STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255115	A. BUILDING _____ B. WING _____	C 07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTER LLC	4540 MANHATTAN RD JACKSON, MS 39206

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and Complaint Investigations (CIs) at the facility from 7/22/24 through 7/25/24. The SA investigated CI MS #25970 related to abuse and CI MS #25912 related to resident hospitalized several times due to hypernatremia. There were no citations related to the complaint's investigations. 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 F656, F658, F679, F690, F804, F810, F812, and F921. The facility held a license for 180 beds, with a census of 150.	F 000		
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	F 656		9/6/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/13/2024

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F 656	Continued From page 1 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care 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 interviews, record reviews, and facility policy reviews, the facility failed to develop/implement the comprehensive care plan for six (6) of thirty (30) sampled residents. Residents #53, Resident #57, Resident #68, Resident #80, Resident #121, and Resident #122 Findings Included: A review of the facility's policy titled, "Care Plan Policy," dated 01/15, revealed "POLICY: Each	F 656	1. Resident #53 plan of care has been reviewed and revised with dietary adding built up utensils to the meal tray for each meal service per the tray card. CNAs will deliver meal tray to the room and verify per the tray card that built up utensils are available on the meal tray for resident # 53 to use while eating. Residents #57, #121, #122 plan of care has been reviewed and revised to include involvement in individual and group	

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F 656	Continued From page 2 resident would have a plan of care to identify problems, needs, and strengths that will identify how the team will provide care .... The care plan contained services provided, preferences, abilities, and care level guidelines. Procedure: 1. The Care Plan will be developed within two days. Subsequent meetings would take place yearly and as needed. 2. The team along with the resident and/or family members, will identify services needed, preferences, ability, and care level guidelines. 3. The Care plan will be reviewed and/or revised yearly with the completion of the Admission/Readmission/Yearly Evaluation and with changes in the resident's condition as needed ..." During the initial tour on 07/22/24 at 10:31 AM, a general observation of the third floor revealed several residents sitting across from the nurse's station in wheelchairs and Geri chairs. Some of the residents were asleep, and some were awake with no activities. There were three residents in the activity room watching television with no activities noted. Record review of the July 2024 third floor Activity Calendar. revealed the facility had one (1) activity scheduled for each morning and two (2) activities scheduled for each afternoon. Throughout the days of observation (July 22, 2024 through July 23, 2024), none of the scheduled activities were observed, nor were there appropriate individualized activities provided for residents on the third floor. Three (3) of the sampled residents (Resident # 57, #121, and #122) were located on the third floor. Resident #53:	F 656	activities per residents choice starting 7/26/24 by the Assistant Director of Nursing and Activities Director through encouragement to attend activities, verbal reminders to attend activities, engaging resident in activities, and how they liked the activity. Resident # 68 has discharged from facility. Resident #80 plan of care has been reviewed and revised to include nurse administration of medicated creams. Residents # 53, 57, 80, 121, 122 care plans have been reviewed for accuracy and completion with corrective actions and no ill effects. 2. All residents have the potential to be affected by the alleged deficient practice. 3. The Interdisciplinary Team has been in-serviced starting 7/25/24 by the Director of Nursing regarding completion of care plans timely and accurately. 4. The Quality Assurance committee will meet to review the care plan audits starting 8/27/24 and monthly times 2 months with the plan of correction reviewed and recommendations for change to the plan if indicated. Meal Service Observation audits will be completed five times a week times eight weeks to during meal to monitor resident assistive devices during meal service starting 7/26/24 by the Dietary Manager and Registered Dietitian. Treatment observation audits will be completed by the Unit Manager and Assistant Director of Nursing starting 7/26/24 five times weekly times eight weeks to ensure medicated creams are applied by a Licensed Nurse. Care Plan Audits are being completed on twenty residents five	

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F 656	Continued From page 3 A record review of the "Care Plan" with a problem onset date of 9/25/17 revealed "Problem/Need: ...Receives adaptive equipment (built-up utensils) to assist with self -feeding ...Approaches ....Built up utensil with meals for self-feeding ..." During an observation and interview on 07/22/2024 at 12:11 PM, with Resident #53 he stated he needed a built-up fork because he was unable to use a conventional fork when eating due to his hand disability. He stated the kitchen staff often forgets to put one on his tray for every meal, forcing him to eat with his hands. He continued by saying when one did in rare instances end up on his tray, he kept it in his room for a day or two until it got dirty, at which point he sent it back to the kitchen to be cleaned, but it would take several days to get another one. Resident #53 added he had asked the kitchen staff several times to place the right fork on his tray, but he thought that whether they followed the instructions on his meal ticket depended on the person working the kitchen that day. He mentioned he also asked the Certified Nursing Assistant (CNA) who brought the tray to get him the appropriate fork, but a lot of the time they nodded, said alright, and never brought one back to his room. At this point, he said he was just tired of asking, so he did the best he could when eating his meals. An observation of the lunch meal tray revealed no built-up fork was provided, only regular silverware. On 07/23/24 at 12:15 PM, during a lunchtime observation of Resident #53's meal, no built-up fork was provided. Only plastic ware was given due to a COVID-19 outbreak. On 07/24/24 at 8:11 AM, observation of the	F 656	times a week times eight weeks to ensure completion and accuracy of the plan of care starting 7/26/24 by the Director of Nursing and Assistant Director of Nursing.	

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F 656	Continued From page 4	F 656		

breakfast tray revealed no built-up fork was provided, only plastic ware due to a COVID-19 outbreak.

