) ask if the staff would have known about the extra linens in storage the DON revealed the staff would have notified her or the ADON and they would have notified laundry. The DON admitted that the washcloth and towel situation had gotten worse since they decided to take the wet wipes away because a resident had been flushing the wipes down the toilet and it stopped up the town's sewer system. An observation on 7/31/23 at 11:20 AM, revealed that Resident #21's room had a strong smell of urine in the room. An observation and interview on 08/01/23 at 9:00 AM, revealed that Resident #21's room had a strong smell of urine. The resident stated that he gives himself a bath when they aren't out of towels and wash clothes, and they run out quick. Record review of Resident #21's Minimum Data	F 584			

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F 584	Continued From page 8 Set (MDS) with an Assessment Reference Date (ARD) of 6/14/23 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact. Record review of Resident #28's MDS with an ARD of 4/25/23 revealed under Section C a BIMS score of 13, which indicated the resident is cognitively intact, Record review of Resident #41's MDS with an ARD of 5/22/23 revealed under Section C a BIMS score of 15, which indicated the resident is cognitively intact. An observation of Resident #50 on 07/31/23 at 11:20 AM, revealed him lying in bed eating lunch. The resident's left and right inner side rails noted with a brown substance adhering. The wall located beside the bed was noted with a brown substance smeared down the wall in the resident's view. The brown substance on the wall measured approximately 10 inches in length x 5 inches in width. An interview with the DON on 8/01/23 at 3:05 PM, confirmed that Resident # 50 had a brown substance smeared on the wall and on both inner side rails. She confirmed that this was not a sanitary environment for the resident to reside in. She revealed it was housekeeping's responsibility to ensure the residents' side rails and walls were cleaned.	F 584			

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F 584	Continued From page 9 An interview with the Regional Housekeeping Director on 8/01/23 at 3:10 PM, confirmed the brown substance on the wall and on Resident #50's side rails. He revealed that if the brown substance was bodily fluids, the nursing department would be responsible for cleaning. He confirmed that this was not a sanitary environment for the resident. Record review of the Admission Record for Resident # 50 revealed he was admitted to the facility on 09/27/22 with medical diagnoses that included Nontraumatic Intracerebral Hemorrhage, Type 2 Diabetes Mellitus and Heart Failure.	F 584			
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		9/14/23	

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F 585	Continued From page 10 §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident	F 585			

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F 585	Continued From page 11 right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, record review and facility policy review, the facility failed to resolve a grievance in a timely manner for one (1) of six (6) residents reviewed for bathing, Resident #49, and foul odors inside the facility for five (5) of 12 residents	F 585	On 8/3/23 grievances were completed by Activities Director for residents # 49 related to bathing, and residents #9, #14, #28, #41, and resident #53 related to foul odors inside the facility.		

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F 585	Continued From page 12 reviewed during resident council. Resident #9, Resident #14, Resident #28, Resident #41, Resident #53. Findings Include: Record review of the facility policy titled "Complaint/Grievance" with a revision date of 10/24/22 revealed, under, "Policy: The center will support each resident's right to voice a complaint/grievance without fear of discrimination or reprisal. The center will make prompt efforts to resolve the complaint/grievance and informed the resident of progress towards resolution. ... The resident should have reasonable expectations of care and services and the center should address those expectations in a timely, reasonable, and consistent manner...Procedure: 1. An employee receiving a complaint /grievance from a resident, family member and /or visitor will initiate a Complaint/Grievance Form. ... 2. Original grievance forms are then submitted to the Grievance Officer / designee for further action. 3. The Grievance Officer / designee shall act on the grievance and begin follow -up of the concern or submit it to the appropriate director for follow -up. 4. The grievance follow -up should be completed in a reasonable time frame; this should not exceed 14 days. 5. The findings of the grievance shall be recorded on the Complaint / Grievance Form. 6. The results will be forwarded to the Executive Director for review and filing. 7. The Grievance Official will log complaints/grievances in Monthly Grievance Log. 8. The individual voicing the grievance will receive follow -up communication with the resolution will be provided to the resident upon request..." During an observation on 7/31/23 at 11:05 AM,	F 585	Quality review of grievance process were conducted on 8/3/23 by Executive Director (ED). All residents have the potential to be affected by this issue. Education on 8/3/23 conducted by Executive Director (ED) with Activity Director on grievance process to ensure issues in Resident Council are addressed following the grievance process. Grievances will be reviewed daily Monday through Friday beginning on 8/4/23 by Executive Director. Beginning on 8/4/23, he Executive Director and/or Social Worker will conduct a quality review of 5 residents weekly x 4 weeks, then every other week x 4 weeks, the monthly x 6 months to Quality Assurance Performance Improvement (QAPI) Committee Meeting. On 9/8/23 we will conduct a QAPI to review our findings from Quality Monitoring to ensure our solution is sustained. We will review all findings from our Quality Monitoring on the first Friday of each month, during the QAPI meeting by the QAPI committee in the monthly meeting for 6 months to ensure our solutions are sustained.		

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F 585	Continued From page 13 the State Agency (SA) noticed a strong smell of urine as soon as you reach the nurses station that lingered between the North and South hallways and the smell extended all the way down the South hallway. During an observation on 7/31/23 at 3:00 PM walking from the front entrance the SA noted a strong smell of urine as soon as you get to the nurse's station and continued down the South hallway. During the Resident Council Meeting on 8/1/23 at 2:00 PM; Resident #9, Resident #14, Resident #28, Resident #41, and Resident #53 complained about the smell of urine and feces on the hallways. Resident #53 and Resident #41 stated they thought it was the dirty barrels on the hall where they put the dirty linens and it sits outside the room doors until they are done in that area. They revealed they have talked about this in the resident council meetings in the past, but it has not been resolved. An observation and interview on 08/01/23 at 03:02 PM with the Administrator confirmed that there was an odor of urine on the South hallway and some areas were worse than others. He confirmed that Resident #46 and Resident #52's rooms smelled of urine. He revealed they both use urinals and sometimes spill them. He confirmed that staff should be emptying the urinal and cleaning it out at least every 2 hours and frequently changing the urinals out as well. He revealed that each residents room gets mopped daily but admitted that those that usually have a strong odor of urine smell should be mopped more often. He stated that the facility is old and does not have good ventilation on the hallways	F 585			

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F 585	Continued From page 14 and they have been working on possibly getting a split unit on each end of the halls to help with that and hopefully help with the smells. He confirmed that it didn't need to smell that way. An interview on 8/1/23 at 4:30 PM with the Activities Director confirmed that residents had complained about the smell of urine and feces in the halls during resident council meetings at times, but they do not want me to write it up as an actual complaint; they just want me to talk with the administrator about it for them and I have. She stated she is not sure what solution they came up with, but that the residents will say that the smell gets better at times and then will get bad again. An interview on 8/2/23 at 2:15 PM with Director of Nurses (DON) and the Assistant Director of Nurses (ADON) stated that they had been here so long they do not notice the smells of urine except occasionally. The ADON stated she just smells filth and thinks it is a ventilation problem, because there is no air circulation on the halls. She revealed that the Administrator has talked with corporate about getting some sort of units to put on both ends of the halls to increase air circulation and stated the air is just stale. An interview on 8/3/23 at 11:40 AM with the Administrator confirmed that he recalls the Activities Director mentioning that the resident's had complained of the smell at times in the past and he has discussed with her the need to write it up as an actual grievance. Resident #9 Record review of Resident #9's "Admission Record" revealed the resident was admitted to	F 585			

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F 585	Continued From page 15 the facility on 12/25/17 with medical diagnoses that include Idiopathic Normal Pressure Hydrocephalus. Record review of Resident #9's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/4/23 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident is cognitively intact. Resident #14 Record review of Resident #14's "Admission Record" revealed the resident was admitted to the facility on 01/27/23 with medical diagnoses that included Rheumatoid Arthritis Unspecified. Record review of Resident #14' MDS with and ARD of 7/11/23 revealed under Section C a BIMS score of 14, which indicated that the resident is cognitively intact. Resident #28 Record review of Resident #28's "Admission Record" revealed the resident was admitted to the facility on 01/27/22 with medical diagnoses that included Unspecified Dementia. Record review of Resident #28's MDS with an ARD of 4/25/23 revealed under Section C a BIMS score of 13, which indicated the resident is cognitively intact, Resident #41 Record review of Resident #41's "Admission Record" revealed the resident was admitted to the facility on 11/29/19 with medical diagnoses that included Dysphagia following Cerebral Infarction.	F 585			

