STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255216	A. BUILDING _____ B. WING _____	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW NURSING & REHABILITATION CENTER	1600 WEST CLAIBORNE AVENUE EXTENDED GREENWOOD, MS 38930

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 11/3/24 through 11/6/24. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F550, F578, F584, F604, F641, F655, F656, F677, F688, F725, F757, F758, F806, F809, and F880. The census at the time of the survey was 61 and the facility is licensed for 91 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		12/19/24

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

Electronically Signed | 11/21/2024

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 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews the facility failed to promote dignity as evidenced by a resident not being assisted with his meal immediately after nursing staff delivered the meal tray to his room for one (1) of eight (8) residents reviewed for dining. Resident #16 Findings Included: Record review of the facility policy titled, " Residents' Rights" with no revision date revealed "Residents Rights Under Federal Law. The facility shall protect and promote the rights of each resident, including each of the following rights: 1. The resident has a right to a dignified existence, self-determination, communication with access to people and services inside and outside the facility..." On 11/3/24 at 5:28 PM, during a continuous	F 550	Resident #16 suffered no ill effects from this deficient practice. On 11/22/2024 Certified Nursing Assistant #8 will be provided an in-service/education by the Director of Nursing to ensure that each resident that requires assistance with eating will have their meals delivered and assistance provided at the same time their room-mate that requires no assistance receives their meal tray. All residents that require asssistance with their meal tray have the potential to be affected by this deficient practice. On 11/20/2024, the Assistant Director of Nursing educated all nursing staff on ensuring that the dignity of all residents that require assistance with meals is maintained and that their meal trays will be delivered and they will be assisted at the same time as their roommate or table	

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F 550	Continued From page 2 observation, Resident #16 was observed in bed as Certified Nursing Assistant (CNA) #8 delivered a meal tray to his room, placing it on the overbed table positioned against the wall and out of the resident's reach. The tray remained covered as CNA #8 exited the room without assisting Resident #16. She then delivered the meal tray to Resident #16's roommate, setting it up for the roommate to eat before leaving the room. Upon exiting, she informed Resident #16 that someone would be in shortly to assist him. Nursing staff were observed walking past the room but did not enter to assist Resident #16. At 5:34 PM on 11/3/24, Registered Nurse (RN) #1 entered the room and began assisting Resident #16 with his meal. She confirmed that Resident #16 could not feed himself and required assistance from the staff. She agreed that CNA #8 should have assisted Resident #16 when she brought the meal tray into the room, rather than leaving it and setting up the roommate's meal. She acknowledged that this could make the resident feel that his needs were not being prioritized. In an interview with CNA #8 on 11/3/24 at 5:40 PM, she explained that as long as the food remains covered, they usually leave the tray in the room and wait for someone to assist the resident. She mentioned that she was assigned to the room but was not specifically tasked with assisting Resident #16 with eating assistance, stating that no one is assigned specifically to assist residents; instead, staff members assist residents as they see the need. She confirmed she was aware that Resident #16 required assistance with eating.	F 550	mate. A 100% review of all residents that require assistance with eating was conducted by the Assistant Director of Nursing on 11/05/2024. Starting on 11/22/2024, The Assistant Director of Nursing will monitor meal times two times per week for twelve weeks to ensure that all residents that require assistance with eating have their meal trays delivered at the same time as their roommate or table mate. Starting on 11/22/2024, The Director of Nursing will monitor meal times one time per week for twelve weeks to ensure residents that require assistance with eating have their dignity maintained during meal times. Any adverse findings will be brought to the facility Quality Assurance meeting on 12/18/2024 for review and action as indicated times twelve weeks.	

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F 550	Continued From page 3 An interview on 11/4/24 at 2:00 PM, with Licensed Practical Nurse (LPN) #2 indicated that the facility has a list of residents who require assistance with eating to inform staff. She stated that while no staff member is specifically assigned to assist residents with eating, all nursing staff are responsible for passing trays and assisting residents requiring help when delivering the tray. In a follow-up interview on 11/4/24 at 2:05 PM, the Director of Nursing (DON) verified that all nursing staff are responsible for passing trays and, when bringing a tray into the room of a resident who requires assistance, they are expected to assist the resident at that time rather than leaving the tray unattended. She agreed that CNA #8 should not have set up the roommate's meal while leaving Resident #16's tray without assistance, acknowledging this as a dignity concern. Record review of the "Admission Record" revealed that the facility admitted Resident #16 on 6/6/14 with diagnoses including Multiple Sclerosis. Record review of the Quarterly Minimum Data Set Assessment (MDS) with an Assessment Reference Date of 9/25/24 revealed, under Section GG Functional Abilities and Goals, Resident # 16 is dependent for eating.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		12/19/24

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F 578	Continued From page 4 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview, record review, and facility policy review, the facility failed	F 578	Resident #58 suffered no ill effects from this deficient practice. On 11/02/2024 the	

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F 578	Continued From page 5 to honor a resident's right to make health care decisions for one (1) of 25 residents reviewed for advanced directives. Resident #58 Findings Include: Record review of the facility policy titled "Advanced Directives" with a revision date of 8/11 revealed under, "Policy Interpretation and Implementation: 1. Prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives." Record review of the "Advanced Directive Form" for Resident #58 revealed a family member signed the form dated 4/23/24, with no signature from the resident. An interview with Resident #58 on 11/4/24 at 1:20 PM, revealed when he admitted to the facility, he did not sign his advanced directives form and explained that no one had spoken to him regarding his code status. He revealed he felt it was important that he make his own decisions because he might not feel the same way as his family members. An interview with Social Services (SS) #1 on 11/4/24 at 1:40 PM, confirmed Resident #58 did not sign his own advanced directive form. She revealed if a resident was cognitive and able to sign it, they should because the residents have a right to self-determination.	F 578	Social Worker and Director of Nursing immediately went to Resident #58 and interviewed him regarding his decision on his advanced directive. Resident #58 decided to remain a full code. All residents that have advanced directives could be affected by this deficient practice. On 11/22/2024 the Administrator will educate the Social Worker and Admissions Nurse on ensuring that all cognitive residents have the opportunity to participate in and sign their own advanced directives. A 100% review of all residents that have advanced directives will be conducted by the facility Social Worker on 11/22/2024. Starting on 11/22/2024 The Social Worker will monitor all cognitive residents advanced directives once per week for twelve weeks to ensure the cognitive residents was provided the opportunity to participate in and sign their own advanced directives. Starting 11/22/2024, the Care Plan Nurse will monitor one resident per week for twelve weeks to ensure the cognitive resident has participated in and signed their own advanced directives and it is care planed. Any adverse findings will be brought to the facility Quality Assurance meeting on 12/18/2024 for review and action as indicated times twelve weeks.	

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F 578	Continued From page 6 An interview with the Director of Nursing (DON) on 11/5/24 at 7:59 AM, revealed Resident #58 was cognitive and could make his own health care decisions. She confirmed he should have been allowed to sign his own advanced directive form, ensuring his wishes were honored. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/14/24 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #58 was cognitively intact. Record review of the "Admission Record" revealed the facility admitted Resident #58 on 4/23/24 with a medical diagnosis that included Nontraumatic Intracranial Hemorrhage.	F 578		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		12/19/24

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F 584	Continued From page 7 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and facility policy review, the facility failed to provide a safe, clean, and comfortable environment, as evidenced by an over-bed table with exposed jagged edging (Resident #4) and a sagging mattress (Resident #58) for two (2) of 61 residents. Findings include: Review of the facility policy titled "Maintenance Service" with a revision date of December 2009 revealed, "Maintenance service shall be provided to all areas of the building, grounds, and equipment." J. ... Ensuring equipment is	F 584	Resident #4 and Resident #58 suffered no ill effects from this deficient practice. On 11/04/2024 the Director of Nursing and the Maintenance Director removed the over bed table from resident #4 room and provided them with a new over bed table. On 11/05/2024 the Maintenance Director removed the sagging mattress for resident #58 and provided them with a new mattress. All residents have the potential to be affected by this deficient practice. A 100% audit will be completed by the	

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F 584	Continued From page 8 maintained in good, operational working order." Resident #4 An observation on 11/03/24 at 4:25 PM, revealed Resident #4 lying in bed with her overbed table pulled up to her. The overbed table edging was missing around the table, exposing chipped and jagged wood. An observation on 11/04/24 at 8:25 AM, revealed the overbed table remained in the same condition as the prior day. During an interview and observation on 11/04/24 at 1:30 PM, Certified Nurse Aide (CNA) #4 confirmed that Resident #4's overbed table was tattered and torn and revealed she had not reported the condition of the overbed table to anyone. She revealed that when they see equipment or anything that needs repair in a resident's room, they are supposed to notify the nurse or maintenance. In an interview and observation on 11/04/24 at 1:48 PM, the Director of Nurses (DON) confirmed that Resident #4's overbed table needed to be replaced and revealed that the resident could get hurt by the exposed wood around the edge of the table. She revealed that all department heads make rounds each morning and look at each room to ensure there are no issues. Record review of the "Admission Record" revealed the facility admitted Resident #4 on 06/22/2020 with medical diagnoses that included Parkinson's Disease with Dyskinesia. Resident # 58	F 584	Maintenance Director on 11/22/2024 to determine if any other over bed table and mattress need to be replaced. If any are needed, orders will be placed with our supplier. Starting on 11/22/2024 The Maintenance Director will do a facility audit one time per month for four months to monitor for any over bed tables or mattresses that need to be replaced. Starting on 11/25/2024 The Administrator will do a facility audit one time per month for four months to ensure there are no over bed tables or mattresses that are in need of replacing. Any adverse findings will be brought to the facility Quality Assurance meeting on 12/18/2024 for review and action as indicated times twelve weeks.	