A record review of the meal ticket dated 07/24/2024 revealed, "Adap Equip (Adaptive Equipment): Built-up Utensils x 2."

Resident #57:

A record review of Resident #57's"Care Plan" revealed "Problem/Need: Resident will need reminders and encouraging to participate in OOR (out of room) group activities of interest ... Approaches: Staff will give resident opportunity to express opinions about activities attended. Staff will give the resident verbal reminders of activities before the commencement of the activity. Staff will engage resident in all group activities."

.A record review of Resident #57's "Face Sheet" revealed an admission date of 04/29/22 with diagnoses that included Pulmonary Hypertension, Chronic Kidney Disease, and Vascular Dementia.

Resident #68:

A record review of Resident #68's care plan revealed the facility had developed a baseline care plan; however, as on 7/25/24, the facility had not developed a comprehensive care plan for the resident.

A record review of Resident #68's "Face Sheet" revealed an admission date of 06/27/24 with diagnoses that included Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Anxiety Disorder, and Bipolar Disorder.

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F 656	Continued From page 5	F 656		

Resident #80:

A record review of the Resident #80's " Care Plan" with a problem onset date of 6/12/24 revealed " ... Actual skin impairment ...Approaches ...Clean right buttocks ...apply zinc oxide daily; Clean left back ...apply zinc oxide daily ...Clean left upper thigh ...apply zinc oxide daily ..." The role specified for this approach was coded as "N" for nurse.

Record review of the July 2024 "Physician Orders" revealed orders dated 6/13/24 for "Pressure ulcer of right buttock ...apply zinc oxide daily; Rash ...left back ...apply zinc oxide daily ...Rash ...left upper thigh ...apply zinc oxide daily ..."

A record review of Resident #80's "Face Sheet" revealed a re-admission date of 06/12/24 with diagnoses that included Primary Hypertension and Rheumatoid Arthritis.

Resident #121:

A record review of Resident #121's " Care Plan" with a problem on set date of 3/29/23 revealed "Long-term resident with potential for decline in psychosocial well-being related to being away from family ...Approaches ...visit with the resident as needed for encouragement ...encourage participation in activities for socialization/stimulation. The Resident enjoys listening to music, dancing, and being involved in social events. Staff will engage the resident in group activities ..."

A record review of Resident #121's "Face Sheet"

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F 656	Continued From page 6	F 656		

revealed an admission date of 03/24/23 with diagnoses of Hypertension, Moderate Intellectual Disabilities, and Anxiety Disorder.

Resident #122:

A record review of the Resident #122's "Care Plan" revealed "(Proper name of Resident #122) has the inability to plan own leisure-time activities related to cognitive impairment and needs encouragement to actively participate in small group activities on the unit... Approaches: Initiate conversation as frequently as possible, Engaging ...in group activities, Assist in planning leisure time activities, Visit with him and assist as needed with selecting the activities ...interested in and will plan to attend ..."

A record review of Resident #122's "Face Sheet" revealed an admission date of 03/15/24 with diagnoses that included Mood Disorder, Parkinson's, and Depression

On 07/25/24 at 11:13 AM, in an interview, Licensed Practical Nurse (LPN) #3, who managed care plans, mentioned that Resident #68 had been admitted on 06/27/24. She explained that the baseline care plan was completed upon admission, but the comprehensive plan should have been finalized by now. She pointed out that the comprehensive care plan provided detailed and specific guidance for the staff on how to care for the resident and emphasized that it was overdue.

On 07/25/24 at 11:19 AM, in an interview, Registered Nurse (RN) #1, responsible for care plans and MDS, acknowledged there was no reason for the delay in completing the

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F 656	Continued From page 7 comprehensive care plan. She took responsibility for ensuring it was done, noting that it provided essential details and interventions for nurses and CNAs to care for residents properly. On 07/25/24 at 3:10 PM, in an interview, the Assistant Executive Director (AED) expressed her expectation for care plans to be completed promptly and in accordance with federal guidelines. She stressed that these plans were crucial for staff to deliver appropriate care to the residents. During an interview on 07/25/24 at 3:30 PM, the Director of Nursing (DON) confirmed the facility failed to follow the residents' care plans by not adhering to the calendar and providing activities to the residents. The DON emphasized that activities were important, and she expected the staff to meet the residents' needs by offering daily activities. The DON also highlighted the importance of staff following care plans, ensuring CNAs only applied barrier cream provided by the facility, and that nurses were responsible for applying zinc oxide as a medication. She further explained that care plans were essential for guiding staff in taking care of the residents, including assisting with meals and managing behaviors.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		9/6/24