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F 585	Continued From page 16 Record review of Resident #41's MDS with an ARD of 5/22/23 revealed under Section C a BIMS score of 15, which indicated the resident is cognitively intact. Resident #53 Record review of Resident #53's "Admission Record" revealed the resident was admitted to the facility on 6/10/23 with medical diagnoses that included Acute and Chronic Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure. Record review of Resident #53's MDS with an ARD of 7/7/23 revealed under Section C a BIMS score of 11, which indicated the resident is moderately cognitively intact. Resident #49 An interview with Resident #49 on 07/31/23 11:15 AM, revealed she had not been getting her bath as scheduled on Monday, Wednesday, and Friday. She revealed her last bed bath was given last Monday. She stated that she was told last Wednesday and Thursday that there was not enough staff, and on Friday she was told the facility ran out of towels and wash cloths. The resident revealed, at one point, therapy was helping complete her baths due to the shortage of staff. She revealed she had filed a grievance regarding not getting her bath and things did get better for about 2 weeks. She revealed that staffing was the problem. The resident revealed that the aides worked with one aide on the hall at times and stated, "It's impossible for them to do all those baths." An interview with the Social Worker (SW) on			F 585			

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F 585	Continued From page 17 08/01/23 at 11:03 AM, revealed that Resident #49 had filed two grievances regarding her not getting bathed and both were considered resolved. She revealed she did follow-up and spoke with the resident, and she voiced no issues. SW stated, "She hasn't said anything else to me about it." An interview on 08/01/23 at 11:16 AM, with Resident #49 revealed that she requested her bathing schedule to be on Monday, Wednesday, and Friday. She stated, "If I did refuse my bath, it was because I only wanted a bath on those days." An interview on 8/01/23 at 3:10 PM, with the DON revealed that Resident #49 had filed two grievances related to not receiving her baths that were dated 5/12/23 and 7/5/23. She revealed that on 5/12/23 the resident requested to get her baths on the 3-11 shift because she was not a morning person. The DON revealed that she updated the bath list and requested the nurses to follow up. The DON revealed that on 7/5/23 she had a meeting with the aides on the 3-11 shift. She revealed that she requested the nurses to follow up with the aides regarding the resident's bath. She stated that the aides would occasionally report that the resident refused because she didn't want to get a bath at that time. The DON revealed that she spoke with the resident concerning this, and the resident reported that the aides on 3-11 came at an odd time that was not convenient for her. An interview on 8/02/23 at 2:17 PM, with Licensed Practical Nurse (LPN) # 1 revealed the facility had a bath schedule at the nurse's desk that the aides were supposed to follow.	F 585			

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F 585	Continued From page 18 An interview with the SW on 08/02/23 at 4:30 PM, revealed that she handled and kept all the grievances. She revealed that the residents that have resided in the facility awhile knew that she handled the grievances and would come by her office, or the staff would come get her. She revealed that as part of the admission process to the facility, she spoke with the residents and families and explained how to report issues or concerns. The SW revealed that once she completed her section of the grievance form, she took it to the morning meeting to discuss with the administrative staff. She revealed she then gave it to the needed department so that the issue/concern could be addressed. She revealed that after the issue/concern was addressed, the grievance form would be returned to her so that she could follow up on the outcome. The SW revealed that the Administrator does not sign off on the grievances. An interview with the Administrator (ADM) on 8/03/23 at 8:45 AM, revealed the grievances were reviewed in the morning meeting. He revealed that he used to sign off on the grievance form, but he currently does not because the form does not have an area for the ADM to sign. He stated he did sign off on Resident council, but not the grievances. The ADM revealed that they recently had an in-service with the corporate team, and they were making some upcoming changes. The ADM revealed that he had spoken with several aides that cared for Resident #49, and they reported that the resident would refuse to bathe at times. The ADM confirmed that the Activity of Daily Living (ADL) documentation did not support refusal and confirmed that here were several days with no documentation to prove bathing occurred.	F 585			

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F 585	Continued From page 19 Record review of the grievance filed by Resident #49 dated 5/12/23 revealed, "Resident not getting a shower." Under, "Documentation of Investigation" revealed "Findings of Investigation: Resident only wants a bed bath on Mon, Wed, Fri." Under "Plan to resolve complaint/grievance: Update bath list for bed bath on Mon, Wed, Fri, under "Results of actions taken: On 24-hour report for nurses to follow up to make sure resident is getting bath" Under, "Complaint/Grievance resolved" Yes is marked. Record review of the grievance filed by Resident #49 on 7/05/23 revealed, "Resident states she hasn't taken a bath since last Wednesday" Revealed under, "Findings of investigation: Spoke with resident says she has to ask for a bath. Currently on 3-11 bath list" Under, "Plans to resolve complaint/grievance: Coach with 3-11 shift nurses and CNA's go over 3-11 bath list" Under "Results of actions taken: Met with 3-11 shift about bath schedule" Under Complaint/Grievance resolved" Yes is marked. Record review of the Admission Record for Resident #49 revealed she was admitted to the facility on 01/23/23 with medical diagnoses that included Rheumatoid Arthritis, Repeated Falls, Chronic Pain Syndrome and Need for Assistance with Personal Care. Record review of the MDS with an ARD of 04/28/23 revealed under section G that Resident # 49 requires one-person physical assist with bathing. Record review of the MDS with an ARD of 04/28/23 revealed under section C a Brief	F 585			

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F 585	Continued From page 20	F 585			
F 641	Interview for Mental Status (BIMS) score of 14, which indicated Resident #49 is cognitively intact.				
SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review the facility failed to correctly code a Minimum Data Set (MDS) related to weight loss for one (1) of 23 MDS records reviewed. Resident #11. Findings include: Review of the facility policy titled, "MDS", with a revision date of 9/25/2017, revealed the center conducts initial and periodic standardized, comprehensive and reproducible assessments no less than every three months for each resident including, but not limited to, the collection of data regarding functional status, strengths, weaknesses and preferences using the federal and/or state required Resident Assessment Instrument (RAI). Record review of the quarterly MDS with an Assessment Reference Date of 4/14/23 revealed Section K 0300 #1 was checked: Yes, on physician prescribed weight loss regimen. An interview on 08/03/23 at 9:17 AM, with the MDS nurse stated she knew the resident had weight loss but was not physician prescribed. She stated the MDS was coded wrong, and it is part of	F 641	On 8/3/23, Minimum Data Set section K was corrected by Minimum Data Set nurse to reflect weight loss for resident #11. Quality Review of residents with weight loss was conducted on 8/3/23 by Director of Clinical Services (DCS) and Assistant Director of Nurses to ensure residents with weight loss were coded correctly on Minimum Data Set. All residents have the potential to be affected by this issue. Education on 8/3/23 conducted by Minimum Data Set Nurse with Dietary Manager (DM) to ensure Minimum Data Set section K is coded correctly. Beginning on 8/3/23, the Minimum Data Set Nurse will conduct a Quality Review of section K of 4 residents with weight loss weekly x 4 weeks, biweekly x 4 weeks, then monthly x 3 months. On 9/8/23 we will conduct a QAPI to review our findings from Quality Monitoring to ensure our solution is sustained. We will review all findings from our Quality Monitoring on the first Friday of each month, during the	9/14/23	

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F 641	Continued From page 21 the MDS process for her check the MDS for accuracy. An interview on 8/1/23 at 9:45 AM, with the Director of Nursing (DON) revealed Resident #11 had been doing fine, they were monitoring routine monthly weights. He got upper respiratory symptoms and next month his weight was significantly down. They monitored weekly weights, and the DON stated the weight loss occurred also because the resident is up and moving around the building constantly and smokes. An interview, with the Administrator on 8/3/23 at 2:00 PM, revealed he didn't know why Section K was marked incorrectly because the assessment was correct. He confirmed it must have just been an entry error. Record review of the Order Summary Report for Resident #11 revealed an order dated 7/24/23 for "Regular diet, Regular texture. Regular/ thin liquids consistency. provide finger foods with all meals, Health shake at lunch and supper. Fortified foods with all meals for DIET." Review of the facility Admission Record for Resident #11 revealed an admission date of 12/28/21 with diagnoses that included Heart Failure, Alzheimer's Disease, Nicotine dependence, Depressive disorder, and Muscle Wasting and Atrophy. Review of the MDS with an Assessment Reference Date (ARD) of 4/14/23 revealed a Brief Interview for Mental Status (BIMS) score of 6 which indicated Resident #11 had severe cognitive impairment.	F 641	QAPI meeting by the QAPI committee in the monthly meeting for 6 months to ensure our solutions are sustained.		

