STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255341	A. BUILDING _____ B. WING _____	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GULFPORT CARE CENTER	11240 CANAL ROAD GULFPORT, MS 39503

(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 The State Agency (SA) conducted an annual recertification survey and Complaint Investigation (CI MS #23919), at the facility from 1/29/24 through 2/1/24. CI MS #23919 was investigated related to infection control and there were no deficiencies cited related to the complaint. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F561, F567, F585, F623, F625, F725, F758, F761, F812, F851 and F919. The facility was licensed for 90 beds and had a census of 72 at the time of survey.	F 000		
F 561 SS=D	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 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	F 561		3/13/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/19/2024

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F 561	Continued From page 1 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 interviews, record review and facility policy review, the facility failed to ensure the resident rights were honored by not consistently providing residents with their choice of receiving showers for three (3) of (18) residents reviewed for choices. Resident #25, Resident #35, and Resident #60. Findings include: Review of the facility's policy, "Bathing" revised 1/24, revealed, " ...Purpose ...To ensure resident comfort and dignity ...Processes 1. Inquire with the resident concerning bathing preferences (e.g., time of day, type of bathing- shower, bed bath, etc.) 2. Offer the resident choice in their bathing routine ...8. Follow resident preferences as stated ..." Record review of the "Inservice Training" document, dated 11/7/23, 12/5/23, and 1/15/24, revealed the staff were educated by Registered Nurse (RN) #1/Staff Development on giving showers to residents and completing shower documentation. Record review of the "Assignment Sheets" revealed the facility had one Certified Nursing Assistant (CNA) Scheduled for the 200 Hall on	F 561	F 561 * Resident #25, #35 and #60 were offered showers on 2/19/24 by the facility's Assistant Director of Nursing. *all residents have the potential to be affected by this practice. * The facility's nursing staff were in serviced on 2/20/24 and 2/21/24 by the facility's Director of Nursing and Staff Development regarding □Bathing□ and Resident rights. The facility's medical director reviewed the policy □Bathing□ with no recommended changes to the policy on 2/20/24. The facility Quality Assessment and Assurance Committee met on 2/20/24 to review the plan of correction for F tag 561. *Beginning 2/19/24, the facility Director of Nursing will interview residents to ensure they are receiving showers as desired and then cross reference with staff documentation for those days. This will occur 3 times weekly for 4 weeks then monthly for two months to ensure ongoing compliance with F tag 561 and will report to the Quality Assessment and Assurance Committee for three months. The first Quality Assessment and Assurance Committee meeting will be held on	

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F 561	Continued From page 2	F 561		

night shift which housed approximately 27 Residents on 1/1/24, 1/5/24, 1/6/24, 1/7/24, 1/11/24, 1/22/24, 1/24/24, 1/26/24, 1/27/24, 1/28/24 and 1/31/24.

Record review of the weekly "Shower Sheets" for the night shift for January 2024 revealed: The week of 1/1/24 through 1/6/24 there were no documented showers on Monday, Tuesday, Wednesday, or Thursday on the shower list. The week of 1/15 through 1/20/24 revealed no documented showers on Wednesday. The week of 1/22/24 through 1/27/24 revealed there were no documented showers for Monday, Tuesday, Wednesday, or Friday. The week of 1/29 to 1/31/24 there was no documentation of showers given for Tuesday or Wednesday.

Resident #25

During an interview on 01/29/24 at 10:52 AM, Resident #25 complained that he does not get a shower. He explained that he was scheduled to receive a shower on the evening shift, but the facility did not have enough staff to provide showers on evenings and weekends.

Record review of the "Completed Care Details", dated 1/1/24 through 1/31/23 revealed Resident #25 did not receive a shower on 1/1/24, 1/3/24, 1/8/24 and 1/12/24.

A record review of the "Face Sheet" revealed the facility admitted Resident #25 on 1/16/21 and he had current diagnoses including Chronic Obstructive Pulmonary Disease and Overactive Bladder.

A record review of the Quarterly Minimum Data

3/12/24.

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F 561	Continued From page 3	F 561		

Set (MDS) with an Assessment Reference Date (ARD) of 11/19/23 revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact.

Resident #35

During an interview on 01/29/24 at 11:00 AM, with Resident # 35, he revealed the facility had only one CNA on his hall on weekends and evenings, and the CNA does not give him showers. The resident said the staff are documenting that he is receiving his showers, but they are not giving them.

Record review of the "Completed Care Details" revealed Resident #35 did not receive a shower on 1/03/24, 1/08/24, 1/22/24 and 1/26/24.

A record review of the "Face Sheet" revealed the facility admitted Resident #35 on 1/25/23 and he had current diagnoses including Chronic Kidney Disease Stage 3, Atrial Fibrillation, and a need for assistance with personal care.

A record review of the Quarterly MDS with an ARD of 12/05/23 revealed Resident #35 had a BIMS score of 15, which indicated he was cognitively intact.

Resident #60

During an interview on 01/29/24 at 10:55 AM, with Resident # 60 revealed the facility does not have enough staff on the weekends and evenings to provide showers.

Record review of the "Completed Care Details" revealed Resident #60 did not receive a shower

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F 561	Continued From page 4	F 561		

on 1/3/24, 1/8/24, 1/17/24, 1/22/24, 1/26/24 and 1/31/24.

A record review of the "Face Sheet" revealed the facility admitted Resident #60 on 9/16/21 and had current diagnoses including Hypertension, Diabetes Mellitus, and Vitamin D Deficiency.

A record review of the Quarterly MDS with an ARD of 1/12/24 revealed Resident #60 had a BIMS score of 14, which indicated she was cognitively intact.

During a phone interview on 2/1/24 at 1:36 PM, with CNA #4, she confirmed she worked the 200 Hall on the 7:00 PM to 7:00 AM (7PM-7AM) shift. CNA #4 explained that she had worked on the hall for several days without any other staff assistance. CNA #4 confirmed she was unable to give the residents showers because several of the residents required two (2) staff members to transfer them or to use the mechanical lifts and she could not do it without help.