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F 584	Continued From page 9	F 584		

An observation and interview with Resident #58 on 11/03/24 at 3:11 PM, revealed him lying in bed. He explained that his mattress was uncomfortable and had a sag in the middle. The resident revealed he had told all of the staff that entered his room that his mattress was uncomfortable.

An observation and interview on 11/4/24 at 8:20 AM, with Resident #58 revealed, the resident lying on a raised perimeter mattress which the resident explained made it difficult for him to turn side to side in the bed.

An observation and interview with Licensed Practical Nurse (LPN) # 1 on 11/4/24 at 1:00 PM, revealed she was not aware of Resident #58's complaints regarding the mattress. She revealed the nursing staff were responsible for changing out the mattresses. LPN #1 confirmed the resident should be comfortable, and the equipment should be in good repair.

An interview with the DON on 11/5/24 at 7:58 AM, revealed Resident #58 should have a regular mattress, but had a raised perimeter mattress because the facility did not have any regular mattresses on hand. She confirmed the resident should have a comfortable mattress.

Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/14/24 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #58 was cognitively intact.

Record review of the "Admission Record"

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F 584	Continued From page 10 revealed the facility admitted Resident #58 on 4/23/24 with a medical diagnosis that included Nontraumatic Intracranial Hemorrhage.	F 584		
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- §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:	F 604		12/19/24

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F 604	Continued From page 11 Based on observation, staff interview, record review and facility policy review, the facility failed to ensure residents were free from physical restraints as evidenced by a resident with full side rails to both sides of the resident's bed for one (1) of two (2) residents reviewed for restraints. Resident #44. Findings Include: A review of the facility policy titled "Residents' Rights" with no revision date revealed "The facility shall protect and promote the rights of each resident, including each of the following rights: ... The resident has a right to be free from any physical restraints imposed or psychoactive drugs administered for the purpose of discipline or convenience and not required to treat the resident's medical symptoms." During an observation on 11/03/24 at 3:35 PM, Resident #44 was observed in bed with side rails extending the length of the bed on both sides. In an interview on 1/4/24 at 1:12 PM, Certified Nursing Assistant (CNA) #3 stated that she did not know why Resident #44 had full side rails on his bed. During an interview on 1/4/24 at 1:17 PM, with a Licensed Practical Nurse (LPN) #1, she stated that Resident #44 has had full side rails for approximately two weeks. She noted that the full side rails were implemented to prevent the resident from getting out of bed, as he had previously used half (1/2) side rails but was climbing out. She mentioned that she contacted hospice to request full side rails, which have been in place since then.	F 604	Resident #44 suffered no ill effects from this deficient practice. On 11/15/2024, Hospice Representative removed the full bed rails from resident #44 bed. On 11/07/2024 the Director of Nursing contacted Resident #44 Responsible Party to get permission to add half bed rails. The care plan was then updated to reflect this change and the Maintenance Director added Resident #44 to the bed rail inspection checklist. All residents that require bed rails could be affected by this deficient practice. A 100% review of all residents that have restraint orders will be conducted by the facility Assistant Director of Nursing on 11/22/2024 to ensure that all bed rails used are appropriate for the resident and all assessments, orders and consents are in place. The Assistant Director of Nursing will educate all nursing staff on Resident Rights ensuring that all residents that have side rails have a restraint assessment conducted and consents signed and care planned. A 100% review of all residents care plans for bed side rails will be conducted by the Director of Nursing on 11/22/2024. Starting on 11/25/2024 The Director of Nursing will monitor all residents two times per week for twelve weeks to ensure all residents are free from restraints or have restraint assessments conducted and signed. Starting on 11/25/2024 The Care Plan	

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F 604	Continued From page 12 In an interview on 1/4/24 at 2:12 PM, the Director of Nursing (DON) verified that Resident #44's bed had full side rails extending the length of the bed on both sides and confirmed that the resident has a history of attempting to get out of bed. She acknowledged that the side rails act as a restraint, preventing the resident from getting out of bed. A record review of Resident #44's "Order Summary" revealed an order for "Bilateral 1/2 Side Rails to Assist with Turning and Positioning" with an onset date of 6/10/24. A record review of the "Assessments" for Resident #44 revealed no documentation of a side rail or restraint assessment. A record review of Resident #44's medical record indicated no consent for the use of the full side rails on the resident's bed. In a follow-up interview with the DON on 11/5/24 at 8:05 AM, she confirmed that Resident #44 did not have a side rail or restraint assessment, consent, or physician orders for full side rails on both sides of the bed. She stated that consent should have been obtained from the resident's representative and that education regarding side rail use should have been provided. Additionally, she acknowledged that an assessment should have been conducted to ensure the full side rails were safe for the resident. Record review of the "Admission Record" revealed that the facility admitted Resident #44 on 7/12/22 with diagnoses including Dementia.	F 604	Nurse will monitor one resident per week for twelve weeks to ensure all restraint orders are care planned. Any adverse findings will be brought to the facility Quality Assurance meeting on 12/18/2024 for review and action as indicated times twelve weeks.	

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F 641	Continued From page 13	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review the facility failed to ensure that the Minimum Data Set Assessment (MDS) was coded accurately for one (1) of 22 sampled residents. Resident #19. Findings Included: Record review of the facility policy, titled "Resident assessment Instrument" revealed " Policy Statement: A comprehensive assessment of a resident's needs shall be made within fourteen (14) days of the resident's admission. Policy Interpretation and Implementation...4. Information derived from comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning. 7. All persons who have completed any portion of the MDS Resident Assessment Form must sign such a document attesting to the accuracy of such information." Record review of Resident #19's Annual MDS with Assessment Reference Date (ARD) of 7/2/24, revealed in Section A 1500 coded as "No", Is the resident currently considered by the state level II PASRR (Preadmission Screening and Resident Review) process to have serious mental illness and/or intellectual disability or a related condition?"	F 641	Resident #19 suffered no ill effects from this deficient practice. On 11/19/2024 the Minimum Data Set Nurse (MDS) modified and transmitted section A 1500 to reflect YES being that resident #19 meets the criteria for having a diagnosis of mental illness as defined by Preadmisson Screening and Resident Review (PASSR). All residents who meet the criteria for mental illness as defined by PASRR could be affected by this deficient practice. A 100% review of all residents that meet the criteria of mental illness as defined by PASRR will be conducted by the Assistant Director of Nursing on 11/22/2024. On 11/22/2024 the Assistant Director of Nursing will educate all MDS staff on proper documentation for all residents that meet the criteria of mental illness as defined by PASRR. Starting on 11/22/2024, The MDS nurse will monitor all residents two times per week for twelve weeks to ensure all residents who meet the criteria for mental illness are documented properly and care planned. Starting on 11/22/2024, The Director of Nursing will monitor one resident per week for twelve weeks to ensure all	12/19/24

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F 641	Continued From page 14 Record review of Resident #19's "Summary of Findings Report", from the PASRR Office, dated 1/29/2019, under "Mental Health" revealed "the individual meets criteria for having a diagnosis of mental illness as defined by PASRR." Interview with MDS Nurse on 11/5/24 at 1:15 PM, she verified that the Annual MDS with an ARD of 7/2/24, for Resident # 19 was coded incorrectly, because the resident does have a mental illness. She agreed that the MDS should be coded correctly to ensure that the resident is receiving the correct level of care. A record review of the "Admission Record" revealed Resident #19 was admitted by the facility on 1/14/19 with a diagnoses including Schizophrenia.	F 641	residents who meet the criteria for mental illness are properly documented and care planned. Any adverse findings will be brought to the facility Quality Assurance meeting on 12/18/2024 for review and action as indicated times twelve weeks.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655		12/19/24

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F 655	Continued From page 15 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, record review, and facility policy review the facility failed to complete a baseline care plan timely and provide a summary of the baseline care plan to the resident and their representative for two (2) of three (3) baseline care plans reviewed. Resident 59 and 166 Findings include: A review of the facility policy titled, "Care	F 655	Resident #59 and Resident #166 suffered no ill effects from this deficient practice. On 11/19/2024 the Care Plan Nurse emailed the baseline care plan to Conservator for Resident #59 to be signed. On 11/08/2024 Resident #166 who is his own Responsible Party reviewed and signed his baseline care plan. All resident baseline care plans could be	

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F 655	Continued From page 16 Plans-Baseline," with a revision date of 12/2016 revealed "Policy Interpretation and Implementation: 1.) To ensure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. ... 4.) The residents and their representatives will be provided with a summary of the baseline care plan..." Resident #59 A record review of the Baseline Care Plan for Resident #59 revealed the care plan was completed on 8/22/24 with no signature of the resident or representative acknowledgement of receipt of the care plan summary findings. In an interview with Resident # 59 on 11/4/24 at 3:00 PM, she revealed that there were no staff that discussed her plan of care with her on admission. Record review of the "Admission Record" revealed the facility admitted Resident #59 on 8/22/24. Record review of Resident #59's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/29/24 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Resident #166 A review of the Baseline Care Plan for Resident #166 revealed the care plan was initiated on 11/1/24, the day of admission by staff but was not completed within 48 hours. Further review of the	F 655	affected by this deficient practice. A 100% review of all residents baseline care plans will be conducted by the Assistant Director of Nursing on 11/22/2024. On 11/22/2024 the Assistant Director of Nursing will educate all care plan staff on proper documentation for all residents upon admission and thereafter. Starting on 11/22/2024 The Care Plan Nurse will monitor all residents two times per week for twelve weeks to ensure all residents baseline care plans are properly documented and all residents responsible parties are notified of any updates on those baseline care plans as needed. Any adverse findings will be brought to the facility Quality Assurance meeting on 12/18/2024 for review and action as indicated times twelve weeks.	