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F 658	Continued From page 8 by: Based on observations, interviews, record reviews, and facility policy review, the facility failed to follow professional standards by allowing a Certified Nursing Assistant (CNA) to apply a medicated cream for one (1) of three (3) residents observed for incontinent care. Resident #80 Findings Include: A review of the facility's policy titled, "Medication Administration General Guidelines," dated 8/16/24, revealed, "Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. ... Procedure: 1. Medications are prepared, administered, and recorded only by licensed nursing, medical, or other personnel authorized by state laws and regulations to administer medications. 2. Medications are administered in accordance with written orders of attending physicians taking into consideration manufacturer's specifications and professional standards of practice ..." An observation on 07/22/24 at 11:47 AM, revealed Resident #80 lying in bed, alert and oriented. Resident #80 stated her buttocks hurt and the CNAs applied cream on her buttocks after each incontinent episode. The State Agency (SA) observed a jar of zinc oxide on the bedside table. An observation on 07/24/24 at 1:54 PM, during incontinent care revealed CNA #1 applied zinc	F 658	1. Resident # 80 is being provided application of medicated creams by a Licensed Nurse. Resident # 80 was assessed by the Assistant Director of Nursing on 7/25/24 with no ill effects. 2. All residents who have medicated creams ordered have the potential to be affected by the alleged deficient practice. 3. The Assistant Director of Nursing in-serviced staff starting 7/25/24 to educate Certified Nursing Assistants not to apply medicated creams like zinc oxide- medication and Licensed Nurses are to apply medicated creams. A 100% room to room audit was completed by the Assistant Director of Nurses on 7/25/24 to ensure removal of any medicated creams from the residents rooms. 4. The results of the observation room audits will be reported to the Quality Assurance Committee monthly starting 8/27/24 times 2 months by the Director of Nursing with the plan reviewed and recommendations for changes to the plan if indicated. The Unit Managers and the Assistant Director of Nursing, will make observation rounds on twenty resident rooms five times weekly times eight weeks starting 7/25/24 to ensure no medicated creams are located in residents rooms.	

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F 658	Continued From page 9 oxide cream on the resident's buttocks and perineal area after completing incontinent care. Record review of the July 2024 "Physician Orders" revealed an order dated 6/13/24, "Pressure ulcer of right buttock ...apply zinc oxide daily..." During an interview on 07/24/24 at 2:15 PM, CNA #1 confirmed she applied zinc oxide to the resident's buttocks and perineal area. CNA #1 explained she was told to use that cream after every incontinent episode. CNA #1 stated she did not know zinc oxide was considered a medication. During an interview on 07/25/24 at 11:00 AM, Licensed Practical Nurse (LPN) #1 confirmed he observed the zinc oxide on the nightstand and that the CNAs were applying the cream. LPN #1 stated "the CNAs are only supposed to use the barrier cream." During an interview on 07/25/24 at 3:30 PM, the Director of Nursing (DON) confirmed the facility failed to follow the facility policy when CNA #1 applied zinc oxide, which is considered a medication. The DON stated, "The CNAs should only apply barrier cream that is provided by the facility, and the nurses are licensed to apply the zinc oxide." The DON stated she did not know the CNAs were using zinc oxide. During an interview on 07/25/24 at 3:45 PM, the Assistant Administrator revealed she expected the staff to follow the nursing standards of practice.	F 658		
F 679 SS=D	Activities Meet Interest/Needs Each Resident	F 679		9/6/24

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F 679	Continued From page 10 CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy, the facility failed to provide activities of interest to meet the needs for three (3) of 30 sampled residents. Residents #57, #121, and #122 Findings Included: Record review of the facility's policy titled, "Activities/Recreation Services Program Planning Consideration" reviewed 10/09 revealed, "Policy: Interdepartmental communications and available resources will be utilized to plan, design, and implement the activities program for enhancement of resident participation. Responsibility: Activity/Recreational Director or designees Procedure: 1. Planned programming will be coordinated with and communicated to all departments. 2. Adequate and appropriate supplies and equipment will be provided for the resident's use on an individual and group basis. 3. An inventory of equipment and supplies to provide programming will be maintained according to the residents' needs and interests. 4.	F 679	1. Resident # 57, #121, #122 are being provided individual and group activities based on the residents needs per their plan of care. Residents #57, #121, #122 plan of care has been reviewed and revised to include involvement in individual and group activities per residents choice starting 7/26/24 by the Assistant Director of Nursing and Activities Director through encouragement to attend activities, verbal reminders to attend activities, engaging resident in activities, and how the resident liked the activity. Residents # 57, 121, 122 were interviewed by the Assistant Director of Nursing on 7/25/24 with no ill effects. 2. All residents have the potential to be affected by the alleged deficient practice. 3. An in-service has been completed with activities staff starting 7/25/24 by the Assistant Director of Nursing regarding provision of individual and group activities based on the resident needs and preferences per their plan of care.	

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F 679	Continued From page 11 Supplies will be accessible for residents to use, and signs posted indicating their availability and location. 5. Community resources will be utilized to enhance the facility activities program. A community resource file will be maintained." A review of the facility's "Residents Bill of Rights" dated 01/23 revealed, "Each resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility in a manner and in an environment that promotes maintenance or enhancement of (his or her) quality of life regardless of diagnosis, severity of condition, ... A. Facility residents shall have the right to: ... 15. Self-determination, which the facility must promote and facilitate through support of resident choice consistent with his or her interest, assessments, and plan of care and make other choices about aspects of his or her life in the facility that are significant to the resident. Including but not limited to: activities, healthcare, schedules (including sleeping, walking, bathing, and eating times), and how she or he spends time both in and outside of the facility should be supported to the extent possible ... 19. To participate in other activities including social, religious, and community activities that do not interfere with the rights of other residents in the facility ..." On 07/22/24 at 10:31 AM, during the initial tour, a general observation of the third floor revealed several residents sitting across from the nurse's station in wheelchairs and Geri chairs. Some of the residents were asleep, and some were awake with no activities. There were three (3) residents in the activity room watching television with no activities noted.	F 679	Residents who prefer to attend group activities will be assisted to group activities starting 7/26/24 on each floor by the activities staff and nursing staff per their preference. Individual activities will be provided for residents who choose to remain in their room by the activity staff starting 7/26/24. 4. Activities rounds audits results and group and individual log reviews audits will be reported to the Quality Assurance committee monthly starting 8/27/24 times two months by the Activities Director with the plan evaluated and recommendations for changes to the plan if indicated. Activities rounds audits will be completed five times a week times eight weeks on each floor by the Department Heads to ensure residents are being provided individual and group activities starting 7/26/24 with resident interviews regarding encouragement for the resident to attend activities, verbal reminders for the resident to attend activities, engaging the resident in activities, staff assistance to activities, and how the resident liked the activity. Group participation and individual participation logs will be reviewed weekly times eight weeks starting 7/29/24 by the assistant executive director.	