During a phone interview on 2/1/24 at 1:48 PM, with CNA #5, she confirmed she worked on the 200 Halls on the 7PM -7AM shift. CNA #5 confirmed she gave the residents bed baths because she could not provide showers to the residents without assistance from another staff member. CNA #5 said most of the residents on the hall used mechanical lifts to be transferred and she could not complete transfers without help.

During a phone interview 2/1/24 at 2:00 PM, with CNA #6, she confirmed she worked the 7PM - 7AM shift on the 200 Hall. CNA #6 explained that she was unable to provide showers for the

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F 561	Continued From page 5	F 561		

residents because they required two (2) to three (3) people to assist due to having to use mechanical lifts. CNA #6 said she tried to keep the residents as clean and dry as possible and would only give the residents bed baths when she worked the hall alone for their safety. CNA #6 said she had complained to the Director of Nursing (DON) and the Staff Development Nurse and was told that they have try to provide those showers. CNA #6 said she did not want to cause an accident with the residents or lose her certification, so she gave bed baths.

During an interview on 02/01/24 at 2:37 PM, with Registered Nurse (RN) #1, she confirmed the facility failed to document resident showers. RN #1 said she has in-serviced the staff to document and the importance of residents receiving their showers. RN #1 said she notified the DON that the showers were not being documented.

During an interview on 2/1/24 at 2:38 PM, with the DON, she confirmed she knew the staff were not documenting or providing showers to the residents. The DON also confirmed that after the Staff Development Nurse had provided in-services and education to the staff regarding documentation and providing showers, there was nothing else put in place to ensure the residents were getting their showers.

During an interview on 2/1/23 at 3:00 PM, with the Administrator, she confirmed the facility failed to document showers for several nights during the month of January. The Administrator said she expected the staff to provide showers on the days they were scheduled and for staff to ask for assistance to provide care for the residents.

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F 567	Continued From page 6	F 567		
F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)	F 567		3/13/24

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F 567	Continued From page 7 The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy review, the facility failed to ensure residents had access to their personal fund accounts on weekends for nine (9) of 18 sampled residents with the potential of affecting 40 residents with personal funds. (Residents #2, 4, 19, 35, 37, 42, 46, 48, and 55) Findings include: A record review of the facility's policy "General Resident Trust Fund Policies", revised 1/20, revealed " ...Residents have the right to manage their financial affairs ...The law and regulations are intended to assure that residents have access to cash funds within a reasonable period of time..." On 1/29/24 at 11:05 AM, during an interview, Resident #19 complained about not getting personal funds on the weekends. She explained she must plan on requesting money on Friday if she wanted money on the weekend because there was no staff at the facility to distribute funds on the weekend. She stated she could get money on the weekend by the Business Office Manager (BOM). On 1/30/24 at 1:30 PM, during the facility's resident council meeting, all the residents stated they were only able to get money from their personal trust fund accounts Monday through Friday. The residents confirmed if they wanted money for Saturday and Sunday, they would have	F 567	F567 *On 2/6/24, the facility administrator met with resident council committee and informed them of the process to access to personal fund accounts on weekends beginning the weekend of 2/10/24. On 2/23/24, the Facility Administrator informed resident #2,4,19,35,37,42,46,48,and 55 were informed how to access personal funds on weekends. *All residents with personal fund accounts have the potential to be affected by this practice. *On 2/2/24, the facility administrator in serviced the business office staff as well as the facility's weekend supervisor regarding □General Resident Trust Fund Policies.□ The facility's medical director reviewed the policy □General Resident Trust Fund Policies□ with no recommended changes to the policy. The facility Quality Assessment and Assurance Committee met on 2/20/24 to review the plan of correction for F tag 567. *Beginning 2/21/24, the facility Administrator will monitor the □Trust Fund□ program twice weekly for 4 weeks and then monthly for two months to ensure ongoing compliance with F tag 567 and will report to the Quality Assessment and Assurance Committee for three months. The first Quality Assessment and Assurance Committee	

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F 567	Continued From page 8 to get it before Friday at 5:00 PM. On 2/01/24 at 12:10 PM, during an interview with the Administrator, she explained an activity staff member was responsible for handing out personal funds on the weekend, but she had quit last week, and the Administrator had not designated any other staff member to take on that responsibility. She was not aware residents were complaining about not having personal funds available on the weekend and she planned on meeting with the resident counsel later this month and discuss personal funds availability. At 12:25 PM on 2/01/24, during an interview with Activity #1, she explained she had been at the facility for two (2) years, and she or any other activity staff have never had access to residents' personal funds. At 12:35 PM on 2/01/24, during a phone interview with Activity #2, the previous activity staff member for the weekend, she explained she never had access to the residents' personal funds on the weekend and had never been made aware of any information regarding personal funds on the weekend. A record review of the "Trial Balance", dated 2/1/24, revealed Residents #2, #4, #19, #35, #37, #42, #46, #48, and #55 had a personal trust fund account at the facility. Resident #2 A record review of the "Face Sheet" revealed the facility admitted Resident #2 on 08/22/14 with current diagnoses including Cerebral Palsy.	F 567	meeting will be held on 3/12/24.	

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A record review of the Minimum Data Set with an Assessment Reference Date (ARD) of 12/11/23 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact.

Resident #4

A record review of the "Face Sheet" revealed the facility admitted Resident #4 on the 03/10/20 with current diagnoses including Atrial Fibrillation.

A record review of the Quarterly MDS with an ARD of 11/30/23 revealed Resident #4 had a BIMS score of 15, which indicated she was cognitively intact.

Resident #19

A record review of the "Face Sheet" revealed the facility admitted Resident #19 on 04/06/23 with current diagnoses including Chronic Obstructive Pulmonary Disease.

A record review of the Quarterly MDS with an ARD of 01/09/24 revealed Resident #19 had a BIMS score of 15, which indicated she was cognitively intact.

Resident # 35

A record review of the "Face Sheet" revealed the facility admitted Resident #35 on 1/25/23 with current diagnoses of including Chronic Kidney Disease Stage 3 and Atrial Fibrillation.