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baseline care plan revealed there was no signature of family, resident or representative notification of the baseline care plan summary findings.

In an interview with Resident #166 on 11/3/24 at 2:00 PM, he revealed that no one explained his plan of care to him when he was admitted.

In an interview with the MDS nurse on 11/04/24 at 12:00 PM, she revealed she was unaware that the Baseline Care Plan needed to be completed within 48 hours or that the findings needed to be discussed with the resident or the representative. She then confirmed that they have not been discussing the Baseline Care Plan findings with the new admission residents or the representatives.
The MDS nurse revealed the purpose of the Baseline Care Plan is to identify resident needs and direct staff resident required care.

In an interview with the Care Plan Nurse on 11/04/24 at 12:15 PM, she revealed that she was unaware of a timeframe for the Baseline Care Plan to be completed. She also revealed she was not aware that the facility was supposed to discuss the care plan findings with the resident/resident representative and confirmed she has not been discussing the baseline plan of care with any of the new admissions.

In an interview with the Director of Nursing on 11/04/24 at 12:22 PM, she revealed she was unaware that the baseline care plan findings needed to be discussed with the resident/resident representative within 48 hours of admission.

Review of the "Admission Record" revealed the

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F 655	Continued From page 18 facility admitted Resident #166 on 11/01/24. Record review of Resident #166's BIM Evaluation dated 11/01/24 revealed a BIMS score of 13, indicating the resident was cognitively intact.	F 655		
F 656 SS=E	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.	F 656		12/19/24

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F 656	Continued From page 19 (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 observation, resident and staff interview, record review and facility policy review, the facility failed to develop and/or implement a person-centered care plan for monitoring side effects of medications, range of motion (ROM) and providing nail care for 11 of 24 resident care plans reviewed. Resident #4, #9, #10, #17, #18, #19, #39, #44, #51, #55 and #58. Findings Include: Record review of the facility policy titled "Comprehensive Assessments and the Care Delivery Process" with a revision date of 12/16 revealed under, "Policy Statement: Comprehensive assessments will be conducted to assist in developing person-centered care plans." Resident # 4 Record review of Resident #4's care plan revealed under focus, "Closed fracture of right	F 656	Resident #44 care plan was updated by the Director of Nursing on 11/05/2024 to include monitoring of anticoagulant use, range of motiong, and to monitor for any signs and symptoms of bleeding or bruising. Resident #10-On 11/06/2024 the Director of Nursing met with the staff on duty to ensure that they were to monitor and document for side effects of psychotropic medications on each shift. Resident #9 finger nails were trimmed on 11/04/2024 by the Treatment Nurse and a Certified Nursing Assistant. Resident #58 fingernails were trimmed on 11/04/2024 by the Treatment Nurse and a Certified Nursing Assistant. On 11/05/2024 the care plan nurse developed a care plan for trimming resident #58 finger nails. Resident #18, #51 and #55 on 11/06/2024 the Director of Nursing met with the nursing staff on duty to ensure that they were to monitor and document for side effects of psychotropic medication use for	

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F 656	Continued From page 20 tibia and fibula", date initiated 05/01/2024. Interventions included Xarelto 10 milligram tablet, monitor for side effects such as abdominal pain, back pain, itching, dizziness, muscle spasms, trouble sleeping, and anxiety. Date initiated 5/6/2024. In an interview on 11/05/24 at 10:46 AM, the Director of Nurses (DON) confirmed that Resident #4 was on an anticoagulant medication and confirmed that Resident #4's care plan was not developed for anticoagulation medication, which should also include monitoring for bleeding and bruising. An interview on 11/06/24 at 9:50 AM, the Care Plan Nurse confirmed that Resident #4 did not have a care plan developed that addressed the potential outcomes associated with the use of an anticoagulant medication, which is bleeding and bruising and revealed it is so important to ensure that adequate monitoring of a blood thinner is being done. Record review of the "Admission Record" revealed the facility admitted Resident #4 on 06/22/2020 with medical diagnoses that included Parkinson's Disease with Dyskinesia. Resident #10 A review of the care plan titled "Psychotropic medication use" with a start date of 10/04/2024, revealed Interventions: "Monitor and document side effects of medication every shift." During an interview on 11/06/24 at 08:57 AM, the DON confirmed they were not monitoring for the side effects of psychotropic medications, and they	F 656	residents #18, #51 and #55. Residents #17, #19 and #39 had their care plans updated with an intervention for range of motion on 11/19/2024 by the Care Plan Nurse. All residents had the potential to be affected by these deficient practices. A 100% Care plan audit was conducted by the Director of Nursing on 11/22/2024. On 11/22/2024 the Assistant Director of Nursing provided in-service education to the nursing staff and the Care Plan nurse regarding monitoring of side effects of anticoagulant use, providing Activities of Daily Living assistance, and for monitoring and documenting the side effects of psychotropic medication use, range of motion, and the use of care plans and ensuring that care plans are developed and updated as needed. Starting on 11/25/2024 The Minimum Data Set nurse and Care plan nurse will monitor documentation for side effects of psychotropic use two times per week times twelve weeks. Starting 11/25/2024 the Assistant Director of Nursing will monitor documentation of anticoagulant use, range of motion, Activities of Daily Living care and the use of documentation for side effects of psychotropic use two times per week times twelve weeks. Any adverse findings will be brought to the facility Quality Assurance meeting on 12/18/2024 for review and action as indicated times twelve weeks.	

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should have been. She revealed Resident #10's care plan was not being followed since the psychotropic medications were not being monitored or documented.

An interview on 11/06/24 at 10:42 AM, the Care Plan nurse revealed the purpose of the care plan is to inform staff on how to take care of each resident individually. She confirmed that according to Resident #10's care plan, she was on psychotropic medications. Since the nurses were not monitoring and documenting the side effects of the medication, the plan of care was not being followed.

Record review of the "Admission Record" revealed Resident #10 was admitted to the facility on 10/04/2024 with medical diagnoses that included Anxiety Disorder.

A record review of the MDS with an ARD of 10/11/2024 revealed that Resident #10 had a BIMS score of 14, which indicated that the resident was cognitively intact.
Resident #9

Record review of Resident #9's care plans revealed under, "Focus: ADLS (activities of daily living): Alterations in ADL's R/T (related to) impaired mobility...Interventions/Tasks ... Trim fingernails and toenails PRN (as needed)". Date initiated 12/13/13.

On 11/03/24 at 2:30 PM, observation revealed, Resident #9 lying in bed with long jagged nails on both hands, measuring approximately three-eighths (3/8) inch in length past the tips of the resident's fingers.

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An observation and interview with the DON on 11/4/24 at 1:10 PM, confirmed Resident #9's nails were long.

An interview with the Care Plan Nurse on 11/6/24 at 10:02 AM revealed the purpose of the care plan was to ensure the resident's needs were taken care of. She confirmed the care plan was not followed for Resident #9's nail care.

Record review of the "Admission Record" revealed the facility admitted Resident #9 on 12/13/13 with a medical diagnosis that included Dementia, unspecified.

Resident #58

Record review of Resident #58's ADL Care Plan revealed a care plan was not developed for nail care.

On 11/03/24 at 3:11 PM, observation and interview with Resident #58 revealed, long nails on both hands that measured approximately one-half (1/2) inch in length. The resident stated he was a diabetic and would like to have his nails cut because he does not like them long.

An observation and interview with Licensed Practical Nurse (LPN) #1 on 11/4/24 at 1:04 PM, confirmed Resident #58 had long nails.

An interview with the Care Plan Nurse on 11/6/24 at 10:02 AM, confirmed a nail care plan was not developed for Resident #58.

Record review of the Quarterly MDS with an ARD of 10/14/24 revealed, under section C, a Brief

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Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #58 was cognitively intact.