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Resident #57:

A record review of Resident #57's "Face Sheet" revealed an admission date of 4/29/2022, with diagnoses that included Pulmonary Hypertension, Chronic Kidney disease, and Vascular Dementia.

A record review of review of the Resident #57's Yearly Minimum Data Set (MDS) with an Assessment Reference Date of 6/18/24 revealed a Brief Interview for Mental Status (BIMS) score of three (3), which indicated the resident had severe cognitive impairment. Section F revealed it was very important to listen to music, do things with groups, and do favorite activities.

During an observation on 7/22/24 at 10:45 AM, Resident #57 was sitting in the hallway in a Geri chair across from the nursing station and was sleeping.

Review of the July "Activity Calendar, "dated 7/22/24 for the third floor revealed "Bingo" was on the schedule for 2:45 PM in the Day Room.

During an observation on 7/22/24 at 2:46 PM, Resident #57 was sitting in the hallway across from the nursing station and was sleeping. There were no activties observed.

Review of the July "Activity Calendar," dated 7/22/24 for the third floor revealed "Coffee" was on the schedule for 3:45 PM in the Day Room.

During an observation on 7/22/24 at 3:47 PM, Resident #57 was observed once again to be sitting in the hallway across from the nursing station and was sleeping. There were no activities

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observed.

Review of the July "Activity Calendar," dated 7/23/24 for the third floor revealed "Brain Teasers" was scheduled for 10:00 AM. Again, there were no activities taking place in the Day Room.

During an observation on 7/23/24 at 10:09 AM, Resident #57 was sitting in the Day Room and was sleeping. The television was on. There were no activities observed.

During an observation on 7/23/24 at 2:54 PM, Resident #57 was observed sitting next to the nursing station and was sleeping. There were no activities observed at this time.

During an observation on 7/24/24 at 10:07 AM, Resident #57 was participating in exercises with Therapy.

In an interview with the Occupational Therapy Assistant (OTA), she stated that the resident does wake up and participate with Therapy. However, if left she had noted that if the resident is not engaged for several minutes, he goes back to sleep. The OTA stated that the Resident #57 receives Therapy twice a day.

Review of the July "Activity Calendar," dated 7/24/24 for the third floor revealed that "Bingo" was scheduled for 2:45 PM in the Day Room. There were no residents playing Bingo at this time in the Day Room.

During an observation on 7/24/24 at 2:45 PM, Resident #57 was sitting next to the nursing station and was asleep.

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In an interview on 7/24/24 at 2:55 PM, Resident #57 explained "there's nothing to do." The resident stated he goes back to sleep until somebody wakes him up to eat or do something else.

In an interview on 7/24/4 at 2:58 PM, Licensed Practical Nurse (LPN) #5 explained that Resident #57 does wake up to eat and to participate in Therapy. LPN#5 stated the resident does sleep most of the time after that. LPN #5 noted that the resident's do not have much to do, as most of the time the Activity Department conducts the activities downstairs with the residents that are able to travel up and down the elevator.

Resident #121:

A record review of Resident #121's "Face Sheet" revealed an admission date of 3/24/23 with diagnoses that included Hypertension, Moderate Intellectual Disabilities, and Anxiety Disorder.

A record review of the Resident #121's Quarterly MDS with an ARD of 5/3/24 revealed a BIMS score of zero (0), which indicated the resident had severe

cognitive impairment. Section F revealed it is very important to listen to music, do things with groups, and do favorite activities. The resident also enjoyed outside outings.

An observation on 7/22/24 at 10:41 AM revealed the resident sitting in her chair talking to a baby doll. No individualized activities appropriate for the resident were observed.

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An observation on 7/22/24 at 2:46 PM revealed the resident ambulating up and down the hallway talking to the baby doll. No individualized activities appropriate for the resident were noted.

An observation on 7/22/24 at 3:47 PM revealed the resident sitting at the end of the hallway in a chair talking to herself with no individualized activities appropriate for the resident noted.

An observation on 7/23/24 at 10:09 AM revealed the resident sitting in the Day Room asleep. The television was on. No individualized activities appropriate for the resident were noted.

An observation on 7/23/24 at 2:54 PM revealed the resident ambulating up and down the hallway talking to the baby doll. No individualized activities appropriate for the resident were noted.

An observation on 7/24/24 at 10:07 AM revealed the resident ambulating up and down the hallway and in and out of other residents' rooms. No individualized activities appropriate for the resident were noted.

An observation on 7/24/24 at 2:45 PM revealed the resident ambulating up and down the hallway. No individualized activities appropriate for the resident were noted.

Resident #122:

A record review of Resident #122's "Face Sheet" revealed an admission date of 3/15/24 with diagnoses that included Mood Disorder, Parkinson's, and Depression.

