

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

PRINTED: 08/12/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255296	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/18/2024
NAME OF PROVIDER OR SUPPLIER DESOTO HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7805 SOUTHCREST PARKWAY SOUTHAVEN, MS 38671		
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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey along with a complaint investigation CI MS #25745 at the facility from 7/15/24 through 7/18/24. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F604, F638, F656, F677, F689, F812 and F851. There were no deficiencies cited related to CI MS #25745. The census at the time of the survey was 99 with a bed capacity of 120.	F 000			
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 604		8/26/24	

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

TITLE

(X6) DATE

Electronically Signed

08/01/2024

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 604	Continued From page 1 §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to ensure there was a physicians order for a bolster sheet that was being used to prevent a resident from getting out of bed for one (1) of 27 residents on sample. Resident #81 Findings Include Review of the facility policy titled, "Restraints" with a revision date of 11/28/17 revealed " ... Restraint Order ...orders for restraint should specify: the rationale (medical necessity) for the use of restraint, the type of restraint ...". An observation on 07/15/24 at 10:50 AM, revealed there was a concave mattress on Resident #81's bed and the resident was gone to dialysis. An interview on 7/16/24 at 9:00 AM, with Registered Nurse (RN) #1 revealed Resident #81 had several falls and the facility had implemented several different measures to prevent them. She stated that the residents' mind has worsened, and she thinks she can still walk sometimes, especially if she wakes up at night. She revealed they had put her bed in the lowest position and	F 604	F604 A physician Order was obtained for the Bolster sheet for resident # 81 on 7/17/24 by the Quality Assurance Nurse. All residents of this facility have the potential to be affected by this practice. 100% Audit was conducted on Bolster sheets throughout the facility by the Medicare Nurse and Restorative Nurse on 7/31/24. The audit showed that one resident had a bolster sheet as intervention for fall. The order was obtained for the one resident on 7/31/24. The Director of Nursing and staff educator will in-service the Interdisciplinary (IDT) on the facility restraint policy on 8/2/24 with the emphasis on added a Bolster Sheet as the Intervention for a fall. The QA Nurse will complete weekly audits for four (4) consecutive weeks on intervention that consists of Bolster sheets starting on 8/2/24. The Quality Assurance Committee will review at one monthly meeting on 8/26/24 to substantiate compliance. QA Nurse will audit every		

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F 604	Continued From page 2 used the concave mattress, because she would forget to use her call light. An interview on 7/16/24 at 3:00 PM, with the Director of Nurses (DON) confirmed Resident #81 had several falls and they have ended up using the concave mattress and it has helped. Record review of Resident #81's physicians orders revealed there was no order for a "Concave mattress" or "Bolster sheet". Record review of the Resident #81 care plans revealed a care plan that was initiated on 12/11/23 for "Risk for Falls" with interventions that included "Bolster sheet to air mattress." An observation, interview and record review on 7/17/24 at 9:40 AM, with RN #1 and Licensed Practical/Quality Assurance Nurse (LPN/QA) #2 confirmed Resident #81 had a "Bolster sheet" on top of her air mattress and did not have an order. She stated that it appeared that it may have been implemented with the fall that occurred 6/8/24. LPN/QA #2 confirmed Resident #81 should have an order for the bolster sheet on her air mattress and that it does prevent her from getting out of bed. An interview on 7/17/24 at 10:12 AM, the DON confirmed Resident #81 did not have an order for the bolster sheet on her air mattress. She stated she was not aware they needed an order since they were using it to define the parameters of the bed. She stated the purpose of the "bolster sheet" is to prevent resident's from getting out of the bed. Record review of Resident #81's "Admission	F 604	three (3) months starting in September and present audit findings to the September QA meeting. Quarterly audits will be presented to the following months QA meeting on a permanent bases to sustain compliance.		