A record review of the Quarterly MDS with an ARD of 12/05/23 revealed Resident #35 had a BIMS score of 15, which indicated he was

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F 567	Continued From page 10	F 567		

cognitively intact.

Resident #37

A record review of the "Face Sheet" revealed the facility admitted Resident #37 on 11/17/22 with current diagnoses including Encounter for Surgical Aftercare Following Surgery on the Digestive System.

A record review of the Quarterly MDS with an ARD of 11/7/23 revealed Resident #37 had a BIMS score of 15, which indicated she was cognitively intact.

Resident #42

A record review of the "Face Sheet" revealed the facility admitted Resident #42 on 07/20/21 with current diagnoses including Atrial Fibrillation.

A record review of the Quarterly MDS with an ARD of 01/15/24 revealed Resident #42 had a BIMS score of 15, which indicated she was cognitively intact.

Resident #46

A record review of the "Face Sheet" revealed the facility admitted Resident #46 on 09/06/23 with current diagnoses including Periprosthetic Fracture Around Internal Prosthetic Hip Joint.

A record review of the Quarterly MDS with an ARD of 01/05/24 revealed Resident #46 had a BIMS score of 15, which indicated she was cognitively intact.

Resident #48

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F 567	Continued From page 11 A record review of the "Face Sheet" revealed the facility admitted Resident #48 on 02/10/21 with current diagnoses including Chronic Kidney Disease. A record review of the Annual MDS with an ARD of 12/07/23 revealed Resident #48 had a BIMS score of 12, which indicated her cognition was moderately impaired. Resident #55 A record review of the "Face Sheet" revealed the facility admitted Resident #55 on 02/17/23 with current diagnoses including Encephalopathy. A record review of the Quarterly MDS with an ARD of 11/17/23 revealed Resident #55 had a BIMS score of 15, which indicated she was cognitively intact.	F 567		
F 585 SS=E	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	F 585		3/13/24

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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.

§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

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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 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:

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F 585	Continued From page 14 Based on interviews, record review, and facility policy review, the facility failed to provide resolution to grievances related to call lights not being answered and Certified Nursing Assistants (CNAs) turning off the call light and not returning for three (3) of six (6) months of Resident Council grievance logs reviewed. Findings Include: A review of the facility's "Grievances-Residents", revised 10/23, revealed, "...The facility shall make prompt efforts to resolve the grievances...The Administrator and his/her designee will conduct an impartial investigation of the allegations and will discuss the findings and recommendations within five (5) work days of receiving the complaint, with the complainant ... In all grievance cases, the resident and/or legal representative will be informed of the result of the investigation ..." On 01/30/24 at 1:30 PM, an interview with the members of the Resident Council revealed, the residents reported unanimously, that on the night shift, throughout the week, they can wait hours for a response to the call light. The residents stated the night shift CNAs will sometimes come in the room, turn off the call light, tell the resident they will be right back and never return. The Residents stated at other times they may wait for hours before they receive a response to the call light. The residents stated they feel the facility is often short-staffed. Residents in attendance were Resident #2, #4, #19, #35, #37, 42, #46, #48, #55, #57, and #178. On 01/30/24 at 1:44 PM, an interview with the Activities Director (AD) revealed she takes notes	F 585	F585 *On 2/20/24, the facility administrator met with resident council committee and informed them of the Grievance program and process related to filing grievances. *all residents have the potential to be affected by this practice. * The facility's nursing staff were in serviced on 2/20/24 and 2/21/24 by the facility's Director of Nursing and Staff Development regarding grievances. The facility's medical director reviewed the policy □Grievances□ with no recommended changes to the policy on 2/20/24. The facility Quality Assessment and Assurance Committee met on 2/20/24 to review the plan of correction for F tag 585. *Beginning 2/21/24, the facility Administrator will monitor Grievances twice weekly for 4 weeks and then monthly for two months to ensure ongoing compliance with F tag 585 and will report to the Quality Assessment and Assurance Committee for three months. The first Quality Assessment and Assurance Committee meeting will be held on 3/12/24.	

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in the Resident Council meetings. The AD reported she is aware of the repeated grievances regarding the call light response times and lack of response by the night shift. The AD stated when she receives grievance reports from the Resident Council Meeting, she reports the grievances from to the Administrator for follow up.

On 01/31/24 at 11:57 AM, an interview with the Director of Nursing (DON) acknowledged that she was aware of the past grievances related to slow response time to call light, no response time to call light, and staff who answer the call light, turning it off and not returning. The DON stated she recently did an in-service with the staff on answering call lights. The DON acknowledged the biggest complaint she has previously heard from the residents is the call light being answered by the CNA and then turning the light off and not coming back. The DON stated she attributes the call light response issue is due to a lack of staff availability. The DON stated she will continue to in-service the staff and will conduct off hour visits.

On 02/01/24 at 7:30 AM, an interview with the Administrator revealed she acknowledged that she was aware of the past grievances reported at the Resident Council meeting for the months of November 2023, December 2023 and January 2024 related to call lights going unanswered and staff answering and not coming back. The Administrator stated the staff are in-serviced on answering the call light. The Administrator stated that her plan is to make odd hour visits to make sure the call lights are answered, monitor the surveillance video to check for problems, order individual bells as a backup and continue to in-service the staff.

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F 585	Continued From page 16 A record review of six months of Resident Council meeting minutes dated August 2023 through January 2024 revealed that for the months of November 2023, December 2023, and January 2024 the residents repeatedly expressed grievances regarding unanswered call lights and CNAs answering the call light, saying they will be right back and not coming back. There was no documented attempts on the meeting minutes form to resolve the grievances.	F 585		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		3/13/24

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(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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

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F 623	Continued From page 18 C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to include the reason for resident transfers in a manner they could understand in the written notification of transfer provided to the resident and the Resident Representative (RR) for two (2) of two (2) sampled residents reviewed for hospitalization. (Resident #16 and Resident #77)	F 623	F 623 *On 2/19/24, resident #16 was notified of the reason for their discharge to the hospital on 11/20/23 in a manner they could understand. Resident #77 is no longer a resident of Gulfport Care Center. *All residents that are discharged from the facility have the potential to be affected by this practice.	