A record review of Resident #122's Admission

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MDS with an ARD of 3/22/24 revealed a BIMS score of 14, which indicated the resident was cognitively intact. Section F revealed it is very important to listen to music, go outside when the weather is good, and participate in religious practices.

During an observation on 7/22/24 at 1:10 PM, Resident #122 was wandering in and out of other residents' rooms with his rollator. The staff continued to redirect the resident. A general observation of the residents watching television revealed no activities observed.

During an interview on 7/22/24 at 1:14 PM, LPN #4 revealed the resident was fixated on his medications and was hard to redirect at times. The resident wandered up and down the hall most of the day.

During an interview on 7/22/24 at 1:27 PM, Resident #122 explained there was nothing to do. The resident also said the staff would not take him outside. He enjoyed music and playing games.

An observation on 7/22/24 at 2:40 PM, revealed Resident #122 wandering up and down the hallway without his rollator. A general observation revealed residents in the Day Room watching television. There were no activities observed.

Review of the July "Activity Calendar," dated 7/22/24 for the third floor revealed "Bingo" was scheduled to take place in the Day Room at 2:45 PM. However, no activity in the Day room was noted during this time.

Review of the July "Activity Calendar," dated

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7/22/24 for the third floor revealed that "Coffee" was on the schedule for 3:45 PM in the Day Room.

An observation on 7/22/24 at 3:50 PM, revealed Resident #122 sitting on his rollator in the hallway. There were no activities taking place in the Day Room at that time.

Review of the July "Activity Calendar," dated 7/23/24 for the third floor revealed "Brain Teasers" was scheduled for 10:00 AM. Again, there were no activities taking place in the Day Room.

During an observation on 7/23/24 at 10:02 AM, Resident #122 was wandering up and down the hallway without his rollator. A general observation of residents in the Day Room revealed a few residents were watching television.

Review of the July "Activity Calendar, " dated 7/23/24 for the third floor revealed "Tomato Sandwiches" was scheduled for 2:45 PM. Again, there were no activities taking place in the Day Room.

An observation on 7/23/24 at 2:45 PM, revealed Resident #122 wandering up and down the hallway without his rollator. A general observation revealed residents watching television in the Day Room.

Review of the July "Activity Calendar," dated 7/24/24 for the third floor revealed that "Leg Stretches" was scheduled for 10:00 AM in the Day Room. Again, there were no activities taking place in the Day Room.

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An observation on 7/24/24 at 10:00 AM revealed Resident #122 wandering up and down the hallway without his rollator. A general observation revealed residents in the Day Room watching television. No activities were observed.

Review of the July "Activity Calendar," dated 7/24/24 for the third floor revealed that "Bingo" was scheduled for 2:45 PM in the Day Room. There were not residents playing Bingo at this time in the Day Room.

In an interview on 7/25/24 at 3:00 PM, Resident #6 revealed she was the Resident Council President. The President confirmed the facility did not provide activities often on the 2nd and 3rd floors. The Resident Council President said most of the activities were done on the first floor. If the resident was unable to come down the elevator, they would not get activities. The President said sometimes they would give them snacks or play ball maybe once or twice a week. On the weekends, the residents had to do activities themselves because there was only one activity aide until they got another one. She was just put in that position about a week ago. The President said they did not have enough staff in the activity department to provide activities to all three floors and in the residents' rooms. The President also said they enjoyed going outside but because of a lack of staff, they did not go outside as much. The President explained some of the residents said they felt like prisoners in the facility. The President revealed they had complained in the past about activities, but nothing was done, so they did not talk about it anymore.

In an interview on 7/25/24 at 3:15 PM, LPN #5 confirmed the facility did not provide activities on

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the third floor. LPN #5 stated that most of the activities occurred downstairs in the Dining Room. The facility just hired a new activity aide, which came up maybe once or twice a week to provide activities with the residents on the third floor. The residents were bored and had a lot of behaviors because of a lack of activities. Most of them had to be redirected in and out of each other's rooms. Some of the residents slept most of the day or watched TV in the dayroom.

During an interview on 7/25/24 at 3:22 PM, the Activity Director explained that she had just become the director within the last two weeks. The Activity Director stated that she worked Monday through Friday and was off at weekends. The Director said her assistant was off every other weekend. The Director also stated that on the weekend the assistant worked, she would be off on Monday and Friday of next week. The Director confirmed there was only one activity aide working on the days that she and the assistant were off. The Director also confirmed the schedule that four weekend days in the month of July both the Director and assistant activity personnel were off. The Director also explained when one of them had the day off, there was only one person providing activities. The Director said she had talked to the Administrator explaining they needed help. They were responsible for providing activities to three floors and in-room activities with residents that were not able to come to the Day Room.

A record review of the facility's "July Schedule" revealed the Activity Director and Activity Assistant were off on 7/13/24, 7/14/24, 7/27/24, and 7/28/24. A record review of the Activity Director and the Activity Assistant's time sheets

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confirmed they did not work on the 13th and 14th of July.

During an interview on 7/25/24 at 3:25 PM, the Activity Assistant explained she was responsible for providing activities on the third floor. The Activity Assistant stated she was off on 7/22/24. The Activity Assistant said she did a balloon toss with the residents on the third floor for fifteen (15) minutes at 9:30 AM on 7/23/24. The Activity Assistant also said she did exercise with the residents for fifteen (15) minutes at 9:00 AM on 7/24/24. The Activity Assistant confirmed both activities were not on the calendar. She was just doing something quick with those residents before having to go downstairs with the big activities.