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F 604	Continued From page 3	F 604			
F 638 SS=B	Record" revealed the resident was admitted to the facility initially on 7/12/23 with medical diagnoses that included Osteomyelitis of Vertebra. Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to complete a Quarterly Minimum Data Set (MDS) resident assessment within the fourteen-day time frame for two (2) of 27 sampled residents. Resident #54 and #59 Findings Include: Record review of the facility policy titled "MDS Assessments" with a revision date of 6/9/2023 revealed "Policy Explanation and Compliance Guidelines: 1. According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate, and standardized assessment of each resident's functional capacity using the RAI (Resident Assessment Instrument) manual. " Record review of the facility's "MDS 3.0 NH (Nursing Home) Final Validation Report" dated 7/11/2024 revealed a warning message for Resident #54 and Resident #59's Quarterly MDS with an Assessment Reference Date (ARD) of	F 638	F638 On 7/11/24 the Minimum Data Set (MDS) Coordinator submitted the Quarterly MDS RI# 54 & RI # 59 All residents of this facility have the potential to be affected by this practice. 100% MDS Audit was conducted by the MDS Coordinator to ensure that facility is in compliance with all quarterly assessments on 7/31/24. The Director of Nursing (DON) in-serviced the MDS team on 7/31/24 on the MDS assessment Policy. The MDS Coordinator will review the MDS calendar with the Interdisciplinary Team (IDT) daily in the morning stand up meeting starting on 7/31/24. CMS Validation Report will be reviewed and Signed by the Administrator and DON Weekly starting on 8/1/24.	8/26/24	

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F 638	Continued From page 4 5/29/24 indicated, "Assessment Completed Late: Z0500B (assessment completion date) is more than 14 days after A2300 (assessment reference date). Record review of Resident #54 and Resident #59's Quarterly MDS with an ARD of 5/29/2024 revealed under section Z0500, Date RN (Registered Nurse) Assessment Coordinator signed assessment as complete indicated "07/11/2024". An interview with the MDS nurse on 7/17/2024 at 11:10 AM, confirmed Resident #54 and Resident #59's Quarterly MDS assessments were completed late. She revealed that she had made corrections to both assessments which caused some delay. The MDS nurse confirmed that both assessments should have been closed by 6/12/2024. She explained they follow the RAI procedure manual for guidance in completing the MDS. An interview with the Director of Nursing (DON) on 7/17/2024 at 11:21 AM, revealed her expectations were for the MDS Nurse to complete the MDS assessments within the designated time frame set forth by CMS (Centers for Medicare and Medicaid Services). Record review of the "Admission Record" revealed the facility admitted Resident #54 on 12/16/2022 with medical diagnosis of Alzheimer's disease. Record review of the "Admission Record" revealed the facility admitted Resident #59 on 8/29/2023 with medical diagnosis of Alcohol dependence with alcohol-induced persisting	F 638	The QA Nurse will review and complete weekly audits of the Validation Reports and MDS schedule for four (4) consecutive week, starting on 8/2/24. Audit records will be reviewed by the Quality Assurance Committee at one monthly meeting on 8/26/24 to substantiate compliance. MDS Coordinator will audit Point Click Care (PCC) MDS schedule report and MDS schedule to Quality Assurance Committee monthly meeting starting on 8/26/24 and ongoing to ensure sustained solution.		

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F 638	Continued From page 5	F 638			
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	F 656			8/26/24

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F 656	Continued From page 6 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review and facility policy review, the facility failed to implement an Activities of Daily Living (ADL) care plan for one (1) of 26 residents care plans reviewed. Resident #93 Findings Included: Record review of the facility policy titled, "Comprehensive Plan of Care" revised 10/10/22 revealed "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment ..." Record review of Resident #93's care plan, date initiated 4/11/24 revealed "Focus: The resident has an ADL self-care performance deficit ...Interventions... Resident is usually extensive assistance x (times) 1 with bed mobility, toilet use, personal hygiene, and dressing... During an interview on 7/15/24 at 10:55 AM, an	F 656	F656 The Oral hygiene was completed on RI#93 by Licensed Practical Nurse (LPN) #1 on 7/16/24. 1:1 in serviced for Certified Nursing Assistant # 1 (CNA) completed by Director of Nursing (DON) on 7/16/24. The Care plan of the resident identifier RI #93 was reviewed and updated by the Quality Assurance LPN on 7/16/24. The facility determined that all residents could be affected. All nurses and Certified nursing assistants were in service beginning on 7/16/24 by the Staff Educator and Restorative Nurse on the importance of following the plan of care for Activities of Daily Living (ADL) emphasizing Oral Care. 100% audit on oral care was completed in the Point of Care, in Point Click Care by the Quality Assurance Nurse began and completed on 7/31/24. The QA Nurses will complete audits on the point of Care of Point Click care for five residents weekly for four (4)		