Record review of the "Admission Record" revealed the facility admitted Resident #58 on 4/23/24 with a medical diagnosis that included Nontraumatic Intracranial Hemorrhage.

Resident # 17

On 11/04/24 at 12:50 PM, an observation of Resident #17 with Licensed Practical Nurse (LPN) #1 , she confirmed that Resident #17's right and left hands were contracted.

A review of a care plan for Resident #17 titled, Risk for new contractures related to Cerebral Palsy, has contractures of left and right hand, revised 9/10/24 revealed no routine services to prevent worsening of the contractures.

On 11/05/24 at 3:20 Pm, in an interview with the DON , she revealed after review of Resident #17's care plan related to the resident 's contracted hands, the care plan was not developed appropriately when range of motion was not added as an intervention.

Record review of the "Admission Record" revealed the facility admitted Resident #17 on 9/11/15 with diagnoses of Cerebral Palsy and contracture to right and left hand.

Record review of Resident #17's MDS with an ARD of 8/22/24 Section GG: 0115 functional limitation in range of motion was coded impairment on both sides of the upper and lower

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extremities.

Resident #18

A review of the "Order Summary Report for Resident # 18 revealed orders for Aripiprazole 30 mg (milligram) one tablet at bedtime related to schizoaffective disorder... Ativan (Lorazepam) one (1) mg tablet 0.5 mg in the morning for generalized anxiety for (4) four days... Ativan one (1) mg tablet 0.5 mg at bedtime for generalized anxiety for (4) four days... Olanzapine 10 mg one tablet at bedtime for schizoaffective disorder... Venlafaxine HCL (hydrochloride) extended one tablet by mouth one time a day related to Major Depressive disorder...

A review of the Order Summary Report for Resident # 18 revealed no order to monitor for side effects of the multiple psychotropic medications ordered.

Record review of a care plan for Resident #18 titled, "Psychotropic medication use Antianxiety, Antidepressant, Antipsychotic," ," revised 9/14/24 revealed Interventions: Monitor for effects and side effects of medication every shift.... Observe for signs of complications such as cognitive behavior problems, sedation, hypotension, gait disturbance, and tremors..

In an interview with the DON on 11/04/24 at 2:45 PM, she confirmed after review of the psychotropic care plans for Resident #18 that staff were not following the care plan intervention for monitoring for side effects of the psychotropic medications. She stated that the purpose of the comprehensive care plan is to identify residents' specific needs and direct the individual care each

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resident needs.

Review of the "Admission Record" revealed the facility admitted Resident #18 on 9/05/24 with diagnoses including Schizophrenia, Bipolar Disorder, and Anxiety Disorder.

Record review of Resident #18's Section N: Medications of the Admission MDS with an ARD 9/12/24 revealed, N: 04115 : High-Risk Drug Classes: antipsychotic, antianxiety, and antidepressant coded yes for receiving the medications.

Resident #51

A record review of the Order Summary Report for Resident # 51 revealed orders for Lorazepam oral concentrate two (2) mg/ml (milligram/milliliter): give .25 mg by mouth every four hours as needed anxiety with an order date of 8/27/24 with no stop date, Ativan 0.5 mg by mouth three times daily, related to anxiety, and Zoloft 50 mg tablet one tablet by mouth at bedtime related to Anxiety.

A continued review of the Order Summary Report for Resident # 51 revealed no order to monitor for side effects of the multiple psychotropic medications ordered.

A record review of a care plan for Resident #51 titled, Anxiety as exhibited by paranoia, revealed Interventions: Monitor effects and side effects of medication (sedation, drowsiness, agitation, headache)...

In an interview with the DON on 11/05/24 at 7:35 AM, she revealed after review of Resident #51 ' s psychotropic care plan that staff were not

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following the intervention for monitoring for side effects.

Review of the "Admission Record" revealed the facility admitted Resident # 51 on 11/30/23 with diagnoses of Mood disorder, and Anxiety.

Record review of Resident #51's Section N: Medications of the Quarterly MDS with an ARD/Target Date of 11/18/24 revealed N: 04115 : High-Risk Drug Classes: antianxiety and antidepressant coded yes for receiving the medications.

Resident #55

A record review of the "Order Summary Report" for Resident # 55 revealed orders for buspirone (5) five mg tablet twice daily for Anxiety, Risperdal (2) two mg at bedtime for bipolar disorder, and Risperdal 0.5 mg daily for bipolar disorder.

A continued review of the Order Summary Report for Resident # 55 revealed no orders to monitor the side effects of the psychotropic medications.

A record review of a care plan for Resident #55, date initiated 5/17/24 titled, Bipolar: impaired thought process, revealed, Interventions: Monitor for side effects such as feeling sleepy in the day or difficulty falling asleep at night, problems with movement, difficulty moving, stiff muscles with movements which are difficult to control, a slow shuffling walk, shakes and drooling, headaches, and putting on weight or changes in appetite.

A record review of a care plan for Resident #55 date initiated 8/14/24 titled, Anxiety: risk for

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episodes of anxiety, revealed, Interventions: Monitor effects and side effects of medication (sedation, drowsiness, agitation, headache).

In an interview with the DON on 11/04/24 at 2:40 PM, she revealed after reviewing the psychotropic drug care plans for Resident #55, staff were not implementing the care plan when there was no side effect monitoring.

Record review of the "Admission Record" revealed the facility admitted Resident #55 on 3/01/24 with diagnoses of Bipolar Disorder, Anxiety Disorder, Borderline Personality Disorder, and Psychotic Disorder with Delusions.

Record review of Resident #51's Section N: Medications of the Quarterly MDS with an ARD 8/23/24 revealed N: 04115 : High-Risk Drug Classes: antipsychotic and antianxiety coded yes for receiving the medications..

Resident #19

An observation on 11/03/24 at 4:00 PM revealed Resident #19 had limited range of motion (ROM) to first through fourth fingers of the left hand at the first finger joints.

During an interview on 11/4/23 at 3:23 PM, with Certified Nursing Assistant (CNA) #10 she stated he is dependent for all care and cannot help at all. She stated that Resident #19 has contractures to his fingers and his legs.

Record review of Resident #19's care plan revised 7/8/24 revealed "Risk for contracture r/t (related to) limited mobility. Residents will not have new development of contractures in the next

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90 days through participation with ADLS allow for rest periods. Interventions included: allow for rest periods as needed, bilateral half transfer bars to aid in turning and positioning , encourage and assist resident to turn and reposition at least q (every) 2 (two) hours ..., encourage resident to attempt task during ADLs (Activities of Daily Living) which he can safely perform, praise resident for all efforts, wheelchair with built in cushion for mobility/locomotion."

Record review and interview with Care Plan Nurse on 11/5/24 at 1:22 PM, of Resident # 19's care plan she verified that the care plan had no interventions developed, like ROM, that would help to prevent contractures for Resident #19.

Record of the "Admission Record" revealed the facility admitted Resident #19 on 1/14/19 with diagnoses including Contracture, left hand.

Record review of the Quarterly MDS with an ARD of 9/24/24, section GG, Functional Limitation in ROM revealed Resident # 19 had impairments to upper and lower extremities on one side.

Resident #39

An observation of Resident # 39 on 11/03/24 at 4:07 PM, revealed Resident #39 had limited ROM of both arms with no braces or splints in use.

During an interview on 11/4/23 at 3:24 PM, with CNA #10 she stated Resident #39 is dependent for all care and cannot help at all. She stated that Resident #39 has contractures to his arms and his legs.

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Record review of Resident # 39's care plan revealed there was no care plan developed related to the prevention of contractures.

Record review and interview with Care Plan Nurse on 11/5/24 at 1:23 PM, of Resident #39's care plan she verified that a care plan had not been developed related to the prevention of contractures for Resident # 39.

Record of the "Admission Record" revealed the facility admitted Resident #39 on 3/18/22 with a diagnosis of Disorders of Bone Density and Structure.

Record review of the Annual MDS with an ARD of 8/22/24, section GG, Functional Limitation in ROM revealed Resident # 39 had impairment to upper and lower extremities on both sides.