During an interview on 7/25/24 at 3:30 PM, the Director of Nursing (DON) stated she expected the Activity Department to provide activities on all floors. The DON said she did not realize the residents were not receiving activities on the third floor.

During an interview on 7/25/24 at 3:45 PM, the Administrator, via phone, explained she did not know the activity staff were not providing activities on the third floor. The Administrator said the Activity Director and the assistant were supposed to alternate weekends. The Administrator stated that she felt two (2) activity personnel were enough staff to meet the residents' activity needs. The Administrator said the facility had volunteers that assisted the residents with activities.

In an interview on 7/25/24 at 4:00 PM, the Assistant Administrator explained she expected the staff to follow the activity calendar. The

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F 679	Continued From page 21 Assistant Administrator said the facility was working on the activity program and creating new ideas to meet the needs of the residents.	F 679		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		9/6/24

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F 690	Continued From page 22 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to prevent possible complications related to a resident with an indwelling suprapubic catheter, as evidenced by an observation of the catheter tubing on the floor for one (1) of 1 resident reviewed with a catheter. Resident #117 Findings Included: On 07/22/24 at 11:49 AM, during an observation, Resident #117 was in the dining room in his wheelchair. There was a catheter tubing dragging on the floor as he propelled himself throughout the dining room and hallway. A record review of the "Physician Orders" for the month of July 2024, revealed an order, dated 4/3/24, for a "16F (French)10cc (cubic centimeter) suprapubic Foley (type of indwelling catheter) to gravity with a closed urinary drainage bag system ..." On 07/23/24 at 12:42 PM, during an interview and observation with Licensed Practical Nurse (LPN) #6, she confirmed Resident #117's catheter tubing was in contact with the floor and acknowledged it was an infection control issue. On 07/24/24 at 11:49 AM, during an interview with the Director of Nursing (DON), she revealed that indwelling catheters can be a significant cause of infection, emphasizing the issue with the tubing touching the floor. She stated that it was the responsibility of all nursing staff to ensure	F 690	1. Resident # 117 has discharged. Resident # 117 was evaluated 7/25/24 by the assistant director of nursing with no ill effects. 2. All residents with catheters have the potential to be affected by the alleged deficient practice. 3. Nursing staff was in-serviced starting 7/25/24 by the Assistant Director of Nursing regarding catheter tubing not touching the floor and the use of privacy bags to minimize infection. A catheter audit was completed 7/29/24 on residents with catheters. 4. Catheter Observation Rounds audit results will be reported to the Quality Assurance committee monthly starting 8/27/24 times two months by the Director of Nursing with the plan reviewed and recommendations for changes to the plan if indicated. Catheter Observation Rounds were started 7/25/24 by Unit Managers and Assistant Director of Nurses to observe catheter tubing to ensure not touching the floor and use of privacy bags three times a week times eight weeks.	

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F 690	Continued From page 23 catheter tubing was not in contact with the floor. On 07/25/24 at 08:15 AM, during an interview with the Assistant Executive Director, she confirmed Resident #117 had a catheter. She stated that it was the nursing staff's responsibility to ensure that catheter tubing was off the floor, acknowledging that it could pose an infection control issue A record review of the "Face Sheet" revealed the facility admitted Resident #117 on 10/20/23 with current diagnoses including Human Immunodeficiency Virus (HIV) disease and Neuromuscular Dysfunction of Bladder. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/28/24 revealed Resident #117 had an indwelling catheter.	F 690		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record reviews, and facility policy reviews, the facility failed to provide a palatable meal for lunch for one (1) of two (2) meal observations. Resident	F 804	1. Resident # 14 is being provided palpable food per food preferences. An updated food preference list was completed by the Dietary Manager	9/6/24

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F 804	Continued From page 24 #14 Findings Included: A review of the facility's policy "Menu Planning and Requirements", dated 2016, revealed, "Guideline: Menus are planned to provide nourishing, palatable, attractive meals that meet the nutritional needs of residents served ..." On 07/22/24 at 12:39 PM, the State Agency (SA) and the Dietary Manager (DM) sampled a lunch tray consisting of a baked pork chop, cabbage, and macaroni and cheese. The DM noted that the macaroni and cheese was bland and lacked a cheese flavor. The SA team concurred with this assessment. On 07/22/24 at 02:24 PM, during an interview, Resident #14 expressed that the food lacked flavor, specifically noting the macaroni and cheese served at lunch was tasteless. She mentioned the food often lacked taste on certain days. On 07/25/24 at 3:14 PM, during an interview, the Assistant Executive Director (AED) emphasized that she expected the Dietary Manager to prepare flavorful and safe meals for the residents. She expressed a desire for the residents to enjoy their meals. A record review of the "Face Sheet" revealed the facility admitted Resident #14 on 11/22/23 with current diagnoses including Type 2 Diabetes Mellitus (DM). A review of Resident #14's "Physician Orders" for the month of July 2024 revealed Resident #14	F 804	7/25/24 based on the resident #14 food items request with meal tray card updated. Resident # 14 was interviewed on 7/25/24 with no ill effects. 2. All residents who are provided meal service have the potential to be effected by the alleged deficient practice. 3. Dietary staff were in-serviced starting 7/25/24 by Dietary Manager regarding preparation and provision of food items that are palpable to taste. 4. Meal service observation rounds results, resident interviews during meal results, and food tasting rounds results will be reported to the Quality Assurance committee monthly starting 8/27/24 times two months by the Dietary Manager with the plan evaluated and recommendations for changes to the plan if indicated. Resident meal service observation, resident interview during meal service, and food tasting rounds will be completed on five residents five times weekly times eight weeks by the Assistant Executive Director and Executive Director to ensure food palpable starting 7/26/24.	