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F 656	Continued From page 7 interview with Resident #93 revealed she had been at this facility about three (3) months. She revealed the Certified Nursing Assistants (CNAs) gave her good baths but she was concerned about her teeth. Resident #93 revealed that the staff had brushed her teeth a few times since she had been here, but they had not brushed her teeth since 1 day last week. She stated, "If I ask, they will sometimes do it, but if I don't ask, it doesn't get done." Resident #93 revealed that she knew that not brushing her teeth could lead to tooth decay and bad breath and she liked her teeth brushed every day. On 07/16/24 at 9:00 AM, an observation and interview with Resident #93 revealed she was sitting up in her wheelchair in her room drinking her coffee. She revealed that if someone would get her a toothbrush and toothpaste and set them up for her, she could brush her own teeth. She revealed that she had her own teeth and stated, "I have good teeth but at this rate, they won't last much longer." On 07/16/24 at 9:05 AM, an observation revealed resident's poor oral hygiene with a yellow substance between her upper and lower teeth and gum line. On 07/16/24 at 1:30 PM an interview with Licensed Practical Nurse (LPN) #1, confirmed the yellow substance on Resident #93's upper and lower teeth and gum line and confirmed that her teeth had not been cleaned. She stated, "Her mouth looks pretty rough." LPN #1 revealed that mouth care should be done every day and she would get it taken care of now. LPN #1 revealed that failure to complete daily oral care could lead to gingivitis, loss of appetite, and other issues.	F 656	consecutive weeks. Audits will be reviewed by the Quality Assurance Committee at one monthly meeting on 8/26/24 to substantiate compliance. Interdisciplinary Team (IDT) will review ADL documentation in the morning meeting starting on 8/1/24 and ongoing.		

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F 656	Continued From page 8 She also revealed that mouth care was included in daily personal hygiene and documented by the CNAs. On 07/16/24 at 1:35 PM, an interview with CNA #1 revealed that personal hygiene included mouth care and was supposed to be done every day. She revealed the CNAs helped residents brush their teeth, they rinsed their mouth and provided mouthwash for the residents. CNA #1 revealed she didn't get there until 8:00 AM today and that Resident #93's mouth care had not been done. On 07/17/24 at 9:20 AM, an interview with Director of Nursing (DON) revealed the CNAs were responsible for resident oral care. She revealed that personal hygiene included oral care and was included in Resident #93's care plan. The DON revealed the purpose of the comprehensive care plans was to ensure the staff knew how to take care of each resident to meet their individualized needs. She agreed Resident #93's ADL Care Plan was not implemented when the CNAs failed to ensure that she received daily oral care. Record review of Resident #93's Admission Record revealed an admission date of 04/03/24 with diagnoses that included Parkinson's Disease without Dyskinesia and Need for Assistance with Personal Care.	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;	F 677		8/26/24	

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F 677	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to ensure Activities of Daily Living (ADL) care was provided daily as evidenced by a resident did not receive daily oral care for one (1) of 26 residents reviewed. Resident #93. Findings Include: Record review of the facility policy "Activities of Daily Living (ADL)" revised 09/15/22 revealed " Policy Explanation and Compliance Guidelines ... 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene..." On 07/15/24 at 10:55 AM, an interview with Resident #93 revealed she was admitted to the facility about three (3) months ago. She revealed the Certified Nursing Assistants (CNAs) gave her good baths, but she had a concern about her teeth not getting brushed. She revealed the CNAs had helped her brush her teeth a few times since she had been there and wasn't sure if they were supposed to help her with this. She stated, "If I ask, they will sometimes do it, but if I don't ask, it doesn't get done." Resident #93 revealed that she brushed her teeth once or twice a day when she was at home. She revealed that she had used a wet washcloth and paper towels to clean her teeth a few times in the facility, but they didn't get her teeth clean. She revealed that she knew that poor oral care could cause tooth decay and bad breath and she would like her teeth to be brushed every day.	F 677	F677 The Oral hygiene was completed by Licensed Practical Nurse #1 (LPN) on 7/16/24 for RI #93. 1:1 in-service for Certified Nursing Assistant #1 (CNA) completed by DON 7/16/24. The Care plan of the resident identifier RI #93 was reviewed and updated by the Quality Assurance LPN. The facility has determined that all residents have the potential to be affected. All nurses and Certified nursing assistants were in serviced beginning on 7/16/24 by the Staff Educator and Restorative Nurse on the importance of following the plan of care for Activities of Daily Livings (ADL) emphasizing Oral Care. The Restorative Nurse will conduct audits of five (5) residents per week for four (4) consecutive weeks. This audit will be reviewed at one monthly Quality Assurance meeting on 8/26/24 to substantiate compliance. Interdisciplinary Team (IDT) will review ADL documentation in the morning meeting starting on 8/1/24 and ongoing. DON will present findings from daily review in the QA meeting starting on 8/26/24 and every month for a minimum of three (3) months and until compliance is sustained.		