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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 entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		9/14/23	

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F 656	Continued From page 23 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 staff interview, record review and facility policy review the facility failed to develop a person-centered care plan for a resident receiving oxygen for Resident #23 & Resident #106, and a resident's choice for Resident #36. The facility failed to implement a person-centered care plan for resident's dependent on staff for their Activities of Daily Living (ADL) for Resident #22, Resident #35, and Resident #44 and for a resident requiring a splint Resident #29 for seven (7) of 23 residents reviewed for care plans. Findings include: Review of the facility policy titled, "Policies and Procedures: Plans of Care" with a revision date of 09/25/17 under "Procedure: Develop and implement an individualized Person-Centered comprehensive plan of care by the Interdisciplinary Team that include but is not limited to-the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, another appropriate staff or professionals in discipline as determined by the resident's needs or as requested by the resident, and to the extent practicable, the participation of the resident and the residents representative..."	F 656	On 8/3/23 resident #23 and resident # 106 care plan was updated by the MDS Nurse to reflect oxygen use, on 8/3/23 resident #36 care plan was updated by MDS Nurse to reflect resident's choice, residents #22, #35, #44 care plans were reviewed to reflect dependence on staff for their Activities of Daily Living (ADL), resident # 29 care plan was reviewed to reflect use of splint. All residents have the potential to be affected by this issue. Root Cause Analysis (RCA) was completed on 8/3/23 by the Quality Assurance Performance Improvement (QAPI) Committee on ensuring all resident care plans are followed. Education on the policies and procedures that govern care plans began on 8/3/23 with the Minimum Data Set (MDS) nurse and Licensed Nurses were educated by Director of Clinical Services. Newly hired licensed nurses will be educated by the Director of Clinical Services (DCS) on the policies and procedures that govern care plans. A Quality Assurance Improvement (QAPI) meeting was held on 8/10/23 to ensure		

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F 656	Continued From page 24 Resident #22 Record review of Resident #22's care plan, last review 6/8/23, revealed, "Focus ...potential for skin problems r/t (related to) thin fragile skin ...needs assist with ADL's...Interventions/Tasks ...BATHING/SHOWERING: Check nail length and clean as necessary. Report any changes to the nurse ...Provide sponge bath when a full bath or shower cannot be tolerated ..." An observation, on 07/31/23 at 12:29 PM and on 08/01/23 at 8:32 AM, revealed Resident #22's fingernails on both hands were long, past the end of the fingers. All the nails on left hand and middle finger on right hand had dark brown substance under each nail. An interview, on 8/1/23 at 3:05 PM with the Director of Nursing (DON) confirmed that long sharp fingernails could result in skin tears for the resident. She stated that if the resident had brown stuff caked between her toes she probably didn't get a good bath. Review of Resident #22's Admission Record revealed an admission date of 5/29/21 with diagnoses that included Cerebral Infarction, Type 2 Diabetes Mellitus, and Alzheimer's Dementia. Review of Section C of the MDS with an ARD of 5/25/23 revealed Resident #22 did not require a Brief Interview for Mental Status (BIMS) to be conducted because the resident is rarely/never understood. Section G Functional Status revealed Resident #22 was totally dependent on two (2) staff members for personal hygiene and bathing. Resident #35	F 656	care plans are updated. Beginning on 8/7/23 Minimum Data Set (MDS) nurse and Director of Clinical Services (DCS) will conduct ongoing monitoring on 4 residents to ensure plan of care is developed and implemented 2x/weekly x 4 weeks, then 1x/weekly x 4 weeks, then monthly for 6 months. Findings will be reported monthly x 6 months by the Minimum Data Set (MDS) nurse at Quality Assurance Improvement (QAPI) meeting. On 9/8/23 we will conduct a QAPI to review our findings from Quality Monitoring to ensure our solution is sustained. We will review all findings from our Quality Monitoring on the first Friday of each month, during the QAPI meeting by the QAPI committee in the monthly meeting for 6 months to ensure our solutions are sustained.		

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F 656	Continued From page 25 Record review of the care plan for Resident #35 revealed a care plan reviewed 6/29/23, "Focus (Proper Name of Resident #35 has an ADL self-care performance deficit r/t (related to) muscle wasting and atrophy, weakness, need assist with ADLs, and dementia ...Interventions ...BATHING/SHOWERING: The resident requires extensive assist by one (1) staff with bathing/showering ...DRESSING: The resident requires limited assist by (1) staff to dress ..." An observation, on 08/02/23 at 9:40 AM revealed Resident #35 wearing the same plaid pants and gray shirt that he had on the day before. An interview on 8/2/23 at 2:20 PM, with CNA #5 revealed that Resident #35 did not get a bath today. Resident #23 During an interview on 8/3/23 at 9:17 AM the MDS nurse confirmed the care plan directs staff on what needs to be done for the resident even if they cannot do it themselves, all information related to a resident's care should be in the care plan. An observation on 07/31/23 at 12:11 PM revealed Resident #23's oxygen cannula not bagged hanging on the front of the concentrator and there was no signage on the door indicating oxygen was in the room. An interview on 8/2/23 at 8:30 AM with the DON revealed that the cannula should have been stored in a bag and there should have been an	F 656			

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F 656	Continued From page 26 oxygen in use sign on the door. Review of the Admission Record for Resident #23 revealed an admission date of 3/17/23 with diagnoses that included Unspecified Dementia, Heart Failure, and Cerebral Infarction. Review of the MDS with an ARD of 4/20/23 revealed Resident #23 was severely impaired and never/rarely made decisions. Resident #106 An observation and interview on 07/31/23 at 12:04 PM revealed Resident #106's oxygen cannula hanging on the concentrator not in a bag and there was no signage on the door indicating oxygen was in use. An interview and record review on 08/03/23 at 9:17 AM with the Minimum Data Set (MDS) nurse confirmed Resident 106's care plan does not cover oxygen storage and signage. She stated that she did not think she needed to put it in the care plan because it is covered in the policy. Review of the Admission Record for Resident #106 revealed an admission date of 11/25/2022 with diagnoses that included Chronic Obstructive Pulmonary Disease and Bronchitis. Review of the MDS with an ARD of 6/28/2023 revealed a BIMS score of 13 which indicated Resident #106 was cognitively intact. Resident #36 Record review of Resident #36's care plans revealed the resident did not have a care plan	F 656			

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F 656	Continued From page 27 regarding his choice to get up around 5 AM and have his bath at that time. An observation and interview, on 07/31/23 at 12:43 PM with Resident #36 revealed he is supposed to get up every morning around 5:00 AM but he rarely does. He stated, "I cannot get myself out of bed and don't have use of my left arm." An interview on 8/3/23 at 11:00 AM, the MDS/Registered Nurse (RN) revealed she had not been made aware that the resident requested to get up around AM and get his baths. She stated that if the resident had made that request, then it needed to be care planned to direct the staff on his choices. An interview on 8/3/23 at 11:45 AM, with the DON and the Assistant Director of Nurses (ADON) revealed everyone knew that the resident liked to get up early and he was on the bath schedule for 11pm -7am so they did not see the need for it to be in his care plans. Record review of Resident #36's "Admission Record" revealed the resident was admitted to the facility on 8/27/21 with medical diagnoses that included Cerebral Infarction, Unspecified. Record review of Resident #36's MDS with an ARD of 5/26/23 revealed under Section C a BIMS score of 15, which indicated that the resident was cognitively intact and under Section G that the resident needed extensive assistance for transferring. Resident #44	F 656			

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F 656	Continued From page 28 Record review of Resident #44's care plans revealed a care plan revised on 6/29/23, "Focus (Proper Name of Resident #44) has an ADL deficit r/t (related to) dementia, weakness, and impaired balance, impaired vision ...Interventions/Tasks ... Bathing: extensive x (times) 1 assist ...Personal hygiene: limited assist with one person assist, Staff will assist resident as needed with ADL's ..." An interview and observation on 07/31/23 at 11:35 AM, with Resident #44 revealed the resident had gray facial hair that was approximately 1 inch long with 1-inch-long gray hair coming out of his ears. The resident revealed he would like to be shaved. An interview on 8/2/23 at 1:30 PM with the DON and the ADON confirmed that shaving is a part of bathing and if the resident needs and wants to be shaved then the staff should take care of that during the resident's bath. An interview on 8/3/23 at 11:00 AM MDS/RN revealed the care plan is in order to direct the staff on care and should be implemented. Record review of Resident #44's "Admission Record" revealed the resident was admitted to the facility on 10/07/2020 with medical diagnoses that included Unspecified Gout, Unspecified Intellectual Disabilities, Unspecified Dementia and Blindness-right eye category 4 and left eye category 2. Record review of Resident #44's MDS with an ARD of 6/23/23 revealed under Section C a BIMS score of 12, which indicated the resident is cognitively intact and under Section G that the	F 656			