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F 623	Continued From page 19 Findings include: Review of the facility's policy, "Discharge Transfer and Planning" revised 9/23, revealed, " ...Before a facility transfers or discharges a resident, the facility must ...Notify the resident and the resident's representatives of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand ..." Resident #16 A record review of the "Face Sheet" revealed the facility admitted Resident #16 on 7/20/21 and he had current diagnoses including End Stage Renal Disease. A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/23 revealed Resident #16 was discharged on 11/20/23 to the hospital. A record review of the "Departmental Notes", dated 11/20/23 at 11:33 AM, revealed Resident #16 was sent to a local acute care hospital for shortness of breath. A record review of the written transfer or discharge notification for Resident #16 revealed the facility completed a transfer notification on 11/20/23 and indicated the reason for the transfer as, "We are no longer able to meet your needs in this facility and the transfer is necessary for your welfare ..." The notification did not include the reason for the transfer as shortness of breath. Resident #77	F 623	*On 2/2/24, the facility administrator in serviced the business office related to Discharge transfer and planning. On 2/20/24 and 2/21/24 the facility Director of Nursing and Staff Development insreviced the facility nursing staff on 'Dirscharge transfer and planning.' The facility's medical director reviewed the policy □Discharge transfer and planning□ with no recommended changes to the policy on 2/20/24. The facility Quality Assessment and Assurance Committee met on 2/20/24 to review the plan of correction for F tag 623. *Beginning 2/21/24, the facility Administrator will monitor Discharge Transfer and planning daily 5 days a week for 4 weeks and then monthly for two months to ensure ongoing compliance with F tag 623 and will report to the Quality Assessment and Assurance Committee for three months. The first Quality Assessment and Assurance Committee meeting will be held on 3/12/24.	

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Record review of the "Face Sheet" revealed the facility admitted Resident #77 on 10/30/23 and he had diagnoses including Peripheral Vascular Disease.

Record review of the Discharge MDS with an ARD of 11/06/23 revealed Resident #77 was discharged to the hospital on 11/6/23.

Record review of the "Physician's Telephone Order", 11/06/23 revealed Resident #77 had a Physician's Order to be transferred to the hospital due to abdominal distention.

Record review of a "Departmental Notes" dated 11/6/23 at 5:33 PM revealed "Resident transported to (proper name of local hospital) d/t (due to) abdominal distention ..."

A record review of the written transfer or discharge notification for Resident #16 revealed the facility completed a transfer notification on 11/6/23 and indicated the reason for the transfer as, "We are no longer able to meet your needs in this facility and the transfer is necessary for your welfare ..." The notification did not include the reason for the transfer as abdominal distension.

During an interview on 01/30/24 at 1:44 PM, with the Director of Nursing (DON), she explained that the nurses call the RR to notify them when a resident is transferred to the hospital and the written notifications are sent out by the Administrator.

During an interview on 1/31/24 at 9:00 AM, with the Administrator, she confirmed she was responsible for sending out the transfer notifications to the RR. The Administrator

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F 623	Continued From page 21 confirmed the written notifications indicated that the facility was unable to meet the resident's needs, but did not include the specific reason resident was transferred.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and	F 625	F625	3/13/24

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F 625	Continued From page 22 facility policy review, the facility failed to provide a resident and the Resident Representative (RR) written information at the time of a resident transfer to the hospital regarding bed hold policies for one (1) of two (2) sampled residents reviewed for hospitalization. (Resident #16) Findings Include: Review of the facility's, "Bed Hold Policy" revised 11/23, revealed, ...2. When a resident is transferred to the hospital ...a copy of the completed form (notice) is provided to the resident, specifying the duration of the bed- hold according to the state plan, and the facilities policy regarding bed-hold periods. In case of emergency transfer, notice "at the time of transfer" means that the family or resident representatives are provided with written notification within 24 hours of the transfer. The requirement is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital. The staff member completing the transfer paperwork should complete the location, time, and date section of the form. A copy of the completed form should also be forwarded to the Accounts Manager. The Accounts Manager will contact the Resident Representative and complete the Verification of telephone notice within 24 hours. The Accounts Manager will also mail a copy of the Bed Hold Notice of Upon Transfer/Therapeutic form for signature by the Resident Representative if the Resident Representative is not available to sign on the day they are contacted. A copy of the completed form should be retained in the residents electronic admission packet ..." A record review of the "Departmental Notes",	F 625	*On 2/19/24, resident #16 was given bed hold notice for their discharge to the hospital on 11/20/23. *All residents that are discharged from the facility have the potential to be affected by this practice. *On 2/2/24, the facility administrator in serviced the business office related to Bed hold policy. The facility's medical director reviewed the policy □Bed Hold□ with no recommended changes to the policy on 2/20/24. The facility Quality Assessment and Assurance Committee met on 2/20/24 to review the plan of correction for F tag 626. *Beginning 2/21/24, the facility Administrator will monitor Bed Holds daily 5 days a week for 4 weeks and then monthly for two months to ensure ongoing compliance with F tag 625 and will report to the Quality Assessment and Assurance Committee for three months. The first Quality Assessment and Assurance Committee meeting will be held on 3/12/24.	

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dated 11/20/23 at 11:33 AM, revealed Resident #16 was sent to a local acute care hospital for shortness of breath.

A record review of the written transfer or discharge notification for Resident #16 revealed the facility completed a transfer notification on 11/20/23.

A review of the medical record revealed there was no documentation indicating the resident and RR received written information regarding bed hold policies at the time of the resident's transfer to the hospital on 11/20/23.

A record review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/23 revealed Resident #16 was discharged on 11/20/23 to the hospital.

A record review of the "Face sheet" revealed the facility admitted Resident #16 on 7/20/21 and he had current diagnoses including End Stage Renal Disease.