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F 677	Continued From page 10 On 7/16/24 at 9:00 AM an observation and interview with Resident #93 revealed she was sitting up in her wheelchair in her room drinking coffee. She revealed that the CNAs had not helped her brush her teeth since one day last week. She revealed that if they would get her a toothbrush and toothpaste and set up for her, she could brush her own teeth. Resident #93 revealed that she had asked staff several times to get her a toothbrush and toothpaste so she could brush her teeth and they told her that they would get someone to do it or they gave other excuses and never returned. Resident #93 stated, "I guess they got busy or forgot about it." She also revealed that she had her own teeth and stated, "I have good teeth but at this rate, they won't last much longer." On 7/16/24 at 9:05 AM, an observation revealed Resident #93 had poor oral hygiene as evidenced by a yellow substance between her upper and lower teeth and gum line. During an interview on 7/16/24 at 1:30 PM, with Licensed Practical Nurse (LPN) #1 in Resident #93's room confirmed the yellow substance on Resident # 93's upper and lower teeth and gum line. LPN #1 stated "Her mouth looks pretty rough." LPN #1 revealed that mouth care should be done every day, she confirmed that Resident #93's teeth had not been cleaned and that she would get it taken care of now. LPN #1 revealed that failure to provide daily oral care to this resident could lead to gingivitis, loss of appetite, tooth decay, and other issues. She revealed that CNAs were responsible for completing daily personal hygiene and it included oral care.	F 677			

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F 677	Continued From page 11 On 7/16/24 at 1:35 PM, an interview with CNA #1 revealed personal hygiene included mouth care and was supposed to be provided every day. She revealed the CNAs helped residents brush their teeth, rinsed their mouth and provided mouthwash for the residents. CNA #1 revealed she didn't get here until 8:00 AM today and assumed the night shift CNA had taken care of Resident #93. CNA #1 looked at Resident #93's teeth and confirmed that her mouth care had not been done. She revealed that failure to provide mouth care could lead to gingivitis and other problems. On 07/17/24 at 9:20 AM, an interview with the Director of Nursing (DON) revealed the CNAs were responsible for providing personal hygiene for all residents. She confirmed personal hygiene included oral care. She revealed that failing to provide oral care for Resident #93 was not healthy and agreed that it could lead to tooth decay, bad breath, and other health problems. She revealed mouth care was supposed to be done every day and as needed. The DON revealed the CNAs on night shift got some of the residents up before the day shift came in and the day shift CNAs got the rest up and stated, "I hate she's fallen through the cracks." She revealed they would resolve this issue now and that she wanted all their residents taken care of. Record review of Resident #93's Admission Record revealed an admission date of 04/03/24 with diagnoses that included Parkinson's Disease without Dyskinesia and Need for Assistance with Personal Care. Record review of Resident #93's Minimum Data Set (MDS) with an Assessment Reference Date	F 677			

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F 677	Continued From page 12 (ARD) of 07/09/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated that she was cognitively intact. Section GG revealed she required partial to moderate assistance with oral hygiene.	F 677			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, Resident Representative (RR) and staff interview, record review and facility policy review the facility failed to prevent the possibility of an accident as evidenced by a physician ordered medication being found in a resident's bed for one (1) of 27 sampled residents. Resident #52 Findings Include: Review of the facility policy titled, "Medication Administration" with a revision date of 6/8/23 revealed under "Policy Explanation and Compliance Guidelines ...#16. Observe the resident consumption of medication". An interview and observation on 07/15/24 at 11:22 AM, with the RR for Resident #52 revealed she was making her mother's bed and found a blue pill in the sheets. This observation revealed	F 689	F689 Medication was removed from the resident bed and the charge nurse disposed of the medication on 7/15/24. All residents have the potential to be affected. The Staff Educator began in-service with all direct care staff on 7/15/24 for nurses to remain at bedside until Medication Administration is complete, in accordance with the Medication Administration Policy. The QA Nurse will audit four (4) nurses weekly on medication administration for four (4) consecutive weeks, starting on 8/2/24. The audit will be presented to one monthly Quality Assurance meeting on 8/26/24 to substantiate compliance.	8/26/24	