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F 656	Continued From page 29 resident needed physical help with bathing. Record review of Resident #29's care plans revealed under, "Interventions/Task: Patient to wear left hand soft, comfy hand splint for 6-8 hours during the daytime shifts in order to prevent left digits contractures due to signs and symptoms of keeping fingers in flexed position. Make sure Velcro straps are not too tight and can place two fingers width underneath straps. Please notify OT (Occupational Therapy) of any skin integrity issues. please perform BUE (Bilateral Upper Extremity) PROM (Passive Range of Motion) daily." An observation of Resident # 29 on 8/01/23 9:45 AM, revealed she was lying in bed with her eyes closed and a hand splint was observed lying on the table beside the bed. An interview with the MDS Nurse on 8/02/23 at 4:19 PM, revealed the purpose of the care plan was to instruct the staff on what care should be provided for the resident. She confirmed that Resident #29 had a care plan for a left-hand splint and stated, "If she's not wearing it, then we did not follow the care plan." An interview with the DON on 8/02/23 at 4:32 PM confirmed that Resident #29 had a care plan for a left-hand splint and stated, "No, we weren't following the care plan." She revealed the purpose of the care plan was to have the information to meet the residents' needs. An interview with RN #1 on 8/03/23 at 8:15 AM, revealed the purpose of the care plan was to	F 656			

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F 656	Continued From page 30 ensure that the resident was able to meet their goals and to ensure the resident gets the necessary care to ensure quality of care. She confirmed that the care plan for Resident # 29 was not followed. Record review of the Admission Record revealed Resident #29 was admitted to the facility on 10/05/22 with medical diagnoses that included Sequelae of Cerebral Infarction, Pseudobulbar Affect, Major Depressive Disorder, Seizures, and Essential (Primary) Hypertension. Record review of the MDS with an ARD of 7/07/23 revealed under section C a BIMS score of 10, indicating Resident # 29 is moderately cognitively impaired.	F 656			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, record review and facility policy review the facility failed to shave, clean and trim nails and bath residents that were dependent on staff for their Activities of Daily Living (ADL) for five (5) of 59 residents reviewed on the initial tour. Resident #22, Resident #35, Resident #38, Resident #44, and Resident 49. Findings include: Record review of the facility policy titled	F 677	Root Cause Analysis was conducted on 8/1/23 by Quality Assurance Performance Improvement (QAPI) Committee and based on findings, the facility failed to shave, clean and trim nails and bath residents dependent on staff for their Activities of Daily Living (ADL) for resident #22, #35, #38, #44, and #49. On 8/1/23 Activities of Daily Living (ADL) care was performed by Certified Nurse Assistant on resident #22, #35, #38, #44, and #49 for nail care, shaving and grooming. On	9/14/23	

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F 677	Continued From page 31 "Grooming Activities" with a revision date of 03/19/19 revealed, under, "Policy: Grooming activities are provided to assist the residents in meeting their physical needs as well as self-esteem needs." Also revealed under, "Procedure: 1. Grooming activities shall be offered daily. 2. Grooming Activities shall include, but are not limited to: Shaving, Applying Make-up, Combing Hair, Nail Care ..." Record review of the facility policy titled "Bathing/Showering" with a revision date of 04/20/22 revealed under "Policy: The resident preferences on bathing/showering will be reviewed and identified upon admission, including frequency, and other preferences. ... Also revealed under, "Procedure: ... Document in the medical record." ... Record review of the facility policy titled "Activities of Daily Living" with an effective date of 02/01/2022 revealed under, "Policy: ... ADLs include bathing, dressing, grooming, hygiene, toileting, and eating. Also revealed under, "Procedure: 1. CNA will review the resident Kardex for information on individual care needs and preferences 2. CNA will provide needed oversight, cueing or assistance to resident 3. CNA will report any changes in ability or refusals to the nurse 4. CNA will document care provided in the medical record." Resident #22 Observations on 07/31/23 at 12:29 PM and on 8/1/23 at 8:32 AM revealed Resident #22's fingernails on both hands were long and grown out past the end of her fingers. All the nails on her left hand and middle finger on right hand had a	F 677	8/1/23 a Quality Review by the Director of Clinical Services (DCS) and Assistant Director of Nurses(ADON) on all dependent residents to ensure that all dependent residents are provided Activities of Daily Living (ADL) as needed. All residents have the potential to be affected by this issue. Education conducted on 8/3/23 by Director of Clinical Services (DCS) with Certified Nurse Assistants and Licensed Nurses on this regulation to ensure all dependent residents are provided Activities of Daily Living (ADL) care. Beginning on 8/3/23 Activities of Daily Living (ADL) skills competency check-offs were initiated with CNAs. Beginning on 8/4/23 Quality Monitoring of Activities of Daily Living (ADL) to include nail care, shaving and grooming for 5 dependent residents to be conducted by Director of Clinical Services and Assistant Director of Nurses (ADON) 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then monthly x 3 months. Findings will be reported monthly by the Director of Clinical Services x 6 months to ensure our solution is obtained. On 9/8/23 we will conduct a QAPI to review our findings from Quality Monitoring to ensure our solution is sustained. We will review all findings from our Quality Monitoring on the first Friday of each month, during the QAPI meeting by the QAPI committee in the monthly meeting for 6 months to ensure our solutions are sustained.		

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F 677	Continued From page 32 dark brown substance under each nail. During an observation and interview, on 8/1/23 at 2:45 PM with Licensed Practical Nurse (LPN) #2 confirmed the brown substance under Resident #22's fingernails and that the nails were long and had sharp broken edges. She stated that the resident could scratch herself or someone else. Resident #22 also had a brown substance between all her toes on both feet. LPN #2 stated that it was horrible and obvious the resident had not been getting a good bath. During an interview on 8/1/23 at 3:05 PM, with the Director of Nursing (DON) confirmed that long sharp fingernails could result in skin tears for the resident. She stated if the resident is not diabetic, the Certified Nursing Assistants (CNA's) are responsible for nail care. The nurses are responsible for checking and cutting the nails of diabetic residents weekly. She stated that if the resident had brown stuff caked between her toes she probably didn't get a good bath. She stated that CNAs are responsible for baths and the wound care nurse is also responsible for doing skin checks. She stated that they were doing the best they can. Review of Resident #22's Admission Record revealed an admission date of 5/29/21 with diagnoses that included Cerebral Infarction, Type 2 Diabetes Mellitus, and Alzheimer's Dementia. Review of Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/25/23 revealed Resident #22 did not require a Brief Interview for Mental Status (BIMS) to be conducted because the resident is rarely/never understood. Section G Functional	F 677			

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F 677	Continued From page 33 Status revealed Resident #22 was totally dependent on two (2) staff members for personal hygiene and bathing. Resident #35 An interview, with Resident #35 on 8/1/23 at 8:30 AM revealed that he did not feel like the care was good here and stated that they are slow to come to the room. During an observation on 08/02/23 at 9:40 AM, revealed Resident #35 wearing the same plaid pants and gray shirt that he had on the day before. During an interview on 8/2/23 at 9:41 AM, with CNA #5 revealed she did not know if Resident #35 was supposed to get a bath today. She stated she did not know when he was supposed to get a shower and did not know how to find out that information. Later that day in an interview on 8/2/23 at 2:20 PM with CNA #5 stated that Resident #35 did not get a bath today and it was not charted that he did. During an interview on 8/2/23 at 2:30 PM, with the DON revealed that if something was not charted then it was not done. Record review of the ADL documentation for baths for Resident #35 revealed five (5) days in July 2023 that no bath/shower was documented for the resident. Record review of Section G of the MDS with an ARD of 6/7/2023 revealed Resident #35 required	F 677			

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F 677	Continued From page 34 one-person physical assist for help in part of bathing activity. Section C revealed a BIMS score of five (5) which indicated Resident #35 was severely cognitively impaired. Review of the Admission Record for Resident #35 revealed an admission date of 5/26/2023 with diagnoses that included Weakness and Overactive Bladder. Resident #44 During an interview and observation on 07/31/23 at 11:35 AM with Resident #44 revealed the resident had gray facial hair that was approximately 1 inch long with 1-inch-long gray hair coming out of his ears and the resident revealed he would like to be shaved. In an interview and observation on 8/1/23 at 1:13 PM, with CNA #1 confirmed that Resident #44 needed to be shaved, have a haircut and the hair in his ears needed to be trimmed. Resident #44 stated he wanted to be shaved, have a haircut, and trim his ear hairs. CNA #1 revealed shaving should be included in the resident's showers or baths and for some reason the other aides wait for her to do it, so he only gets it done when he is assigned to her. During an interview with the DON and the Assistant Director of Nurses (ADON) on 8/2/23 at 1:30 PM, confirmed that shaving is a part of bathing and if the resident needs and wants to be shaved then the staff should take care of that during the resident's bath. Record review of Resident #44's "Admission Record" revealed the resident was admitted to	F 677			