Resident #44

Record review of Resident #44's care plan revealed "Focus: Restless/Agitation/Mood Disorder ...Interventions included: Lexapro Oral tablet 5 mg (milligrams) ...Monitor for SE (side effects) such as: Anxiety, irritability, or high or low mood · Feeling restless · Dizziness · Confusion · Headache Date Initiated: 06/10/2024. Lorazepam 2 mg/ml (milligrams per milliliter) ...Monitor for SE such as: Drowsiness, dizziness, loss of coordination, headache, nausea, blurred vision, change in sexual interest/ability, constipation, heartburn, or change in appetite Date Initiated: 04/17/2024. Risperidone 0.25 mg ...Monitor for SE such as: Drooling, nausea, weight gain. Date Initiated: 08/19/2023. Trazadone 50 mg ...Monitor for SE such as N/V

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F 656	Continued From page 30 (nausea/vomiting), diarrhea, nervousness.. Date initiated 2/19/23" Record review of Resident #44's Electronic Medication Administrator Record (EMAR) revealed no documentation of monitoring for side effects of psychotropic medications prior to 11/4/24. Interview with the DON on 11/5/24 at 8:05 AM, she verified that Resident #44 had no documentation that he was being monitored for side effects of psychoactive medications. She stated she thought that the monitoring for side effects did not pull over when they changed computer systems. She stated failure to monitor for side effects could lead to over sedation, increased risk for falls. Interview with the Care Plan Nurse on 11/5/24 at 1:10 PM she agreed that Resident #44's care plan was not followed with regard to monitoring for side effects of psychotropic medications. Record review of the "Admission Record" revealed that the facility admitted Resident #44 on 7/12/22 with diagnoses including Dementia and Anxiety.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff	F 677	Residents #9, #12, #17, and #58 suffered	12/19/24

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F 677	Continued From page 31 interviews and record review, the facility failed to provide assistance with Activities of Daily Living (ADL) care to maintain hygiene as evidenced by: Resident # 9, # 17, #58 were observed with long jagged fingernails and Resident #12 was observed with unkept and greasy hair and an unkept beard for four (4) of 61 residents reviewed for ADL care. Residents #9, #12, #17 and #58. Findings Included: Record review of a statement on facility letterhead, undated, and signed by the Administrator revealed "We do not have a direct policy ADLs." Resident #9 An observation on 11/03/24 at 2:30 PM revealed, Resident #9 lying in bed with long jagged nails on both hands, measuring approximately three-eighths (3/8) inch in length past the tips of the fingers with a brown substance underneath. An observation and interview with the Director of Nursing (DON) on 11/4/24 at 1:10 PM, confirmed Resident #9's nails were long and had a brown substance underneath. She revealed the treatment nurse was responsible for cutting and cleaning the residents' nails. She explained the facility did not have a task set up for the residents to get nail care on a routine basis. The DON revealed the long nails, and the brown substance underneath could cause an infection if the resident scratched herself. Record review of the "Admission Record" revealed the facility admitted Resident #9 on 12/13/13 with medical diagnoses that included	F 677	no ill effects from this deficient practice. On 11/04/2024 Residents #9, #17, and #58 nails were trimmed by the Treatment Nurse with assistance from Certified Nursing Assistant. The Care Plan Nurse added PRN nail care to care plan for residents #9, #17 and #58. On 11/04/2024 the Treatment Nurse also assessed those residents and all other residents with weekly skin audits. On 11/04/2024 Resident #12 was transferred from bed to wheelchair and received shower, shampoo, and shave. All residents could be affected by this deficient practice. A 100% review of all residents nails to be trimmed, facial hair groomed, showers, and hair to be shampooed, will be conducted by the Assistant Director of Nursing on 11/22/2024. On 11/22/2024 the Assistant Director of Nursing will educate all Nursing staff on proper hygiene care for all residents to maintain the dignity of each resident. Starting 11/22/2024, the Treatment Nurse will monitor all residents two times per week for twelve weeks to ensure all residents are receiving the proper hygiene care to maintain the dignity of each resident. Starting 11/25/2024, the Director of Nursing will monitor one resident per week for twelve weeks to ensure all residents are receiving the proper hygiene care to maintain the dignity of each resident. Any adverse findings will be brought to the facility Quality Assurance	

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F 677	Continued From page 32 Dementia, unspecified. Resident #12 An observation on 11/03/24 at 3:15 PM, revealed Resident #12's hair was unkept and greasy in appearance and his beard/facial hair was unkept and disheveled. An observation on 11/04/24 at 8:00 AM, revealed Resident #12's appearance was the same as the previous observation on 11/3/24 at 3:15 PM. In an observation of Resident #12 with Licensed Practical Nurse (LPN) #1 on 11/04/24 at 12:55 PM, she revealed that Resident # 12's hair appeared very oily and unkept, his face appeared oily, and his facial hair appeared unkept, and he needed to be shaved. She also revealed that Resident #12 had a strong body odor that was related to the need for a bath and good personal hygiene care. She stated that concerns from not bathing/shaving the resident could lead to dandruff build-up and skin concerns. In an interview with the DON on 11/05/24 at 7:15 AM, she revealed that staff failing to provide needed ADL care like bathing and grooming could lead to skin issues. Review of the "Admission Record" revealed the facility admitted Resident #12 on 12/15/21 with diagnoses that included Epilepsy. Record review of Resident #12's Section GG: Self-Care of the MDS with an ARD of 9/25/24 was coded as dependent for personal hygiene. Resident #17	F 677	meeting on 12/18/2024 for review and action as indicated times twelve weeks.	

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An observation on 11/03/24 at 2:44 PM, revealed Resident #17 fingernails were untrimmed and approximately (one) 1 inch in length past the tips of the fingers and jagged in appearance.

In an observation of Resident #17 with LPN #1 on 11/04/24 at 12:50 PM, she confirmed Resident #17's fingernails on both hands were long and jagged. She stated that the nails being long and jagged could cause skin concerns such as breakdown.

In an interview with the DON on 11/05/24 at 3:20 PM, she revealed staff not cutting the resident's nails could lead to skin concerns.

Review of the "Admission Record" revealed the facility admitted Resident #17 on 9/11/15 with diagnoses that included Contractures to right and left hands.

Record review of Resident #17's Section GG: Self-Care of the MDS with an ARD of 8/22/24 was coded as dependent for personal hygiene.

Resident #58

An observation and interview on 11/03/24 at 3:11 PM, with Resident #58 revealed, long nails on both hands that measured approximately one-half (1/2) inch in length. The resident stated he was a diabetic and would like to have his nails cut because he does not like them long.

An observation and interview with LPN #1 on 11/4/24 at 1:04 PM, confirmed Resident #58 had long fingernails. She revealed the resident was a diabetic and his nails must be cut by a nurse.

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F 677	Continued From page 34 LPN #1 revealed the nail care task was not set up to prompt staff to cut nails, and explained the facility did not have anyone who went around regularly to do nail care. She confirmed the resident could scratch himself or the staff. Record review of the "Admission Record" revealed Resident #58 was admitted to the facility on 4/23/24 with diagnoses that included Type 2 Diabetes Mellitus. Record review of the Quarterly MDS with an ARD of 10/14/24 revealed, under section C, a Brief Interview for Mental for Status (BIMS) summary score of 15, which indicated Resident #58 was cognitively intact.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	F 688		12/19/24

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F 688	Continued From page 35 by: Based on observation, staff interview, record review and facility policy review, the facility failed to provide the services needed for a resident to maintain and/or improve their level of range of motion (ROM) and mobility for four (4) of 32 residents reviewed for positioning and mobility. (Resident #17, # 19, #22, and #39). Findings include: Record review of facility policy titled " Resident Mobility and Range of Motion" with a revision date of 7/2017 revealed "Policy Statement, 1. Residents will not experience an avoidable reduction in range of motion (ROM). 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. 3. Residents with limited will receive appropriate services, equipment and assistance to maintain or improve mobility unless a reduction in mobility is unavoidable." Resident #17 An observation on 11/03/24 at 2:44 PM revealed Resident #17 to have a right and left-hand contracture with no device in place. In an observation of Resident #17 with Licensed Practical Nurse (LPN) #1 on 11/04/24 at 12:50 PM, she confirmed that Resident #17's left and right hands were contracted. A record review of the "Order Summary Report" for Resident # 17 revealed there were no orders for services for the right- and left-hand contractures.	F 688	On 11/04/2024 the Occupational Therapist evaluated residents #17, #19, #22 and #39 for passive range of motion to prevent worsening of contractures. On 11/05/2024 the Care Plan Nurse updated the care plans for residents #17, #19, #22, and #39 to reflect Range of Motion for contractures. All residents with limited range of motion have the potential to be affected by this deficient practice. On 11/26/2024, the Director of Clinical Services will provide in-service education to the Certified nursing assistants and nurses regarding providing the services needed for a resident to maintain and or improve their level of range of motion. The Assistant Director of Nursing starting on 11/26/2024 will check off Nurses and CNA's on range of motion to ensure we are providing range of motion for residents who require said service. Starting on 11/25/2024 The Care Plan nurse will monitor Physician orders five times a week for twelve weeks to ensure care plans are developed for range of motion in an effort to prevent contractures. Starting on 11/25/2024, The Director of Nursing will monitor three residents three times a week times twelve weeks for signs and symptoms of developing contractures, range of motion, and to ensure care plans have been developed for range of motion. Any adverse findings	

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F 688	Continued From page 36 A record review of the "Task Report" for November 2024 for Resident # 17 revealed there was no documentation of services to be provided to the right and left-hand contractures. In an interview with the Occupational Therapist (OT) on 11/4/24 at 3:04 PM, he verified Resident #17 had contractures to bilateral hands. He stated that Resident #17 would benefit from ROM exercises to possibly prevent worsening of the contractures. In an interview with Certified Nurse Assistant (CNA) #1 on 11/04/24 at 3:13 PM, she revealed she was assigned to Resident #17, and confirmed she did not do any exercises or range of motion to his contracted hands. An interview with the Director of Nursing (DON) on 11/05/24 at 3:30 PM, revealed that staff not providing ROM to the contracted hands could lead to worsening of the contractures. In an interview with CNA #2 on 11/05/24 at 8:15 AM, she revealed she was assigned to Resident #17, and confirmed she did not do any exercise or ROM to his hands. She revealed they used to have a restorative program, but no longer have it right now. Record review of the "Admission Record" revealed the facility admitted Resident #17 on 9/11/15 with a diagnosis of Contracture to Right and Left Hand. Record review of Resident #17's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/22/24 Section GG: 0115 functional limitation in range of motion was coded	F 688	will be brought to the facility Quality Assurance meeting on 12/18/2024 for review and action as indicated times twelve weeks.	