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F 804	Continued From page 25 had a Physician's Order, dated 11/22/23, for "Regular, NAS (No Added Salt) DM precautions." A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/03/24 revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact.	F 804		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and facility policy reviews, the facility failed to ensure adaptive equipment was consistently provided at each meal for one (1) of one (1) resident observed during mealtime requiring adaptive utensils. Resident #53 Findings Include: A review of the facility's policy titled, "Adaptive Devices," dated 2016 revealed, "Guideline: Adaptive eating devices will be available to all residents who need them to promote independence in dining. Adaptive devices will be available for residents at mealtime according to their individualized plan of care. Procedure: ... 4. Resident meal cards will specify the resident's order for adaptive devices. 5. Food and Nutrition Services staff will provide each resident is given	F 810	1. Resident # 53 is being provided assistive devices-built up fork and spoon for eating with each meal provided per the plan of care. Resident # 14 was assessed by the Assistant Director of Nursing 7/25/24 with no ill effects. 2. All residents with assistive devices have the potential to be affected by the alleged deficient practice. 3. Dietary staff and nursing staff were in-serviced starting 7/25/24 by the Assistant Director of Nursing regarding provision of assistive devices during meal service for residents who utilize assistive devices to eat to enhance their meal service per their plan of care. A 100% audit was completed for all residents who utilize assistive devices for meal service by Dietary Manager and Therapy Manager	9/6/24

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F 810	Continued From page 26 the appropriate devices(s) for each meal ..." On 07/22/2024 at 12:11 PM during an observation and interview with Resident #53 stated he needed a built-up fork because he was unable to use a conventional fork when eating due to his hand disability. He stated the kitchen staff often forgets to put one on his tray for every meal, forcing him to eat with his hands. He continued by saying when one did in rare instances end up on his tray, he kept it in his room for a day or two until it got dirty, at which point he sent it back to the kitchen to be cleaned, but it would take several days to get another one. Resident #53 added he had asked the kitchen staff several times to place the right fork on his tray, but he thought that whether they followed the instructions on his meal ticket depended on the person working the kitchen that day. He mentioned he also asked the Certified Nursing Assistant (CNA) who brought the tray to get him the appropriate fork, but a lot of the time they nodded, said alright, and never brought one back to his room. At this point, he said he was just tired of asking, so he did the best he could when eating his meals. An observation of the lunch meal tray revealed no built-up fork was provided, only regular silverware. On 07/23/2024 at 12:15 PM, during a lunchtime observation of Resident #53's meal, no built-up fork was provided. Only plastic ware was given due to a COVID-19 outbreak. On 07/24/2024 at 08:10 AM, during a follow-up interview with Resident #53, he revealed that once again, his breakfast tray was delivered with no built-up fork provided, only plastic ware due to a COVID-19 outbreak. Resident #53 reported he ate with his hands since staff once again omitted	F 810	with the assistive device added to the resident meal tray card. Dietary staff will place the assistive device on the residents meal tray during tray setup for each meal. 4. Assistive device rounds audit results will be reported to the Quality Assurance committee monthly starting 8/27/24 times two months with reports by the Dietary Manager and Unit Manager with the plan evaluated and recommendations to changes to the plan if indicated. Assistive device usage rounds will be completed by the Dietary Manager and Unit Manager to include use of built up fork and spoon during meal service with observation five times a week times eight weeks to ensure usage during meal service starting 7/26/24.	

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F 810	Continued From page 27	F 810		

a built-up fork with his tray. Resident #53 said, "It (expletive) me off when I have to eat with my hands because it is a challenge, and I do not like doing that!" He claimed he got frustrated with always requesting the built-up fork and not getting one.

In an interview with the Dietary Manager on 07/24/2024 at 2:35 PM, she disclosed that she had been employed at this facility for the past three years. She confirmed Resident #53 needed a built-up fork on his tray for each meal. She explained that the facility had been running low for the past two weeks, which may be one of the reasons it had not been included on his tray. She also mentioned that a supply order that included the forks was placed a few weeks ago and they were still awaiting their arrival.

In an interview with the Registered Dietitian conducted on 07/24/2024 at 2:48 PM, she confirmed that the built-up fork was to be provided to Resident #53 at each meal. She clarified that in her understanding, the resident required this fork to eat because of a lack of strength in his hand to grasp a standard fork. She agreed that eating his food was a challenge without the built-up fork.

In an interview with CNA #7 on 07/24/2024 at 3:09 PM, she disclosed that she observed the resident's tray without a built-up fork on at least two occasions during dinner when she worked the evening shift. She indicated that he had requested that the dietary department provide him with one at each meal on numerous occasions. It was surprising to her that they did not as it was clearly stated in black and white that he required one on his meal ticket.