On 01/30/24 at 1:44 PM, in an interview with the Director of Nursing (DON), she explained the nurses call the families to notify them the resident was transferred to the local hospital. The Bed hold letters are sent out by the Administrator.

On 1/31/24 at 9:00 AM, in an interview with the Administrator, she explained she was responsible for providing the resident and the RR information regarding bed hold. The Administrator confirmed the notification of resident transfers did not address bed hold duration or the reserve bed payment policy.

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F 725	Continued From page 24	F 725		
F 725 SS=F	Sufficient Nursing Staff 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 observation, interviews, record review, and facility policy review, the facility failed to provide sufficient nursing staff resulting in residents not receiving showers and call lights not answered timely for five (5) of 18 sampled residents (Resident #25, #35, #60, #4, #65) and had the potential to affect all 72 residents residing	F 725	F725 *On 2/20/24, resident #25,#35,#60,#4 and #65 were assessed by facility's Assistant Director of Nursing with no adverse findings noted. *All residents have the potential to be affected by this practice.	3/13/24

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F 725	Continued From page 25 in the facility. Findings include: A record review of the facility's "Nursing Services-Staffing" policy, revised 11/17 revealed "1. Staffing - The facility will have sufficient nursing staff twenty-four hours every day to provide nursing and nursing related services to attain or help maintain the highest practicable physical, mental, and psychosocial well-being of each resident...2. The facility will comply with established staffing requirements by the individual state governing agencies ... 6. The facility will actively recruit staff necessary to meet the requirements ..." Record review of the provider's reporting data "Casper Report" revealed the facility triggered excessively low weekend staffing and triggered a one star rating for one quarter dated July 1-September 30, 2023. A record review of the facility's "Facility Assessment", updated 11/06/23 revealed " ... Staffing plan: Staffing plan includes maximizing recruitment and retention of staff consistent with increasing access to higher quality care and supporting caregivers per the President's executive order ... We review our schedule and staffing needs daily based on current census, new admissions, discharges, and any other change in status by our residents. We also ensure that we are meeting at least the minimum requirements set by the State Department of Health ..." The Assessment also included the positions and daily average number for the following: " Licensed Practical Nurse (LPNs) 8, Nurse Aides 12, Registered Nurses (RNs) 2,	F 725	* The facility's Director of Nursing and Staff development were in serviced on 2/20/24 by the facility Administrator related to □Nursing Services-Staffing.□ The facility's medical director reviewed the policy □Nursing Services-Staffing□ with no recommended changes to the policy on 2/20/24. The facility Quality Assessment and Assurance Committee met on 2/20/24 to review the plan of correction for F tag 725. *Beginning 2/19/24, the facility Director of Nursing will ensure scheduled staff are present, if not an on-call rotation is in place to cover the shift if needed; residents will be interviewed to ensure call lights are answered timely and showers are offered. This will occur 3 times weekly for 4 weeks then monthly for two months to ensure ongoing compliance with F tag 725 and will report to the Quality Assessment and Assurance Committee for three months. The first Quality Assessment and Assurance Committee meeting will be held on 3/12/24.	

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other staff needed for behavioral healthcare and services 1..."

This tag is cross referenced to:

F561- Based on interviews, record review and facility policy review, the facility failed to ensure the resident rights were honored by not consistently providing residents with their choice of receiving showers for three (3) of (18) residents reviewed for choices. Resident #25, Resident #35, and Resident #60.

Resident #25
During an interview on 01/29/24 at 10:52 AM, Resident #25 complained that he does not get a shower. He explained that he was scheduled to receive a shower on the evening shift, but the facility did not have enough staff to provide showers on evenings and weekends.

Record review of the "Completed Care Details", dated 1/1/24 through 1/31/23 revealed Resident #25 did not receive a shower on 1/1/24, 1/3/24, 1/8/24 and 1/12/24.

A record review of the "Face Sheet" revealed the facility admitted Resident #25 on 1/16/21 and he had current diagnoses including Chronic Obstructive Pulmonary Disease and Overactive Bladder.

A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/19/23 revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact.

Resident #35

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During an interview on 01/29/24 at 11:00 AM, with Resident # 35, he revealed the facility had only one Certified Nursing Assistant (CNA) on his hall on weekends and evenings, and the CNA does not give him showers. The resident said the staff are documenting that he is receiving his showers, but they are not giving them.

Record review of the "Completed Care Details" revealed Resident #35 did not receive a shower on 1/03/24, 1/08/24, 1/22/24 and 1/26/24.

A record review of the "Face sheet" revealed the facility admitted Resident #35 on 1/25/23 and he had current diagnoses including Chronic Kidney Disease Stage 3, Atrial Fibrillation, and a need for assistance with personal care.

A record review of the Quarterly MDS with an ARD of 12/05/23 revealed Resident #35 had a BIMS score of 15, which indicated he was cognitively intact.

Resident #60
During an interview on 01/29/24 at 10:55 AM with Resident # 60 revealed the facility does not have enough staff on the weekends and evenings to provide showers.

Record review of the "Completed Care Details" revealed Resident #60 did not receive a shower on 1/3/24, 1/8/24, 1/17/24, 1/22/24, 1/26/24 and 1/31/24.

A record review of the "Face Sheet" revealed the facility admitted Resident #60 on 9/16/21 and she had current diagnoses including Hypertension, Diabetes Mellitus, and Vitamin D Deficiency.

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A record review of the Quarterly MDS with an ARD of 1/12/24 revealed Resident #60 had a BIMS score of 14, which indicated she was cognitively intact.

During a phone interview on 2/1/24 at 1:36 PM, with CNA #4, she confirmed she worked the 200 Hall on the 7:00 PM to 7:00 AM (7PM-7AM) shift. CNA #4 explained that she had worked on the hall for several days without any other staff assistance. CNA #4 confirmed she was unable to give the residents showers because several of the residents required two (2) staff members to transfer them or to use the mechanical lifts and she could not do it without help.