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F 677	Continued From page 35 the facility on 10/07/2020 with medical diagnoses that included Unspecified Intellectual Disabilities, Unspecified Dementia and Blindness-right eye category 4 and left eye category 2. Record review of Resident #44's MDS with an ARD of 6/23/23 revealed under Section C a BIMS score of 12, which indicated the resident is cognitively intact and under Section G that the resident needed physical help with bathing. Resident #38 An observation on 07/31/23 at 12:02 PM, of Resident #38 revealed long nails, with a thick brown substance underneath. An observation on 8/01/23 at 12:53 PM, of Resident # 38 revealed she was sitting in a wheelchair in her room and nails were observed to be long with a dark brown substance underneath. An observation and interview on 8/01/23 at 1:00 PM, with CNA # 6 confirmed that Resident #38's nails were long and dirty. She revealed the CNA's do not cut or clean the residents' nails and revealed that it was the responsibility of the wound nurse. An observation and interview on 8/01/23 at 1:04 PM, with RN # 1 confirmed that Resident #38's nails were long and dirty. She revealed that it was the Wound Nurse's job to clean and cut the residents' nails and confirmed that Resident #38 could scratch herself and cause skin issues and stated, "It's infection control." An observation and interview on 8/01/23 at 1:30	F 677			

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F 677	Continued From page 36 PM, with the DON confirmed that Resident #38's nails were dirty and needed trimming. She revealed that the aides were responsible for cleaning the nails as part of their routine daily care with the bathing. She revealed the aides can cut the nails of the residents if the resident was not a diabetic. She stated, "They know that they should be doing that every day." Record review of the Admission Record for Resident #38 revealed the resident was admitted to the facility on 11/30/21 with medical diagnoses that included Cerebral Infarction, Dysphasia, Essential (Primary) Hypertension, and Pseudobulbar Affect. Record review of the MDS with an ARD of 6/19/23 revealed under section C a BIMS score of 10, indicating Resident #38 is moderately cognitively impaired. Resident #49 During an interview with Resident #49 on 7/31/23 at 11:15 AM, revealed she had not been getting her bath as scheduled on Monday, Wednesday, and Friday. She revealed that her last bed bath was given last Monday (7/24/23). An interview on 8/01/23 at 3:42 PM, with LPN # 2 revealed Resident # 49 did refuse some baths. She stated, "She likes certain people to give her baths and if they're not here, she will refuse." In an interview on 08/01/23 at 11:16 AM, with Resident #49 revealed that she requested her bathing schedule to be on Monday, Wednesday, and Friday only. The resident stated, "If I refuse, it is because I only want a bath on those days."	F 677			

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F 677	Continued From page 37 During an interview on 8/02/23 at 2:17 PM, with LPN # 1 revealed the facility had a bath schedule at the nurse's desk that the aides were supposed to follow. Record review of the ADLs for the month of May 2023 revealed there was not any documentation for the bathing task for Monday 5/22/23. Documentation revealed under Monday, 5/29/23, "3 - Not Applicable" for the bathing task. Record review of the ADLs for the month of June 2023 revealed there was not any documentation for the bathing task for Monday 6/5/23. Documentation revealed under, Friday, 6/02/23, Monday, 6/19/23, Wednesday, 6/21/23 and Monday 6/26/23, "3 - Not Applicable" for the bathing task. Record Review of ADLs for the month of July 2023 revealed there was not any documentation for the bathing task for Friday 7/14/23, Monday 7/24/23 and Wednesday 7/26/23. Documentation revealed under, Monday 7/3/23, "3 - Not Applicable" for the bathing task. An interview with the DON on 8/02/23 2:25 PM, confirmed that Resident # 49's bathing task revealed missing documentation supporting that resident was given a bath. She stated, "I really couldn't say if she had taken a bath those days." She revealed that the aides sometimes leave after their shift without documenting. She confirmed that if the task was not documented, then it was not done. Record review of the Admission Record for Resident #49 revealed she was admitted to the	F 677			

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F 677	Continued From page 38 facility on 01/23/23 with medical diagnoses that included Rheumatoid Arthritis, Repeated Falls, Chronic Pain Syndrome and Need for Assistance with Personal Care. Record review of the MDS with an ARD of 04/28/23 revealed under section G that Resident #49 requires two-person physical assist with personal hygiene The MDS revealed under section C a BIMS score of 14, which indicated Resident #49 is cognitively intact.	F 677			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, record review and facility policy review the facility failed to apply a splint to a resident as ordered for one (1) of 16 residents reviewed with contractures.	F 688	Root Cause Analysis was conducted by the Quality Assurance Performance Improvement (QAPI) Committee on 8/10/23 and based on findings, the	9/14/23	

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F 688	Continued From page 39 Resident #29 Findings include: Review of the facility policy titled "Contractures, Prevention" with a revision date of 08/22/2017 revealed under, "Policy: To prevent contracture of extremities for those residents who no longer have full use of their extremities. Procedure:... Some residents may have braces or splints to prevent or help release contractures - be sure to follow the physician's order regarding the schedule of when to put these on and when to remove them..." An observation of Resident #29 on 07/31/23 at 12:25 PM, revealed she was lying in bed, unable to arouse to verbal stimuli and a hand splint was located on a table beside the bed. During an observation of Resident # 29 on 8/01/23 at 9:45 AM, revealed she was lying in bed with her eyes closed and a hand splint located on the table beside the bed. An interview with the Occupation Therapist (OT) on 8/1/23 at 1:15 PM, revealed that Resident #29 was recently discontinued from therapy services and had a physician's order to wear a left-hand splint during the daytime hours. An interview and observation with Registered Nurse (RN) # 1 on 8/1/23 at 1:20 PM, revealed Resident #29 had a physician order to wear left hand splint for 6-8 (six-eight) hours during the daytime hours. She revealed the aides were responsible for applying the splint when they got her up and removed it when she went to bed. She confirmed that Resident # 29 did not have the	F 688	facility failed to apply a splint to resident # 29 as ordered. On 8/1/23, splint was applied on resident # 29 left hand by treatment nurse. On 8/1/23 a Quality Review of all residents was conducted by the Director of Clinical Services for resident requiring splint use. All residents at risk for contractures have the potential to be affected by this issue. Education initiated on 8/3/23 by Director of Clinical Services (DCS) applying splints as ordered by physician with Wound Nurse, licensed nurses, and Certified Nurse Assistance. Newly hired staff will be educated by Director of Clinical Services on the procedures and policies that govern splinting on residents with contractures. Beginning on 8/4/23 Quality Monitoring of 3 residents with physician orders for splinting to be conducted by Director of Clinical Services and or Therapy Services 3x/weekly x 4 weeks, 2x/weekly x 4 weeks, then monthly x 6 months. Findings will be reported monthly x 6 months by Director of Clinical Services to Quality Assurance Performance Improvement (QAPI) Committee to ensure a solution is obtained. On 9/8/23 we will conduct a QAPI to review our findings from Quality Monitoring to ensure our solution is sustained. We will review all findings from our Quality Monitoring on the first Friday of each month, during the QAPI meeting by the QAPI committee in the monthly		

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F 688	Continued From page 40 left-hand splint on and stated, "Maybe the aide didn't know." She revealed that Resident #29 could develop a worsening contracture by not wearing the splint. During an observation and interview with the Director of Nursing (DON) on 8/01/23 at 1:30 PM, confirmed that Resident #29 was not wearing the left-hand splint. She revealed that the Therapy Dept just discontinued the resident from therapy services and wrote the physician's order for the splint on 7/29/23. She revealed that the splint shows up on the Treatment Administration Record (TAR) for the Wound Nurse to apply. The DON revealed she was not sure why the Wound Nurse had not applied it and confirmed that Resident # 29 could develop a worsening contracture by not wearing it as ordered. An interview with the Wound Nurse on 8/03/23 at 9:40 AM, revealed she did not apply the splint to Resident #29's left hand on 7/31/23 and 8/01/23. She revealed it was brought to her attention by the Director of Nursing on 8/01/23, and it was applied later in the day. She confirmed that Resident #29 could develop worsening contractures by not wearing. Record review of Resident #29's Order Summary Report revealed an order dated 07/28/23, "Patient to wear left hand soft, comfy hand splint for 6-8 hours during the daytime shifts in order to prevent left digits contractures due to signs and symptoms of keeping fingers in flexed position. Make sure Velcro straps are not too tight and can place two fingers width underneath straps. Please notify OT (Occupational Therapy) of any skin integrity issues..."	F 688	meeting for 6 months to ensure our solutions are sustained.		