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impairment on both sides of the upper and lower extremities

Resident #19

On 11/3/24 at 4:00 PM, an observation and interview with Resident # 19 revealed that the resident had limited ROM to first through fourth fingers of the left hand at the first finger joints. Resident #19 stated he did not receive ROM exercises or braces.

Record review of Resident #19's Electronic Medical Record (EMAR) revealed no documentation of that Resident #19 received ROM exercises or bracing.

On 11/4/24 at 3:00 PM, an interview with OT verified Resident #19 had contractures at first finger joints of 1st through 4th fingers of left hand. He stated that the resident would benefit from ROM exercises and could have possibly prevented the contractures.

During an interview with CNA #10 on 11/4/23 at 3:23 PM, she stated that Resident #19 is dependent for all care and cannot help at all. She stated that Resident #19 has contractures to his fingers and his legs, but she does not perform any type of ROM on the resident.

Record review of the "Admission Record" revealed the facility admitted Resident #19 on 1/14/19 with a diagnosis of Multifocal Motor Neuropathy.

Record review of the Quarterly MDS with an ARD of 9/24/24, section GG, Functional Limitation in ROM revealed Resident # 19 had impairments to

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upper and lower extremities on one side.

Resident #39

On 11/03/24 at 4:07 PM, an observation of Resident # 39, revealed Resident #39 had limited ROM of both arms with no braces or splints in use.

Record review of "OT Plan of Care", dated 11/4/24 for Resident #39 revealed "Exacerbation of BUE (bilateral upper extremity) AROM (Active Range of Motion).

During an interview on 11/4/24 at 8:51AM, Resident #39's Representative stated the resident did not have contractures on admission and he had never received therapy and/or bracing.

In an interview on 11/4/24 at 3:02 PM, the OT verified Resident #39 had contractures of his bilateral elbows. He stated that the resident would benefit from ROM exercises and bracing elbows and that ROM could have possibly prevented the contractures.

On 11/4/23 at 3:24 PM, during interview CNA #10 stated that Resident # 39 is dependent for all care and cannot help at all. She stated that Resident #39 had contractures to his arms and his legs, but she does not perform any type of ROM on the resident.

Record of the "Admission Record" revealed the facility admitted Resident #39 on 3/18/22 with a diagnosis of Disorders of Bone Density and Structure.

Record review of the Annual MDS with an ARD of

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8/22/24, section GG, Functional Limitation in ROM revealed Resident # 39 had impairment to upper and lower extremities on both sides.

Resident #22

An observation of Resident #22 on 11/03/24 at 3:15 PM, revealed the resident lying in bed with his left arm drawn toward his chest. The resident was observed to be unable to move it on command.

An interview with the OT on 11/4/24 at 2:50 PM, revealed Resident #22 was not receiving any therapy services related to the contracture and explained that he knew it had been a year since he had. He revealed the resident would benefit from passive range of motion (PROM) to prevent worsening of the contracture.

An interview with the DON on 11/4/24 at 3:10 PM, revealed that the facility did not have a restorative nursing program.

An interview with CNA #9 on 11/4/24 at 3:25 PM, revealed Resident #22 was able to move his arms by himself, so she did not do any exercises with him. She revealed the resident kept one of his legs bent and would holler out when it was moved.

An interview with the DON on 11/05/24 at 3:20 PM, revealed that not providing PROM to Resident #22 could lead to worsening contractures.

An interview with CNA #7 on 11/6/24 at 9:25 AM, revealed that she did not perform exercises with Resident #22 during daily care and confirmed it

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F 688	Continued From page 40 was not set up on the task for them to do. Record review of the "Resident Care Kardex" for Resident #22 revealed there was not a task set up for PROM. Record review of the MDS with an ARD of 8/30/24 revealed under, section GG, Resident #22 had upper and lower extremity impairment on one side. Record review of the "Admission Record" revealed the facility admitted Resident #22 on 6/29/23 with a medical diagnosis that included Hemiplegia and hemiparesis following Cerebral Infarction affecting the left non-dominant side.	F 688		
F 725 SS=D	. Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.	F 725		12/19/24

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F 725	Continued From page 41 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to ensure sufficient weekend nursing staffing for the 3rd quarter payroll-based journal (PBJ) for one (1) of three (3) quarters reviewed. Findings include: Record review of the facility policy titled "Staffing" with a revised date of April 2007 revealed, " ... 1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met." Record review of "PBJ Staffing Data Report CASPER Report 1705D FY (Fiscal Year) Quarter 3 2024 (April 1-June 30)", revealed "Excessively Low Weekend Staffing-Triggered. Triggered=Submitted Weekend Staffing data is excessively low." An interview on 11/04/24 at 10:00 AM, the Assistant Director of Nurses (ADON) revealed	F 725	No residents suffered any adverse effects due to this deficient practice. All residents has the potential to be affected due to this deficient practice. On 11/22/2024 the Administrator will educate Human Resource Director, Director of Nursing, and Assistant Director of Nursing on Facility policy on Staffing to ensure facility maintains adequate staffing on each shift to ensure that residents need and services are met. On 11/22/2024 Human Resources Director will conduct 100% audit of all employee payroll hours and agency invoices to ensure hours are calculated and accurate to Payroll Based Journal. Starting on 06/20/2024 The Facility began utilizing two staffing agencies to fill positions with call ins or for time off requests. Starting 11/25/2024, the Assistant Director of Nursing and Director of Nursing will	

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F 725	Continued From page 42 she is responsible for staff development and scheduling. She revealed she was not employed as the ADON during the 3rd quarter dates of April-June 2024 but worked part-time for the facility. She revealed that the facility had an issue maintaining enough staff for the weekends during that time and confirmed that after she reviewed the weekend staffing for the third (3rd) quarter, it was due to low staffing. She revealed that they now have agency staffing to help ensure they are adequately staffed. During an interview on 11/05/24 at 1:45 PM, Human Resources (HR) confirmed the PBJ for the third quarter of 2024 was entered accurately. She revealed we were running low on staffing due to excessive call-ins and staff either clocking in late or out early. She stated that she is responsible for inputting the direct care hours into the dashboard and then submits to the corporate office. In an interview on 11/06/24 at 9:25 AM, the Administrator revealed she became the Administrator at the end of May 2024, and started working on ensuring they were adequately staffed to care for their residents. She revealed that they now have agency staff on board while actively trying to hire staff and feels like the staffing issue has improved with the help of the agency staff.	F 725	review schedule to ensure adequate staffing levels are obtained. This will be completed two times per week for twelve weeks. On 11/20/2024 staff will be educated on Facility's Time and Attendance Policy, the facility has a Policy to issue disciplinary actions when employees call out without sufficient notice or documentation. Those disciplinary actions can be write ups and or termination. On 11/25/2024 and going forward the Human Resources Director will email the Administrator, DON, and ADON with staffing PPD levels to ensure we are adhering to state guidelines. On 11/25/2024, Human Resources Director will conduct audit of payroll hours monthly times three months to ensure hours are correct. Starting on 11/25/2024 The Administrator will verify findings to ensure accuracy times twelve weeks. Any adverse findings will be presented to the facility Quality Assurance meeting on 12/18/2024 for review and action as indicated times twelve weeks.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		12/19/24

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F 757	Continued From page 43 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, record reviews and facility policy review, the facility failed to monitor a resident receiving anticoagulant medication for side effects for one (1) of (10) residents on anticoagulant medications. Resident #4 Findings include: Record review of the facility policy titled "Anticoagulation-Clinical Protocol" with a revision date of September 2012 revealed " ... Monitoring and Follow-Up ... 4. The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria (blood in the urine), hemoptysis (vomiting blood), or other evidence of bleeding, the nurse will discuss the situation with the physician ..."	F 757	Resident #4 suffered no ill effects from this deficient practice. On 11/05/2024 the Director of Nursing added an order for Resident #4 on the Medication Administration Record every shift daily to check and monitor for signs and symptoms of bleeding, bruising or any possible side effect of an anticoagulant. On 11/07/2024 the Director of Nursing conducted an audit of all residents and added orders to any resident on an anticoagulant for nurses to monitor for side effects every shift daily on Medication Administration Record (MAR). All residents on anticoagulants could be affected by this deficient practice. A 100% review of all residents on anticoagulants will be conducted by the	