During a phone interview on 2/1/24 at 1:48 PM, with CNA #5, she confirmed she worked on the 200 Halls on the 7PM -7AM shift. CNA #5 confirmed she gave the residents bed baths because she could not provide showers to the residents without assistance from another staff member. CNA #5 said most of the residents on the hall used mechanical lifts to be transferred and she could not complete transfers without help.

During a phone interview 2/1/24 at 2:00 PM, with CNA #6, she confirmed she worked the 7PM - 7AM shift on the 200 Hall. CNA #6 explained that she was unable to provide showers for the residents because they required two (2) to three (3) people to assist due to having to use mechanical lifts. CNA #6 said she tried to keep the residents as clean and dry as possible and would only give the residents bed baths when she worked the hall alone for their safety. CNA #6 said she had complained to the Director of Nursing (DON) and the Staff Development Nurse

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and was told that they have try to provide those showers. CNA #6 said she did not want to cause an accident with the residents or lose her certification, so she gave bed baths.

During an interview on 02/01/24 at 2:37 PM, with Registered Nurse (RN) #1, she confirmed the facility failed to document resident showers. RN #1 said she has in-serviced the staff to document and the importance of residents receiving their showers. RN #1 said she notified the DON that the showers were not being documented.

During an interview on 2/1/23 at 3:00 PM, with the Administrator, she confirmed the facility failed to document showers for several nights during the month of January. The Administrator said she expected the staff to provide showers on the days they were scheduled and for staff to ask for assistance to provide care for the residents.

Resident #4

On 01/29/24 at 11:18 AM, during an interview and observation with Resident #4, she complained staffing was low especially on the weekends. She reported the facility used a lot of agency staff and the agency staff did not know the residents. She also complained the nurses gave medications at different times and she had to go find the nurse for her medications. Resident #4 said that staffing being low happened on all shifts.

A record review of the "Face Sheet" revealed the facility admitted Resident #4 on 03/10/20 with current diagnoses including Atrial Fibrillation.

A record review of the Quarterly MDS with an ARD of 11/30/23 revealed Resident #4 had a

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BIMS score of 15, which indicated she was cognitively intact.

Resident #65
On 01/29/24 at 9:58 AM, during an interview with Resident #65, she reported staff would answer call lights and would say they would be right back and not come back for two (2) hours. She stated that this occurred on all shifts.

A record review of the "Face Sheet" revealed the facility admitted Resident #65 on 01/02/24 with current diagnoses including Other Specified Fracture of Right Pubis.

A record review of the Admission MDS with an ARD of 01/09/24 revealed Resident #65 had a BIMS score of 8, which indicated her cognition was moderately impaired.

On 01/30/24 at 1:30 PM, in a Resident Council meeting, the council members revealed that throughout the week on the night shift, they may wait hours for a response to the call light. The residents stated the night shift CNAs would sometimes come in the room, turn off the call light, tell the resident they will be right back, and never return. The residents stated they feel the facility is often short-staffed.

On 01/31/24 at 3:00 PM, during an interview with the Director of Nursing (DON), she explained she has 4 (four) full-time nurses. She explained the facility currently used an agency and contracted nursing staff, but she planned on phasing out the use of the agency. She reported the acuity of residents that were admitted to the facility was much higher than was previously admitted.

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F 725	Continued From page 31 On 01/31/23 at 4:30 PM, during an interview with the Administrator, she explained she expected staffing to meet the requirements and needs of residents.	F 725		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		3/13/24

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F 758	Continued From page 32 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to ensure an as needed (PRN) psychotropic medication was limited to a 14-day duration without clinical rationale documentation for one (1) of five (5) residents reviewed for unnecessary medications. Resident #13 Findings include: A record review of the facility's policy, "Psychotropic Medications", revised 10/22, revealed " ... Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and PRN orders for psychotropic drugs are limited to 14 days. Except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the	F 758	F758 *On 2/19/24, resident #13 was assessed by the facility Assistant Director of Nursing with no adverse findings noted. On 2/6/24, resident #13□s order for Lorazepam was discontinued by the facility Medical Director. *All residents receiving psychotropic medications have the potential to be affected by this practice. * The facility's nursing staff were in serviced on 2/20/24 and 2/21/24 by the facility's Director of Nursing and Staff Development regarding □Psychotropic meds. The facility's medical director reviewed the policy □Psychotropic meds□ with no recommended changes to the policy on 2/20/24. The facility Quality Assessment and Assurance Committee met on 2/20/24 to review the plan of correction for F tag 758. *Beginning 2/21/24, the facility Director of	

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F 758	Continued From page 33 resident's medical record and indicate the duration for the PRN order ..." Record review of the "Face Sheet" revealed the facility admitted Resident #13 on 08/15/17 and she had diagnoses including Anxiety Disorder and Major Depressive Disorder. A record review of the "Physician Orders" for the month of January 2024 revealed Resident #13 had a Physician's Order, dated 9/19/23 for "Lorazepam 2 mg (milligram)/ml (milliliter) oral concentrate: give 0.5 ml sublingual, as needed every 6 hours ..." There was not a stop date or duration of 14 days indicated on the order. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/11/23, Section N, revealed Resident #13 received antipsychotic, antianxiety, and antidepressant medications during the lookback period. A record review of the "Pharmaceutical Consultant Report Psychoactive Gradual Dose Reduction" (GDR), dated 01/15/24 revealed " ... Lorazepam 1 mg Q (every) 6H (hour) PRN (Note: Please provide 14-day stop date.) ..." The document was signed by the facility's Nurse Practitioner (NP) on 01/22/24 and indicated to continue the current use of the medications and deferred to the Psychiatric NP for (GDR) management. On 02/01/24 at 12:35 PM, during an interview with facility's NP, she explained she was aware that PRN psychotropic medications should be limited to a 14-day duration because the pharmacy consultant has advised them of this	F 758	Nursing will monitor the Psychotropic medication orders weekly for 4 weeks and then monthly for two months to ensure ongoing compliance with F tag 758 and will report to the Quality Assessment and Assurance Committee for three months. The first Quality Assessment and Assurance Committee meeting will be held on 3/12/24.	