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F 688	Continued From page 41 Record review of Resident #29's Treatment Administration Record (TAR) revealed there was not any documentation under 7/31/23 for applying the left-hand splint at 0900. Record review of the Admission Record revealed Resident #29 was admitted to the facility on 10/05/22 with medical diagnoses that included Sequelae of Cerebral Infarction, Pseudobulbar Affect, Major Depressive Disorder, Seizures, and Essential (Primary) Hypertension. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/07/23 revealed under section G that Resident #29 has a functional limitation in range of motion impairment to the upper extremity on one side. Section C revealed a Brief Interview for Mental Status (BIMS) score of 10, indicating Resident # 29 is moderately cognitively impaired.	F 688			
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. 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, interview, record review, and facility policy review, the facility failed to post oxygen in use signage on the door for two (2) of 11 residents receiving respiratory care. Resident	F 695	Root Cause Analysis conducted on 8/10/23 by Quality Assurance Performance Improvement (QAPI) Committee and based on findings, facility	9/14/23	

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F 695	Continued From page 42 #23 and Resident #106 Findings include: Record review of the facility policy titled, "Oxygen Safety" with a revision date of 1/25/2018 revealed, "Policy: All personnel shall utilize oxygen in accordance with state and federal regulations. Procedure: ...D ...2 ...Oxygen in Use signs shall be placed on the doors of rooms where oxygen is in use ..." Resident #23 During an observation on 07/31/23 at 12:11 PM, revealed Resident #23 had a an oxygen concentrator in the room and there was no signage on the door indicating oxygen was in the room. During an observation on 8/1/23 at 9:00 AM revealed the oxygen concentrator had been removed from the resident's room. On 8/2/23 at 8:30 AM, in an interview with the Director of Nursing (DON) revealed that someone must have taken the oxygen out of the room and there should have been a sign on the door. She stated that most of the time if oxygen is ordered as needed they do not keep it in the room. If the resident gets short of breath they bring a concentrator from the supply closet. Record review of the Order Summary Report revealed a physician order for Resident #23 dated 7/20/23 revealed Oxygen as needed (PRN) 2 liters (L) as needed for shortness of breath. Record review of the Admission Record for	F 695	failed to post oxygen in use signage on the door of resident #23 and resident # 106. On 8/1/23 all residents requiring Oxygen were assessed for necessary signage and date by Director of Clinical Services and Assistant Director of Clinical Services. Oxygen Signage placed on resident #106 door, oxygen concentrator removed from resident # 23 room on 8/1/23. All residents requiring the use of oxygen have the potential to be affected by this issue. Education initiated on 8/3/23 by Director of Clinical Services and Assistant Director of Clinical Services on placing oxygen signage on door of residents receiving oxygen with Licensed Nurses. New hired Licensed Nurses will be educated by Director of Clinical Services and/or Assistant Director of Clinical Services during orientation. Beginning on 8/1/23 Quality monitoring of 4 residents with oxygen to be conducted by the Director of Clinical Services and/or Infection Preventionist 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, the monthly x 6 months. Finding will be to be reported to Quality Assurance Performance Improvement (QAPI) monthly x 6 months by Director of Clinical Services to ensure solution is obtained. On 9/8/23 we will conduct a QAPI to review our findings from Quality Monitoring to ensure our solution is sustained. We will review all findings from		

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F 695	Continued From page 43 Resident #23 revealed an admission date of 3/17/23 with diagnoses that included Unspecified Dementia, Heart Failure, and Cerebral Infarction. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/20/23 revealed Resident #23 was severely cognitively impaired and never/rarely made decisions. Resident #106 During an observation on 07/31/23 at 12:04 PM, revealed Resident #106 had an oxygen concentrator in the room and there was no signage on the door indicating oxygen was in use. During an interview on 8/1/23 at 3:15 PM with the DON confirmed that there should be oxygen signs on every door for residents receiving oxygen. Record review of the Order Summary Report for Resident # 106 revealed a physician order dated 6/30/23 "Oxygen a 2 l/min (liters/minute) via NC (nasal cannula) As Needed PRN... for sob (shortness of breath)". Record review of the Admission Record for Resident #106 revealed an admission date of 11/25/2022 with diagnoses that included Chronic Obstructive Pulmonary Disease and Bronchitis. Review of the MDS with an ARD of 6/28/2023 revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated Resident #106 was cognitively intact.	F 695	our Quality Monitoring on the first Friday of each month, during the QAPI meeting by the QAPI committee in the monthly meeting for 6 months to ensure our solutions are sustained.		
F 725 SS=E	Sufficient Nursing Staff	F 725		9/14/23	

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F 725	Continued From page 44 CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review the facility failed to provide sufficient staff to provide the care needed to the individual residents for two (2) of four (4) days of survey. Findings Include:	F 725	Root Cause Analysis was conducted on 8/10/23 by the Quality Assurance Performance Improvement (QAPI) Committee. Based on findings, the facility failed to provide sufficient staff to provide the care needed for resident # 46 and resident # 36, resident # 49, and resident # 52. On 8/1/23 Resident #49 was		

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F 725	Continued From page 45 Review of the typed statement on facility letterhead dated August 2, 2023, and signed by the Administrator revealed, " ... (Proper Name of Facility) does not have a policy on staffing. Facility Staffing is based off of the acuity of the residents as described in the Facility Assessment." Review of the typed statement on facility letterhead revealed the facility does not have a policy on answering of call lights and was signed by the Administrator. Resident #46 An observation and interview on 07/31/23 at 11:05 AM with Resident #46 revealed a strong urine odor in the room. The resident revealed he needs someone to come empty his urinal, but he cannot reach his call light. This observation revealed the resident's call light was laying in the floor behind his bed and his urinal was full of urine. He stated they never come when you need them. An observation and interview on 7/31/23 at 11:30 AM revealed Resident #46's urinal was still full of urine and his call light was within reach. The resident revealed the staff came in and turned his call light off but did not empty the urinal. Record review of Resident #46's Admission Record revealed he was admitted to the facility on 6/25/21 with medical diagnoses that included Cerebral Infarction and Need for Assistance with Personal Care. Record review of Resident #46's Minimum Data Set (MDS) with an Assessment Reference Date	F 725	offered a bath by Certified Nursing Assistant (CNA) and refused, Resident #36 was gotten up by Certified Nursing Assistant (CNA) at 10 am on 7/31/23, Resident #46 urinal was emptied at 11:45 am by Certified Nursing Assistant (CNA), Resident # 52 received ADL care on 8/1/23 by Certified Nursing Assistant (CNA). On 8/10/23, Executive Director(ED) and Director of Clinical Services(DCS) conducted a Quality Review of facility process to determine education needed. All residents have the potential to be affected by this alleged deficient practice. On 8/3/23 education was initiated by Regional Director of Clinical Services to provide education to Director of Clinical Services and Executive Director to ensure staffing is adequate to provide necessary care for resident needs. Beginning 9/14/23 facility to have CNA class monthly to ensure adequate staffing levels. Beginning on 8/3/23 any Nurse opening will be filled by hiring new nurses to the facility. On Call Nurses/CNAs will be available to fill call ins as needed. Beginning on 8/7/23, the Director of Clinical Services and Executive Director will conduct quality improvement monitoring of staffing levels for the facility daily x 4 weeks, 3x/weekly x 4 weeks, then weekly x 3 months. Findings will be reported to Quality Assurance monthly x 6 months by Director of Clinical Services and/or Executive Director to ensure		

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F 725	Continued From page 46 (ARD) of 6/27/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact and in Section G that the resident needed extensive assistance with ADL's. An interview on 7/31/23 at 11:15 AM, with Certified Nurse Assistant (CNA) #1 revealed they are always short staffed, and three (3) CNAs called in today. She stated, she had been asking for help all morning and no one would come help, but as soon as the State Agency walked in everyone came out of their offices and started helping. She revealed that Resident #36 had been on his call light ever since she got here at AM, because he wanted to get up and 11 PM-7 AM shift is supposed to get him up, but they did not probably because they were shorthanded. She stated that she explained to the resident that she had to pass breakfast trays and had some resident's she needed to get up for therapy and he understood. She revealed that the Director of Nurses (DON) walked past Resident #36's room with the call light on and told me that resident needed me, and I told her I knew that but had not had a chance to get to him and she kept on walking. She stated they have 3 CNAs on duty with 58 residents in the building. She stated that she has 20 residents assigned to her, ten (10) must be gotten up for therapy and about 20-25 are supposed to get baths today. She stated she has several that must be turned and have incontinent care and it is hard to do those rounds every two (2) hours since she is alone. She revealed she is asked to work overtime a lot and usually volunteers to do so and works six (6) days a week normally. She stated that the facility just does not have enough help.	F 725	solution is obtained. On 9/8/23 we will conduct a QAPI to review our findings from Quality Monitoring to ensure our solution is sustained. We will review all findings from our Quality Monitoring on the first Friday of each month, during the QAPI meeting by the QAPI committee in the monthly meeting for 6 months to ensure our solutions are sustained.		