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F 757	Continued From page 44 Record review of the "Order Summary Report" with active orders as of 11/5/24 revealed an order with a start date of 6/10/24 for Xarelto Oral Tablet 10 mg (Rivaroxaban) Give 1 tablet by mouth one time a day. Record review of the "Order Summary Report" and the "Medication Administration Record" (MAR) for November 2024 revealed there was not a monitoring tool for staff to monitor for signs of bruising and bleeding with the anticoagulant (blood thinner) medication Xarelto. On 11/05/24 at 10:46 AM, an interview with the Director of Nurses (DON) confirmed that Resident #4 was on an anticoagulant and did not have adequate monitoring for the medication. She revealed that monitoring for side effects of bleeding and/or bruising is supposed to be under supplementary documentation in the actual physician orders and confirmed that it was not. She revealed inadequate monitoring of the anticoagulant medication places the resident at risk for bleeding. Record review of the "Admission Record" revealed the facility admitted Resident #4 on 06/22/2020 with medical diagnoses that included Parkinson's disease with Dyskinesia, History of Pulmonary Embolism, History of Transient Ischemic Attack (TIA), and Cerebral Infarction.	F 757	Assistant Director of Nursing on 11/22/2024. On 11/20/2024 the Assistant Director of Nursing will educate all nursing staff on the proper dosage and monitoring of all residents on anticoagulants. Starting 11/25/2024, the Assistant Director of Nursing will monitor all residents on anticoagulants two times per week for twelve weeks to ensure all residents receiving anticoagulants are receiving the proper dosage and monitoring. Starting 11/25/2024, the Director of Nursing will monitor one resident on anticoagulants per week for twelve weeks to ensure all residents receiving anticoagulants are receiving the proper dosage and monitoring. Any adverse findings will be brought to the facility Quality Assurance meeting on 12/18/2024 for review and action as indicated times twelve weeks.	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental	F 758		12/19/24

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processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

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F 758	Continued From page 46 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review the facility failed to monitor for side effects and obtain a stop date for a psychotropic medication for five (5) of 40 residents receiving psychotropic medications reviewed. Resident #10, #18, #44, #51 and #55 Findings include: A review of the policy titled, "Behavioral Assessment, Intervention and Monitoring," revised December 2016 revealed " ... Management: 10.) When medications are prescribed for behavioral symptoms, documentation will include a.) Rationale for use ... h.) Monitoring for efficacy and adverse consequences ..." Resident #10 Record review of Resident #10's "Order Summary Report" with active orders as of 11/3/24 revealed an order dated 10/18/24 " Buspirone HCl oral tablet 10 mg (milligrams) Give 2 tablets by mouth two times a day related to anxiety disorder." An additional order dated 10/7/24 revealed "Venlafaxine HCl oral tablet 75 mg Give 1 tablet by mouth two times a day related to anxiety disorder." The order summary revealed there was not an order to monitor for side effects of the multiple psychotropic medications ordered.	F 758	Residents #10, #18, #44, #51, and #55 suffered no ill effects from this deficient practice. On 11/06/2024 the Care Plan Nurse updated care plans and orders for residents #10, #18, #51 and #55 for nurses to monitor for psychotropic medication every shift daily. On 11/07/2024 the Care Plan Nurse audited all residents who are on a psychotropic drug and put in orders for residents who are on a psychotropic medications and put in orders for residents to be monitored by nurses every shift daily. On 11/05/2024 the Director of Nursing conducted an audit and implemented stop dates for any resident on as needed (PRN) Lorazepam. All residents on psychotropic drugs could be affected by this deficient practice. A 100% review of all residents on psychotropic and psych drugs will be conducted by the Assistant Director of Nursing on 11/22/2024. On 11/22/2024 the Assistant Director will educate the Care Plan Nurse and nurses on monitoring and auditing all residents on psychotropic medications and psych medications. Starting 11/25/2024, the Care Plan Nurse will monitor all residents on psychotropic medications and psych medications two times per week for twelve	

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F 758	Continued From page 47 A record review of the "Medication Administration Record" (MAR) for the month of October 2024 revealed Resident #10 received Buspirone 10 mg and Venlafaxine 75 mg. There was no documentation on the MAR regarding monitoring for side effects of the psychotropic medications. On 11/06/24 at 8:57 AM, an interview the Director of Nurses (DON) confirmed they were not monitoring for side effects of psychotropic medications, and they "should have been." She revealed it should have been on the physician's orders, which would then pull over to the MAR to ensure the nurses were adequately monitoring for side effects and documented accordingly. Record review of the "Admission Record" revealed the facility admitted Resident #10 on 10/04/2024 with medical diagnoses that included Anxiety Disorder. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/11/24 revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident is cognitively intact. Resident #18 A review of the "Order Summary Report" with active orders as of 11/3/24 revealed an order dated 9/5/24 for "Aripiprazole 30 mg Give one tablet at bedtime related to schizoaffective disorder. An order dated 10/31/24 for Ativan (Lorazepam) one (1) mg tablet give 0.5 mg in the morning for generalized anxiety for (4) four days. An order dated 10/31/24 for Ativan (1) mg tablet give 0.5 mg at bedtime for generalized anxiety for (4) days ... An order dated 10/23/24 for	F 758	weeks to ensure all residents receiving psychotropic medications are receiving the proper dosage and monitoring. Starting 11/25/2024, the Director of Nursing will monitor one resident on psychotropic medications and psych medications per week for 12 weeks to ensure all residents receiving as needed psychotropics medications are receiving the proper dosage and monitoring. Any adverse findings will be brought to the facility Quality Assurance meeting on 12/18/2024 for review and action as indicated times twelve weeks.	

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Olanzapine 10 mg Give one tablet at bedtime for Schizoaffective disorder ... An order dated 9/5/24 for Venlafaxine HCL (hydrochloride) extended Give one tablet by mouth one time a day related to Major Depressive disorder ..." The order summary revealed there was not an order to monitor for side effects of the multiple psychotropic medications ordered.

In an interview with the DON on 11/04/24 at 2:45 PM, she confirmed that Resident #18 did not have any monitoring in place for the side effects of the psychotropic medications.

Review of the "Admission Record" revealed the facility admitted Resident #18 on 9/05/24 with diagnoses of Schizophrenia, Bipolar Disorder, and Anxiety Disorder.

Record review of Resident #18's MDS, Section N, with an ARD of 9/12/24 revealed, N: 04115 : High-Risk Drug Classes: antipsychotic, antianxiety, and antidepressant coded yes for receiving the medications.

Resident #51

A review of the "Order Summary Report" with active orders as of 10/3/24 revealed an order dated 8/27/24 for "Ativan Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth three times a day related to Anxiety disorder due to know physiological condition." An additional order dated 8/27/24 revealed "Lorazepam oral concentrate two (2) mg/ml (milligram/milliliter): Give 0.25 mg by mouth every four hours as needed Anxiety disorder. The orders did not include a stop date. An order dated 9/19/24 revealed "Zoloft 50 mg tablet give one tablet by mouth at bedtime related

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to Anxiety." The order summary revealed there was not an order to monitor for side effects of the multiple psychotropic medications ordered.

In an interview with the DON on 11/04/24 at 2:00 PM, she revealed there were no monitoring tools in place to monitor for side effects of psychotropic medications for Resident #51. She revealed concerns from not monitoring the psychotropic medications is to watch for adverse reactions like sedation, tremors, and tardive dyskinesia. She also revealed she was unaware that prn (as needed) Ativan (Lorazepam) needed to have a stop date after 14 days to evaluate the residents' need for further use because the resident was on Hospice services.

In an interview with Licensed Practical Nurse (LPN) #1 on 11/05/24 at 8:05 AM, she revealed all residents on psychotropic medications should be monitored for side effects and notify the provider of changes. She stated the monitoring used to be on the medication record but was no longer on it after the facility switched electronic medical record companies.

Review of the "Admission Record" revealed the facility admitted Resident # 51 on 11/30/23 with diagnoses of Mood disorder and Anxiety.

Record review of Resident #51's Quarterly MDS with an ARD 11/18/24,Section N, revealed in N: 04115 : High-Risk Drug Classes: antianxiety and antidepressant coded yes for receiving the medications.

Resident #55

A review of the "Order Summary Report" with

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active orders as of 11/3/24 revealed an order dated 8/22/24 for "buspirone oral tablet five (5) mg Give 1.5 tablet by mouth two times a day related to Anxiety Disorder." An additional order dated 6/19/24 revealed "Risperdal Tab 0.5 mg Give 1 tablet by mouth at bedtime related to bipolar disorder." An additional order dated 5/16/24 revealed Risperidone Tab 0.5 mg Give (2) two mg at bedtime for bipolar disorder." The order summary revealed there was not an order to monitor for side effects of the multiple psychotropic medications ordered.

On 11/04/24 at 2:40 PM, an interview with the DON revealed there were no monitoring tools in place to monitor for the psychotropic drugs for Resident #55.

In an interview with LPN#2 on 11/5/24 at 3:00 PM, she confirmed that all residents on psychotropic medications should be monitored for side effects to identify adverse reactions from the medications. She revealed she was unsure why there was no monitoring in place.