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F 810	Continued From page 28 On 07/25/2024 at 8:02 AM, in an interview with the Assistant Administrator, she revealed she was aware that the facility was running low on the built-up forks. She indicated an order was placed a few weeks ago when she realized it during one of her audits. A record review of the meal ticket dated 07/24/2024 revealed "Adap (Adaptive) Equip (Equipment): Built-up Utensils x 2." A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/11/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #53 was cognitively intact. A record review of the "Face Sheet" revealed Resident #53 was admitted to the facility on 09/25/2017. His diagnoses included Paraplegia.	F 810		
F 812 SS=E	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	F 812		9/6/24

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F 812	Continued From page 29 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 maintain sanitary practices within professional standards for food service safety related to hand hygiene for one (1) of two (2) kitchen observations. Findings Included: A review of the facility's policy, "Proper Hand Washing and Glove Use", dated 2016, revealed, " Guideline: All employees will use proper hand washing procedures ...Procedure ...4. Employees will wash hands before and after ...touching any part of their uniform, face, or hair ..." On 07/22/24 at 10:29 AM, an observation of the Registered Dietitian (RD) revealed on two (2) occasions while she stood adjacent to the steam table, she picked up an ink pen from the kitchen floor and placed it back on the steam table. After placing the ink pen on the steam table, the RD proceeded to handle a food service utensil which was placed in a pan of pureed pork chops on the steam table, the food thermometer, and the menu book. The RD was observed licking her fingers and flipping through the resident's meal cards that were placed on each tray. On 07/22/24 at 11:00 AM, during an interview with the RD, she acknowledged picking the pen up from the floor and placing it back on the steam table on two (2) occasions during the lunch	F 812	1. The Registered Dietitian immediately washed her hands on 7/22/24. Dietary staff are providing food services per sanitary practices with hand washing as needed. 2. All residents have the potential to be affected by the alleged deficient practice. 3. Dietary staff have been in-serviced starting 7/25/24 by the Assistant Executive Director regarding maintaining sanitary practices for food services safety related to hand hygiene. Dietary staff will wash hands if they leave the tray line to obtain an item and return, will not pick up items off the floor when dropped during meal service, and will not lick fingers to turn tray cards. 4. Dietary observation rounds results and checklist results will be reported to the Quality Assurance committee monthly starting 8/27/24 times two months with reports by the Executive Director with the plan evaluated and recommendations to changes to the plan if indicated. Dietary observation rounds and checklist will be completed by the Assistant Executive Director and Executive Director starting 7/25/24 five times weekly times eight weeks to ensure food is being provided under sanitary practices and with good hand hygiene.	

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F 812	Continued From page 30 mealtime. The RD confirmed that she would not want her food to be contaminated with items that had been on the floor or exposed to saliva. On 07/22/24 at 11:05 AM, during an interview with the Dietary Manager (DM), she acknowledged observing the RD licking her fingers and flipping through meal tickets meant to be placed on residents' trays and twice picking up an ink pen from the floor, placing it back on the steam table, and proceeding to touch other items in the kitchen without using hand hygiene. The DM stated she expected staff to use hand hygiene in the kitchen. The DM stated the staff were trained yearly regarding infection control. On 07/24/24 at 03:40 PM, during an interview with the Assistant Administrator (AA), she acknowledged the incidents as reported. The AA revealed she expected her staff to always follow safety protocols and to use hand hygiene whenever they touched a contaminated surface. The AA reported the staff received in-service training on infection control annually.	F 812		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe environment for residents as evidenced by unlocked biohazard rooms on two (2) of four (4) days of survey.	F 921	1. The Housekeeping and Laundry Supervisor immediately locked the Bio-hazard room on 7/23/24. Bio-hazard doors are being kept closed and locked when not in use by staff.	9/6/24

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F 921	Continued From page 31 Findings Included: During an observation on 07/22/24 at 12:00 PM, there was an unlocked door marked "Biohazard" on the second floor of the facility. Inside, a red biohazard can was open with red biohazard bags visible, alongside housekeeping chemical dispensers containing Vindicator (a type of disinfectant) and Super Shine All (a type of floor cleaner). A record review of the "Safety Data Sheet" (SDS), dated 02/04/21, revealed Vindicator had a health hazard for acute oral toxicity and skin corrosion/irritation. A record review of the "Safety Data Sheet", dated 10/22/21, revealed Super Shine had a health hazard for serious eye damage/eye irritation. On 7/23/24 at 10:30 AM, during an observation and interview with the Housekeeping and Laundry Supervisor, she observed the biohazard room door was not secured on the second floor of the facility. She stated that biohazard doors should always remain closed and securely locked to ensure the safety of residents. In an interview on 07/24/24 at 9:05 AM, the Assistant Nursing Home Administrator (ANHA) acknowledged that biohazard room doors should always be closed and locked to ensure the safety of residents and visitors. The ANHA emphasized that it is the responsibility of all employees to ensure these doors are secure, highlighting the potential risks posed by exposure to medical waste or chemicals.	F 921	2. All residents have potential to be affected by unlocked bio-hazard doors. 3. Nursing, housekeeping, and maintenance staff have been in-serviced starting 7/25/24 by the Assistant Director of Nursing regarding keeping bio-hazard doors closed and locked when not in use. A 100% audit of all bio-hazard doors ensured that they were closed and locked when not in use. 4. Bio-hazard doors round results will be reported to Quality Assurance monthly starting 8/27/24 times two months with reports from the Director of Nursing with the plan evaluated and recommendation for changes to he plan if indicated. Bio-hazard doors rounds are being completed five times weekly times eight weeks to ensure bio-hazard doors are closed and locked when not in use starting 7/25/24 by Unit Manager, Assistant Director of Nursing, Maintenance Supervisor, and Housekeeping Supervisor.	