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F 758	Continued From page 34 requirement. She stated that if a resident was currently followed by behavioral health services, she referred the resident to the Psychiatric NP for a medication review. On 02/01/24 at 12:55 PM, during a phone interview with the Psychiatric NP, she explained she had visited Resident #13 for the first time yesterday (01/31/24) and completed a GDR on the resident's medication and left the paperwork and orders with the facility. She stated she was aware of the 14-day limitation for PRN psychotropic medications. On 02/01/24 at 2:00 PM, during an interview with the Director of Nursing (DON), she explained she was aware of the 14-day duration period for psychotropic medications and Resident #13's PRN order had been overlooked. The DON confirmed Resident #13 had a physician's order for Lorazepam PRN since 09/19/23. At 2:15 PM on 02/01/24, during an interview with the Administrator, she explained she expected all staff, including the NPs, to follow the regulations for psychotropic medications.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		3/13/24

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F 761	Continued From page 35 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to discard insulin vials after the discard date for one (1) of three (3) medication carts reviewed. Findings include: A review of the facility's policy "Medication Storage", revised 11/17 revealed " ... Medication storage shall meet all applicable federal, state, and local guidelines ..." On 01/31/24 at 3:39 PM, during an observation of the Medication Cart on the 100 Hall, and an interview with Licensed Practical Nurse (LPN) #3, observed a vial of Levemir insulin with an opened date of 11/15/23 for Unsampled Resident #12 and a vial of Lantus with an opened date of 11/24/23 for Resident #34. LPN #3 confirmed the "opened" dates for both vials were past 28 days and should have been discarded. She stated that	F 761	F761 *On 1/31/24, facility Director of Nursing and Assistant Director of Nursing audited the facility's three nursing carts for expired medications. All undated or expired medications were discarded and re-ordered via facility pharmacy as needed. *All residents receiving insulin have the potential to be affected by this practice. * The facility's nursing staff were in serviced on 2/20/24 and 2/21/24 by the facility's Director of Nursing and Staff Development regarding □Medication Storage and Destruction of unused, expired or discontinued medications□ The facility's medical director reviewed the policy □Medication Storage and Destruction of unused, expired or discontinued medications□ with no recommended changes to the policy on	

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F 761	Continued From page 36 giving insulin after 28 days could make the insulin less effective. LPN #3 explained that she did not administer either insulin and was unsure who was responsible for checking the insulin on the medication carts. A record review of Levemir medication insert, revised 7/2022, revealed " ... After vials have been opened: Opened Levemir vials can be stored ... at room temperature up ...Throw away all opened Levemir vials after 42 days, even if they still have insulin left in them ..." A record review of "Instructions for Use Lantus", dated 2022, revealed " ... After LANTUS vials have been opened (in-use) Store in-use (opened) LANTUS vials ... at room temperature below 86 degrees F for up to 28 days ... The LANTUS vial you are using should be thrown away after 28 days ..." On 02/01/24 at 1:25 PM, during an interview with the Director of Nursing (DON) and the Administrator, they stated they expected staff to follow all policies on insulin and medication storage. On 02/01/23 at 3:14 PM, during an interview with the DON, she explained the facility did not have a policy on insulin storage, including open or discard dates, but the facility followed the manufactured recommendations.	F 761	2/20/24. The facility Quality Assessment and Assurance Committee met on 2/20/24 to review the plan of correction for F tag 761 *Beginning 2/21/24, the facility Director of Nursing will monitor □Insulin vials□ weekly for 4 weeks and then monthly for two months to ensure ongoing compliance with F tag 761 and will report to the Quality Assessment and Assurance Committee for three months. The first Quality Assessment and Assurance Committee meeting will be held on 3/12/24.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		3/13/24

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	255341	A. BUILDING _____ B. WING _____	02/01/2024

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F 812	Continued From page 37 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review, the facility failed to store food in accordance with professional standards for food service safety related to food items not dated with a use-by-date, food items without an identifying label, and food items opened and exposed for one (1) of three (3) kitchen observations. Findings Include: A review of the facility's policy "Food Storage Labeling", revised 5/18, revealed "POLICY: The facility will ensure the safety and quality of food by following good storage and labeling procedures. Procedure: 1. Labeling a. All foods in the facility will be labeled. Information included on the label: Name of the Food ... Date of storage... 3. Rotations ...b. Foods stored in storage units will be surveyed routinely to identify and discard foods that have passed its manufactured use-by	F 812	F812 *On 1/29/24, all unlabeled / undated food was discarded by the temporary Dietary Manager. *All residents have the potential to be affected by this practice. *The facility's dietary staff were in serviced on 2/20/24 and 2/21/24 by the facility's administrator related to □Food Storage Labeling.□ The facility's medical director reviewed the policy □Food Storage Labeling□ with no recommended changes to the policy on 2/20/24. The facility Quality Assessment and Assurance Committee met on 2/20/24 to review the plan of correction for F tag 812. *Beginning 2/21/24, the facility administrator will monitor the kitchen for unlabeled / undated food three times weekly for 4 weeks and then monthly for two months to ensure ongoing compliance	

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F 812	Continued From page 38 date or expiration date ... 4. Monitoring storage temperatures ...d. Product Placement Food is stored in containers that are ...tightly sealed or covered ..." On 01/29/24 at 09:11 AM, an observation of the kitchen and interview with the Dietary Manager (DM) revealed: 1. Refrigerator #1 contained an opened package of cheddar cheese slices, loosely wrapped, with the cheese slices exposed with no opened by or use by date noted; 14 portioned glasses of milk on a tray undated and unlabeled, eight (8) portioned glasses of what the DM identified as "orange juice", unlabeled and undated, (3) portioned glasses of what the DM identified as "apple juice", unlabeled and undated. 2. Refrigerator #2 contained (1) opened and portioned, single serving cup of what the DM identified as "pudding" with no label and no date; seven (7) portioned cups of minimally processed cut strawberries with no date. 3. Freezer #1 contained (1) opened and loosely wrapped package of what the DM identified as "mango bars", with no date or label, two (2) unopened packages of what the DM identified as "collard greens" with no label or date, (1) opened package of what the DM described as "diced onions" with no label or date, (1) opened package of submarine rolls, containing six (6) rolls, with visible white markings on the rolls indicative of freezer burn, with a best if used by date of May 07/2023. 4. The spice rack contained 4 containers of spices with the lids opened leaving the spices	F 812	with F tag 812 and will report to the Quality Assessment and Assurance Committee for three months. The first Quality Assessment and Assurance Committee meeting will be held on 3/12/24.	