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F 689	Continued From page 13 she was holding the blue pill. She stated she had called for the nurse. She stated this is not the first time she has found medicine in her mother's bed, but it has been a while. An observation and interview on 7/15/24 at 11:25 AM, with Licensed Practical Nurse (LPN) #3 confirmed the blue pill found in Resident #52's bed was Levothyroxine 150 micrograms (mcg). An observation at this time of the resident's medication cards confirmed this pill was Levothyroxine 150 mcg. She stated that it was supposed to have been given between 5-6 AM this morning. She stated the nurse should always stay with the resident to make sure the resident has swallowed all the medications. She stated she would make the Registered Nurse (RN) supervisor aware. An interview on 7/15/24 at 11:30 AM, with RN #1 confirmed the nurse giving the medications should always stay with the resident and make sure the resident has swallowed all medications. An interview on 07/16/24 03:11 PM, with the Director of Nurses (DON) confirmed the medication nurses should always stay with the resident until they had swallowed all medications. She stated the purpose was to make sure the resident took all of their medication, and that no other resident would have access to it. An interview on 7/16/24 at 8:50 PM, with LPN #5 revealed she was Resident #52's nurse on Sunday night 7/14/24 going into Monday morning 7/15/24 and confirmed she gave the resident her medicine while she was in her wheelchair. She stated she has only worked with this resident twice but was warned by other staff members that	F 689	Quality Assurance Nurses will audit Medication Administration every three (3) months starting in November and will present audit to the November QA meeting. Quarterly audits will be presented to the following months QA meeting on a permanent bases to sustain compliance.		

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F 689	Continued From page 14 she tends to not swallow all her medications. She stated the purpose of staying with the resident to make sure they swallow the pills is to make sure they do not get choked on the medications, or that there are no medications left that other residents could find and take. An interview on 7/16/24 at 9:04 PM, with LPN #6 revealed she was Resident #52's nurse on Saturday night 7/13/24 going into Sunday morning 7/14/24 and she gave the resident her medication while she was sitting in her wheelchair. She revealed she always stays with her resident while they take their medicines to make sure they swallow it all. She stated she had been warned about this resident not always wanting to swallow her medicines, so she was aware of that possibility, but she stayed with her. She stated that the purpose of staying with the resident while they take their medicines is because its physicians orders, they get the medicines they need and to make sure no other resident gets them. Review of Resident #52's "Admission Record" revealed the resident was admitted to the facility on 1/29/21 with medical diagnoses that included Alzheimer's disease. Review of the "Care Profile" for Resident #52 revealed a physician order dated 10/11/23 for "Levothyroxine TAB (tablet) 150 mcg Give 1 tablet by mouth one time a day." Record review of Resident #52's July 2024, Medication Administration Record (MAR) revealed Levothyroxine 150 mcg was documented as given daily through 7/16/24.	F 689			

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F 812 F 812 SS=F	Continued From page 15 Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §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 interview, and facility policy review, the facility failed to prevent the possibility of cross contamination to food, as evidenced by failure to perform hand hygiene after picking up a soiled item off the floor during steam table temperature checks for one (1) of three (3) kitchen observations. Findings Include: Review of the facility policy titled "Infection Prevention and Control" with a revision date of 6/8/2023 revealed "Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe,	F 812 F 812	F812 The dietary staff member involved was in-serviced by the Staff Educator on 7/18/24. All residents have the potential to be affected. All dietary employees will be in-serviced by the Staff Educator starting on 8/1/24 on infection control, focusing on cross-contamination. The Infection Prevention nurse will		8/26/24