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F 725	Continued From page 47 An interview on 8/1/23 at 3:30 PM, with the Activities Director confirmed she is working the South Hall this afternoon because they only have one aid. She stated that staffing is an issue because there are a lot of "call ins". She revealed that some things do not get done such as showers because we do not have enough staff. Resident #36 An observation and interview on 07/31/23 at 12:43 PM with Resident #36 revealed that this facility needs staff bad. Resident #36 stated they do not have enough people to take care of us. He revealed he is supposed to get up every morning around 5:00 AM but he rarely does and its usually because they do not have enough staff. He revealed it was 10 AM before a staff member was able to get him up this morning. He stated, I cannot get myself out of bed and don't have use of my left arm. An interview on 8/1/23 at 1:10 PM with CNA #1 confirmed that Resident #36 likes to have his baths early of the morning and likes to stay up after that, so he is scheduled for his bath on the 11 PM-7 AM shift. She revealed about 2-3 times a week that does not happen, and they must do his bath and get him up on the 7 AM-3 PM shift. An interview on 8/3/23 at 8:20 AM with the Director of Nurses (DON) confirmed that Resident #36 has made the request to be got up and bath given on the 11 PM-7 AM shift. She confirmed there are times that he is not able to be gotten up on the 11 PM-7 AM shift and it is usually due to staffing. Record review of Resident #36's MDS with an			F 725			

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F 725	Continued From page 48 ARD of 5/26/23 revealed under Section C a BIMS score of 15, which indicated that the resident was cognitively intact and under Section G that the resident needed extensive assistance for transferring. Resident Council Meeting On 8/1/23 at 2:00 PM, during the Resident Council Meeting, Resident's #9, Resident #14, Resident #21, and Resident #41 revealed that the facility is short staffed a lot. Resident #41 stated that you hear the aides and nurses talking about being short staffed all the time. Resident #14 revealed it takes the staff a long time to answer the call light, that she has had to wait an hour before for them to answer the call lights. Resident #28 revealed he has had to wait 2 hours before for the staff to answer the call light. Record review of Resident #9's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/4/23 revealed under Section C a Brief Interview for Mental Status score of 13, which indicated the resident is cognitively intact. Record review of Resident #14' MDS with and ARD of 7/11/23 revealed under Section C a BIMS score of 14, which indicated that the resident is cognitively intact. Record review of Resident #21's MDS with an ARD of 6/14/23 revealed under Section C a BIMS score of 15, which indicated the resident is cognitively intact. Record review of Resident #28's MDS with an ARD of 4/25/23 revealed under Section C a BIMS score of 13, which indicated the resident is	F 725			

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F 725	Continued From page 49 cognitively intact. Record review of Resident #41's MDS with an ARD of 5/22/23 revealed under Section C a BIMS score of 15, which indicated the resident is cognitively intact. Resident #49 On 07/31/23 at 11:15 AM, in an interview with Resident # 49 , revealed she had not been getting her bath as scheduled on Monday, Wednesday, and Friday. She revealed her last bed bath was given last Monday. She revealed she was told last Wednesday and Thursday that there was not enough staff to do it, and on Friday she was told the facility ran out of towels and wash cloths. The resident revealed, at one point, therapy was helping complete her baths due to the shortage of staff. She revealed call ins were the main concern with staffing. On 8/01/23 at 2:25 PM, an interview with the DON , confirmed that Resident # 49's bathing task revealed missing documentation supporting that resident was not given a bath. She stated, "I really couldn't say whether she had a bath those days or not." She revealed that the aides sometimes leave after their shift without documenting. She stated, "It goes back to the staffing issue; When we have two or three aides on the floor, it's hard to find the time to document." She confirmed that if it's not documented, then it's no way to prove the bath was done. Record review of the MDS with an ARD of 04/28/23 revealed under section C a BIMS score of 14, which indicated Resident #49 was	F 725			

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F 725	Continued From page 50 cognitively intact. Resident #52 An observation on 7/31/23 at 11:10 AM of Resident #52's room revealed his room smelled strong of urine. An interview and observation on 08/01/23 at 9:56 AM with Resident #52 revealed that he has prosthetic legs and when he is in bed without his legs on and uses his urinal, he calls for them to come empty it and the resident revealed that the staff sometimes takes 2-3 hours to come, or they will come and turn his light off and never empty the urinal. An interview on 8/1/23 at 1:53 PM, with Resident #52 revealed he must use his call light to have staff come clean him up when he uses the bathroom, and it usually takes them a long time to get to him especially on the night shift. He revealed if they don't show up in time then he tries to clean himself. He stated that the staff now know they would be better off to come clean me themselves because I make a mess. He stated, "I just wish they would answer my call light quicker instead of going to take care of someone else while I've been waiting 30-45 minutes". Record review of Resident #52's MDS with an ARD of 5/23/23 revealed in Section C a BIMS score of 14, which indicates the resident is cognitively intact and under Section G that the resident needed extensive assistance for toileting, personal hygiene, and bathing. An interview and review of the staffing grid for the last 14 days with the DON and the Assistant	F 725			

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F 725	Continued From page 51 Director of Nurses (ADON) on 8/2/23 at 2:15 PM, revealed staffing is an issue. They both admitted that they have plenty of staff but have a lot of trouble with "call ins". The ADON revealed they had 5 CNA's and 1 LPN call in on Monday 7/31/23, 5 CNAs called in on Tuesday, and 2 CNAs called in this morning. The DON stated they just do not know what to do to make people come to work. When reviewing the staffing grid for the past 14 days, it was documented that they had 4 CNAs on duty 7 AM-3 PM on 7/31/23. When the State Agent ask about the documented 4 CNA's because there were only 3 on duty when we entered the building at 11:00 AM on 7/31/23 the ADON admitted that 2 CNAs had called in for the 7 AM-3 PM shift Monday and CNA #7 went to work the floor after their morning meeting. When the SA asked what time the morning meeting was over, she revealed it ended around 10:30 AM, When the SA ask what time the majority of baths were completed, both the DON and ADON admitted they would be done between 7 AM-11 AM. The ADON stated that she thought 2 CNAs were coming in late and they usually are here by 9 AM, so she assumed they had already come in and no one told her any different.. Review of the facilities list of CNA'S revealed the facility had 24 CNAs with five (5) being full time and 19 being "As Needed" (PRN). The ADON stated that she admits there are things that don't get done due to not having enough staff such as baths. The DON agreed with the ADON and stated, we just try to do what's needed the most with the staff we have. An interview and review of the Facility Assessment with the Administrator on 8/2/23 at 11:15 AM, revealed on page 8 under "Staffing Plan 3.2. Based on your resident population and their needs for care and support, describe your	F 725			

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F 725	Continued From page 52 general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time and in the staff, graph revealed that the facility needed 8 LPN's, 14-15 CNAs, and 3 other nursing personnel". During this interview the Administrator revealed that the graph information under "Staffing Plan" in the Facility Assessment that showed the facility needed eight (8) LPN's and 14-15 CNA's and 3 other nursing personnel was for a 24-hour period. Record review of the Staffing Grid for the past 14 days with the DON and the ADON revealed there were two days where the facility failed to provide sufficient staff to meet the needs of the residents. An interview on 8/2/23 at 1:45 PM, with the Administrator confirmed that the facility has issues with staffing especially CNA's. He revealed he is not sure how to make these people come to work but agreed it is not the resident's fault and they were needed for resident care. An interview with the DON on 8/01/23 at 2:50 PM, confirmed that the facility had been struggling with staffing issues for a while. She stated, "Especially the CNA's." She revealed yesterday (7/31/23) they had 3 aides for the entire building with a census of 58, making each aide responsible for 19 or 20 residents. She revealed that they had 5 aides on the schedule and one aide called in and one aide called and said she would be late, but never showed. She revealed the nurses from the office usually come out to help when the aides are short but confirmed that the office staff failed to come out and help yesterday with only three aides. She stated, "We should have been helping."	F 725			