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F 812	Continued From page 39 exposed. 5. The Dietary Manager acknowledged the food items were inadequately stored, outdated, exposed, undated, and unlabeled during the initial kitchen observation. The DM stated going forward he intends to conduct one on one in-services and to visibly follow up with staff for labeling and food storage. The DM stated it is the responsibility of the staff who opens the food item to label and date the item and the kitchen aides are responsible for dating and labeling foods as they are unloaded from the delivery truck. On 01/30/24 at 10:58 AM, an interview with the Cook revealed it is the responsibility of the person who opens a food item to date and label the item. The cook stated it is the responsibility of the managers to label and date foods off the truck. On 02/01/24 at 11:03 AM, in an interview with the Kitchen Aide (KA) revealed the KAs are responsible for labeling and dating foods as they are unloaded from the truck. The KA revealed it is the responsibility of the person who opens the food item to label and date the item.	F 812		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by	F 851		3/13/24

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F 851	Continued From page 40	F 851		

CMS.

§483.70(q)(1) Direct Care Staff.
Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(q)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(q)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

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F 851	Continued From page 41 §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview and Certification and Survey Provider Enhanced Reports (Casper) reporting data review, the provider failed to ensure their Payroll Based Journal (PBJ), (information of the staffing hours for the appropriate care of the residents) was accurately submitted to the Centers for Medicare and Medicaid Services (CMS) for one (1) of four (4) quarters reviewed. (4th Quarter) Findings include: Review of the provider's Casper reporting data revealed the facility triggered excessively low weekend staffing for the 4th Quarter (July 1, 2023 - September 30, 2023). On 01/31/24 at 09:45 AM, during an interview with the Administrator, she explained she was not aware the facility had triggered for low weekend in the 4th Quarter of 2023. She stated that she approved the facility's employee hours for PBJ submission and advised the corporate office that the hours were approved and were ready to be submitted. The Administrator advised that after reviewing the audit report, there were contract staff that were not included in the hours that were	F 851	* facility failed to input agency contract hours prior to verifying Payroll Based Journal. Facility is unable to correct previous PBJ submission. * All residents have the potential to be affected * On 2/20/24 the facility business office was inserviced by the facility Administrator related to inputting contract staff hours into PBJ. The facility Quality Assessment and Assurance Committee met on 2/20/24 to review the plan of correction for F tag 851. * Beginning 2/21/24, the facility Adminsitrator will monitor the PBJ entries 5 days a week for 4 weeks and then weekly for two months to ensure ongoing compliance with F tag 851 and will report to the Quality Assessment and Assurance Committee for 3 months. The first Quality Assessment and Assurance Committee meeting will be held on 3/12/24.	

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F 851	Continued From page 42 submitted to CMS. She confirmed there were four (4) contract/agency staff that did not have hours inputted into PBJ and therefore the information submitted to CMS regarding staffing hours was inaccurate.	F 851		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review, the facility failed to ensure call lights were functioning for two (2) of 14 resident rooms on the 300 Hall. Room #301 and Room #314 Findings Include: A record review of the facility's policy "Call Light/Bell", revised 01/24, revealed "Purpose: To provide the resident a means of communication with staff members ...To provide staff members a means of summoning assistance when they are with the resident ... Procedure ... 8. If the call light is defective, immediately report this information to the unit supervisor. Discuss with the charge nurse a rounding schedule to ensure that the resident's needs are met until the call light is in working order again ..."	F 919	F919 *On 1/31/24, the facility maintenance director replaced the call light cord for room 301 and reset the bathroom light for room 314. *all residents have the potential to be affected by this practice * The facility maintenance director was in serviced on 2/20/24 regarding □Call Light / Bell□ by the facility administrator. The facility's medical director reviewed the policy □Call Light / Bell□ with no recommended changes to the policy on 2/20/24. On 2/19/24, an outside provider began installation of a new Call Light system for the facility. The facility Quality Assessment and Assurance Committee met on 2/20/24 to review the plan of correction for F tag 919.	3/13/24

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F 919	Continued From page 43 On 01/31/24 at 10:30 AM, during an observation of the call lights in resident rooms on the 300 Hall, with the Director of Nursing (DON) and the Administrator, revealed there were two (2) resident rooms (Room #301 and Room #314), with call lights that did not light up and were not audible in the hallway or at the nurses' station. The call light for Room 314 was observed to have wires that were exposed. On 01/31/24 at 11:57 AM, in an interview the DON, she acknowledged she was not aware the two (2) call lights were not functioning properly for Room 301 and Room 314 until they were checked today. On 02/01/24 at 7:30 AM, in an interview with the Administrator, she acknowledged the call lights for Room 301 and Room 314 were not functioning properly and she expected all lights to function properly at all times. On 02/01/24 at 7:48 AM, an interview with the Maintenance Director, he revealed he routinely checks four (4) call lights per week. He explained that he checked the lights by activating the call light and checking to see if it lights up in the hallway outside of the resident's door. He confirmed that the call lights should always work and that he was unaware that the call lights for Room 301 and Room 314 were not functioning properly. A record review of the Maintenance Director's "Weekly Inspector Checklist" with resident call light system check logs from 11/03/23 through 01/26/24 revealed the room numbers 301 and 314 were not listed on the log.	F 919	*Beginning 2/21/24, the facility Maintenance Director will monitor 8 rooms call light function weekly for 4 weeks and then monthly for two months to ensure ongoing compliance with F tag 919 and will report to the Quality Assessment and Assurance Committee for three months. The first Quality Assessment and Assurance Committee meeting will be held on 3/12/24.	

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