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F 812	Continued From page 16 sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines..." During an observation of the lunch meal steam table temperature checks on 7/17/2024 at 11:58 AM, Dietary Staff #1 dropped a pen on the floor. She retrieved the pen from the floor and continued to check and record the food temperatures without washing her hands. An interview with Dietary Staff #1, on 7/17/2024 at 12:08 PM, revealed she was nervous and should have stopped and washed her hands to prevent the spread of bacteria to the food. An interview with the Administrator, on 7/17/2024 at 12:36 PM, revealed Dietary Staff #1 should have got a new pen or washed her hands after retrieving the pen from the floor to continue temperature checks. He acknowledged bacteria could cross contaminate the food.	F 812	observe the steam table prep for cross contamination three times weekly for four (4) consecutive weeks, starting on 8/2/24. The audit will be reviewed at one monthly Quality Assurance meeting on 8/26/24 to substantiate compliance. Quality Assurance Nurses will audit steam table prep for cross contamination every three (3) months starting in September and will present audit to the September QA meeting. Quarterly audits will be presented to the following months QA meeting on a permanent bases to sustain compliance. Corrective action completion date: 8/26/24.		
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 CMS. §483.70(q)(1) Direct Care Staff.	F 851		8/26/24	

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F 851	Continued From page 17 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. §483.70(q)(4) Data format. The facility must submit direct care staffing	F 851			

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F 851	Continued From page 18 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, record review and facility policy review, the facility failed to accurately submit staffing data into the Payroll-Based Journal (PBJ) system for two (2) of 2 quarters reviewed. First and Second Quarters of 2024. Findings Include: Record review of the facility policy, "Nursing Services and Sufficient Staff" revised 10/12/22 revealed " ... Policy Explanation and Compliance Guidelines... 7. The facility is responsible for submitting timely and accurate staffing data through the CMS (Centers for Medicaid/Medicare Services) Payroll-Based Journal (PBJ) system ..." Record review of the "PBJ (Payroll Based Journal) Staffing Data Report CASPER Report 1705D FY (Fiscal Year) Quarter 2 2024 (January 1-March 31)" revealed "Excessively Low Weekend Staffing Triggered. Triggered =Submitted Weekend Staffing data is excessively low." Record review of the "PBJ Staffing Data Report CASPER Report 1705D FY Quarter 1 (October 1 - December 31)" revealed "Excessively Low Weekend Staffing Triggered. Triggered = Submitted Weekend Staffing data is excessively	F 851	F851 A complete audit of Payroll Based Journal (PBJ) data was conducted on 7/19/2024. This audit was conducted to ensure that all potential erroneous data was immediately corrected All residents have the potential to be affected. On 7/19/2024 the facility administrator educated the payroll coordinator on Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to Centers for Medicare and Medicaid Services (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 CMS. Payroll coordinator to audit PBJ data weekly for six (6) weeks, starting on 8/2/24. The Administrator will review the audit weekly for six (six) weeks, starting on 8/5/24. Audits will be reviewed in		

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F 851	Continued From page 19 low." On 07/16/24 at 9:20 AM, an interview with the Administrator (ADM) revealed he was aware they triggered excessively low weekend staffing for January through March 31, 2024, and for the last quarter, October 1 through December 31, 2023. He revealed that he was unsure why they triggered low staffing because they had more than adequate staffing. He revealed their staff ratio was usually above 3.0. The ADM revealed the Payroll Coordinator was responsible for gathering the information and putting in the data for the PBJ and submitting it. He revealed they had been trying to figure out why they triggered low weekend staffing so they could get it fixed but they couldn't find the problem. He revealed the Payroll Coordinator had contacted CMS (Centers for Medicare and Medicaid Services) and they were looking into it. The ADM revealed there seemed to be glitches in the system because they had trouble printing out the PBJ Staffing Data Report after submitting their information. On 07/16/24 at 9:30 AM, an interview with the Payroll Coordinator revealed when she realized they triggered for excessively low weekend staffing, she contacted CMS by phone, and she hadn't heard back. She revealed after she submitted the payroll information, she was not able to run the PBJ Staffing Data Report for January 1 through March 31 due to glitches in the system. The Payroll Coordinator stated she double checked everything and confirmed that the information was submitted correctly but she was afraid it would trigger again because they didn't know how to fix it or why it triggered low staffing. She stated, "We have more than enough staff." She revealed she enters agency	F 851	facility Quality Assurance meeting starting on 8/26/2024 . Payroll Coordinator will audit for Administrator to review every three (months) starting in November and ongoing to ensure sustained solution. PBJ data will be reviewed by the IDT in the monthly facility QA meeting each month going forward.		

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F 851	Continued From page 20 staff hours manually, but all other direct care staff hours roll over to her directly from their payroll system. The Payroll Coordinator revealed she always compares the date in their payroll system and makes sure it is correct before she submits it. Record review of the "Staffing Grid" for the quarters that triggered for low weekend staffing revealed staffing in the facility was sufficient.	F 851			