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F 880 F 880 SS=D	Continued From page 53 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880 F 880		9/14/23	

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F 880	Continued From page 54 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and record review, the facility failed to store oxygen tubing in a bag to prevent the possibility of contamination and infection for two (2) of 12 resident receiving respiratory treatments. Resident #23 and Resident #106. Findings include:	F 880	Root Cause Analysis conducted on 8/10/23 by the Quality Assurance Performance Improvement (QAPI) Committee and based on findings, the facility failed to store oxygen tubing in a bag to prevent the possibility of contamination and infection for resident # 23 and resident # 106 who received respiratory treatments. On 8/1/23,		

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F 880	Continued From page 55 An observation, on 07/31/23 at 12:11 PM revealed Resident #23's oxygen cannula not bagged hanging on the front of the concentrator. An interview on 8/2/23 at 8:30 AM with the Director of Nursing (DON) revealed that someone must have taken the oxygen out of the room, but the cannula should have been stored in a bag. Record review of the Order Summary Report revealed a physician order for Resident #23 dated 7/20/23 revealed Oxygen as needed (PRN) 2 liters (L) as needed for shortness of breath. Record review of the Admission Record for Resident #23 revealed an admission date of 3/17/23 with diagnoses that included Unspecified Dementia, Heart Failure, and Cerebral Infarction. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/20/23 revealed Resident #23 was severely cognitively impaired and never/rarely made decisions. Resident #106 An observation and interview, on 07/31/23 at 12:04 PM revealed Resident #106's oxygen cannula hanging on the concentrator not in a bag. Resident #106 stated that she did not know it was supposed to be in bag. An observation and interview, on 8/1/23 at 2:30 PM with Licensed Practical Nurse (LPN) #2 confirmed Resident #106's oxygen cannula was laying on the bed not in a bag. She stated that using a dirty cannula could cause a respiratory infection. She stated that the Certified Nursing	F 880	resident # 106 oxygen tubing was stored in a bag to prevent the possibility of contamination and infection by Licensed Practical Nurse. On 8/1/23, resident #23 oxygen concentrator was removed as it was no longer needed by the Licensed Practical Nurse. All residents receiving oxygen therapy have the potential to be affected by this alleged deficient practice. Education initiated on 8/3/23 by Director of Clinical Services with Licensed nurses to ensure oxygen tubing is stored properly. Newly hired Licensed Nurses will be educated on policy and procedures for proper storage of oxygen tubing. Beginning on 8/1/23 the Director of Clinical Services and/or Assistant Director of Clinical Services will conduct quality improvement monitoring 3x/weekly x 4 weeks, then 2x/weekly x 4 weeks, then weekly x 3 months. Findings will be reported to Quality Assurance Performance Improvement (QAPI) monthly x 6 months by Director of Clinical Services and/or Assistant Director of Clinical Services to ensure compliance is obtained. On 9/8/23 we will conduct a QAPI to review our findings from Quality Monitoring to ensure our solution is sustained. We will review all findings from our Quality Monitoring on the first Friday of each month, during the QAPI meeting by the QAPI committee in the monthly meeting for 6 months to ensure our solutions are sustained.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/03/2023
NAME OF PROVIDER OR SUPPLIER HILLTOP MANOR HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 KIRKLAND STREET UNION, MS 39365		
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F 880	Continued From page 56 Assistants (CNA) and the nurses were responsible for making sure and educating the resident to place the cannula in a bag when not in use. Record review of the Order Summary Report for Resident # 106 revealed a physician order dated 6/30/23, "Oxygen a 2 l/min (liters/minute) via NC (nasal cannula) As Needed... for sob (shortness of breath)". Record review of the Admission Record for Resident #106 revealed an admission date of 11/25/2022 with diagnoses that included Chronic Obstructive Pulmonary Disease and Bronchitis. Review of the MDS with an ARD of 6/28/2023 revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated Resident #106 was cognitively intact. An interview on 8/1/23 at 3:15 PM with the DON confirmed that oxygen tubing should be stored in a bag to prevent contamination and infection. She stated that all staff are responsible for noticing if the tubing is not in a bag when not in use.	F 880			
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and facility policy review the facility failed to maintain an effective pest control program to prevent flying insects for four (4) of	F 925	Root Cause Analysis conducted on 8/1/23 by the Executive Director and based on findings, the facility failed to keep the facility free on pests. Ecolab	9/14/23	

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F 925	Continued From page 57 four (4) survey days. Findings Included: Record review of the facility policy titled "Pest Control" with an effective date of 11/30/2014 revealed under, "Policy: The facility will maintain a pest control program, which includes inspection, reporting, and prevention." Also revealed under, "Procedure: ... 3. Treatment will be rendered as required to control insects and vermin. 4. Any unusual occurrence or sighting of insects should be reported immediately to the Supervisor (See policy- Maintenance Repair Request Form). Proper action will be taken..." An observation on 7/31/23 at 11:15 AM, of the main dining room during the lunch meal revealed seven residents eating their meal with five to six flies flying over and landing on the tables and trays. Residents observed swatting at flies with their hands while trying to eat. An observation on 7/31/23 at 11:20 AM, revealed a fly over the uncovered cornbread on the steam table. Dietary staff was alerted, and they covered the cornbread. An observation on 07/31/23 at 12:16 PM, revealed Resident #47 lying in bed and was non-verbal. The Survey Agent (SA) observed two flies hovering over the resident and landing on the resident and the bedside table in the room. An observation on 8/01/23 11:01 AM, down the main entry corridor, revealed two to three flies swarming around the front door entry area. During an observation of medication pass on	F 925	Pest Control was called on 8/1/23, Ecolab arrived on 8/3/23 to place an additional fly light in the Dining Room. Ecolab also treated affected areas for Resident #47, Resident #50, and Resident #14 in the facility to control pests, treatment was effective on 8/3/23. All residents in the facility have the potential to be affected by this issue. Beginning on 8/3/23 the Executive Director conducted education with the Dietary Manager and staff on limited use of back door in kitchen, related to primary source of flying insects entry into the facility. On 8/3/23 program to control flying pest outside of the rear area of the kitchen was initiated by Ecolab Pest Control. An air curtain will be placed at the rear exit of kitchen by the Maintenance Director by 9/14/23. Beginning on 8/3/23 the Executive Director(ED) and/or Maintenance Director will conduct quality improvement monitoring of flying insects in the kitchen and 2 resident rooms 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 3 months. Findings will be reported to Quality Assurance Performance Improvement (QAPI) monthly x 6 months by Director of Clinical Services and/or Assistant Director of Clinical Services to ensure compliance is obtained. On 9/8/23 we will conduct a QAPI to review our findings from Quality Monitoring to ensure our solution is sustained. We will review all findings from		

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F 925	Continued From page 58 South Hall on 8/02/23 at 8:02 AM, Survey Agent (SA) observed several flies and gnats flying around the medication cart. An observation on 8/2/23 at 11:00 AM, revealed five (5) flies in the kitchen around the food prep table. An observation of Resident # 50 on 8/02/23 at 2:10 PM, revealed the resident lying in bed with eyes closed and two flies hovering and landing on the resident's side rail and bed linen. An interview with Resident # 14 on 8/02/23 3:45 PM, revealed they have issues in the dining room with numerous flies while they're trying to eat. She revealed she had noticed four to five flies flying around while the residents were trying to eat. An interview with the Administrator (ADM) on 8/3/23 at 8:40 AM, confirmed that the facility had an issue with flies. He revealed that the facility used Eco-Lab for pest control. He revealed that Eco Lab came out to the facility about 2 weeks ago but did not address the flies because at that time, flies were not an issue. He revealed he had one insect light in the kitchen to address the flies. An observation and interview, on 08/03/23 at 09:04 AM, with the Dietary Manager (DM) confirmed flies in the kitchen. She stated that they come in every time someone opens the back door. The DM confirmed six (6) flies on a pipe above the food prep table and others flies around the sink and window. She stated that flies are nasty and carry disease. An interview on 08/03/23 at 10:00 AM, with the	F 925	our Quality Monitoring on the first Friday of each month, during the QAPI meeting by the QAPI committee in the monthly meeting for 6 months to ensure our solutions are sustained.		

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F 925	Continued From page 59 ADM confirmed that he was aware of the fly problem. He stated the kitchen has one insect light and he had thought about a fan for the back door but had not gotten one.	F 925			