Review of the "Admission Record" revealed the facility admitted Resident #55 on 3/01/24 with diagnoses of Bipolar disorder, Anxiety Disorder, Borderline Personality Disorder, and Psychotic Disorder with Delusions.

Record review of the Quarterly MDS with an ARD of 8/23/24, Section N, revealed in N:04115: High-Risk Drug Classes: antipsychotic and antianxiety coded yes for receiving the medications.

Resident #44

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Record review of "Order Summary Report" with active orders as of 10/31/24 revealed an order dated 8/18/23 for Risperidone Tab 0.25 MG (milligrams), Give 1 tablet orally one time a day related to Psychotic disorder with delusions. An additional order dated 11/17/22 for Risperidone Tab 1 MG, give 1 tablet orally one time a day related to Psychotic disorder with delusions. An order dated 2/3/23 for Trazodone HCl Tab 50 MG, give 1 tablet orally one time a day for related to Insomnia. An order dated 6/7/24 for Lexapro Oral Tablet 5 MG (Escitalopram Oxalate), Give 1 tablet by mouth one time a day for anxiety. An order dated 4/17/24 for Lorazepam Concentrate 2 MG/ML (milligrams per milliliter), Give 0.5 milliliter orally every four (4) hours as needed for restlessness and agitation with no stop date. The order summary revealed there was not an order to monitor for side effects of the multiple psychotropic medications ordered.

During an interview with the DON on 11/5/24 at 8:05 AM, she verified that Resident #44 had an PRN order for Lorazepam with no stop date. She stated that she was not aware that residents on hospice had to have a 14-day stop date for Lorazepam. She also verified that Resident #44 had no documentation that he was being monitored for side effects of psychoactive medications. She stated she thought that the monitoring for side effects did not pull over when they changed computer systems. She agreed failure to have a stop date for lorazepam and to monitor for side effects could lead to over sedation and increased risk for falls.

Record review of the "Admission Record" revealed that the facility admitted Resident #44 on 7/12/22 with diagnoses which included

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F 758	Continued From page 52 Dementia.	F 758		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and facility policy review, the facility failed to accommodate a resident's food preference during one (1) of three (3) meal services observed. (Resident # 55) Findings Include: A review of the facility policy titled, "Resident Nutrition Services," with a revision date of 11/2015 revealed, "Policy Statement: Each resident shall receive meals, with preferences accommodated ..." A dining observation on 11/3/24 at 5:45 PM, revealed the Admission Nurse set the meal tray up for Resident #55. The meal tray was observed to have a ham and cheese sandwich with no observation of the Admission Nurse offering the resident condiments for the sandwich, and there were no condiments observed on the meal tray.	F 806	On 11/03/2024 the Admissions nurse was inserviced by the Administrator that condiments offered to residents in an effort to provide them a pleasurable dining experience. On 11/18/2024 the Dietary Manager inserviced the dietary staff to ensure there is an ample supply of condiments. All residents have the potential to be affected by this deficient practice. Starting 11/22/2024, the Food Service Manager will observe two residents per day times five days per week for twelve weeks to ensure proper condiments are available and being offered to the residents. Starting on 11/22/2024, the Charge Nurse will monitor two residents per meal times five days a week times twelve weeks to	12/19/24

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F 806	Continued From page 53 An interview with the Admission Nurse on 11/3/24 at 5:48 PM, confirmed Resident # 55 did not have any condiments on her meal tray and that the residents were provided with condiments if they asked for them. In an interview with Resident #55 on 11/3/24 at 5:50 PM, she revealed she prefers both mayonnaise and mustard on her sandwiches. A continued dining observation on 11/3/24 at 6:00 PM revealed no observations of staff offering any condiments to Resident #55 for her ham and cheese sandwich. In an interview with the Dietary Manager (DM) on 11/4/24 at 8:50 AM, she confirmed that the condiments for Resident #55 's sandwich should have come out on her meal tray from the dietary department. She then stated that the staff passing the tray should have asked the resident what her preference of condiments was for her sandwich and asked the dietary staff for the condiments. An observation of a drawer in the dining room on 11/4/24 at 8:57 AM with the DM revealed a drawer full of condiments. She stated the staff working in the dining room always have access to this drawer and could have gotten the condiments needed. In an interview with the Admission Nurse on 11/04/24 at 1:13 PM, she confirmed she should have asked Resident #55 what type of condiment she would like on her sandwich during the evening meal on 11/3/24, but she just did not even think about it.	F 806	ensure each resident is being offered proper condiments. Any adverse findings will be brought to the facility Quality Assurance meeting on 12/18/2024 for review and action as indicated times twelve weeks.	

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F 806	Continued From page 54 In an interview with the Director of Nursing (DON) on 11/04/24 at 1:20 PM, she revealed that staff assisting Resident #55 with her evening meal tray on 11/3/24 should have asked the resident what she would like on her sandwich. She then revealed that by not doing so, it could cause the resident to not eat the food provided and lead to weight loss. Review of the "Admission Record" revealed the facility admitted Resident #55 on 3/01/24 with diagnoses that included Unspecified dementia. Record review of Section C of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/23/24 revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating the resident had moderate cognitive impairment.	F 806		
F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative	F 809		12/19/24

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F 809	Continued From page 55 meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident/staff interviews, and facility policy review, the facility failed to ensure snacks/nourishments were offered to residents for two (2) of four (4) survey days. Resident #10. Findings include: Review of the facility policy, "Resident Nutrition Services", with a revised date of November 2015, revealed, " ... Policy Interpretation and Implementation ...8 ... Snacks are available to the residents 24 hours a day. The resident may request snacks as desired, or snacks may be scheduled between meals to accommodate the resident's typical eating patterns ..." During an interview on 11/03/24 at 03:45 PM, Resident #10 revealed that she often gets hungry, especially at bedtime. She revealed they put the snacks out at the nurse's station, but you must go up there if you want anything. They don't come around to your room and offer any snacks. She revealed that one night, I specifically asked my Certified Nursing Assistant (CNA) for cheese and crackers, but she didn't get anything for me. She may have forgotten about it. In an interview on 11/04/24 at 1:20 PM, Resident #10 revealed that she was not offered a snack last night, nor has she been offered one today. She revealed that she kept her cookie, soup and four packs of crackers from her supper last night,	F 809	On 11/04/2024 Resident #10 was assessed by Registered Nurse and displayed no ill effects due to this deficient practice. On 11/22/2024 Food Service Manager met with Resident #10 to update food and snack preferences. All residents have the potential to be affected by this deficient practice. On 11/03/2024 the Food Service Manager was in-serviced by the Administrator that snacks should be available to residents twenty four hours in a day in an effort to provide and accommodate the residents typical eating patterns. On 11/18/2024 the Food Service Manager in-serviced the dietary staff to ensure there is an ample supply of snacks provided on the carts. On 11/20/2024 the Director of Nursing in-serviced the nursing staff on ensuring that they are passing snacks or monitoring the passing of snacks by certified nursing assistants. Starting on 11/22/2024, the Food Service Manager will observe two snack carts per day times five days a week for twelve weeks to ensure proper snacks are available and being offered to the residents. Starting on 11/25/2024, the Charge Nurse will monitor two snack carts times five days a week times twelve	

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F 809	Continued From page 56 so she ate those before going to bed. In an interview on 11/04/24 at 1:35 PM, CNA #4 revealed that she was assigned to the resident today. She revealed that she passed out hydration but didn't ask the resident about a snack because CNA #5 usually passes out the snacks. During an interview and observation on 11/04/24 at 2:25 PM, CNA #6 revealed that usually CNA #5 passes out the daytime snacks, and the nurses or aides on the other shifts pass out the snacks. She revealed the aides typically pass out the bedtime snacks. An observation of a tray of snacks, consisting of marshmallows, graham crackers, and nutty buddy bars, was sitting on a tray at the nurse's station. An interview on 11/04/24 at 3:13 PM, CNA #5 revealed that she was passing out the snacks at one time and would get a tray for each hall and go down the hall and make sure everyone who was able to have a snack was getting one because if you didn't, the snack tray would sit at the nurse's station. The residents sitting around the desk would get several snacks, but the others didn't. She revealed that several months ago, a dietary aide told me she couldn't give me the tray, but it had to be put at the nurse's station, so now I think everyone is just supposed to be passing them out to their residents. In an interview on 11/04/24 at 3:25 PM, the Dietary Manager (DM) revealed snacks are passed out at 10 AM, 2 PM, and 7 PM, and the dietary aide takes them out to the nurse's station and leaves the tray and the CNA pass them out. She revealed that snacks should be offered three	F 809	weeks to ensure each resident is being offered proper snacks. Any adverse findings will be brought to the facility Quality Assurance meeting on 12/18/2024 for review and action as indicated times twelve weeks.	

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F 809	Continued From page 57 times a day in addition to their meals. During an interview on 11/04/24 at 3:35 PM, the Assistant Director of Nurses (ADON) revealed that the residents should receive hydration and snacks three times daily. She revealed CNA #6 was passing out the snacks, but she heard that a dietary aide had told her that they needed to be set up at the nurse's station, so honestly, the only ones who were getting the snacks would be those sitting around the nurse's station or if someone asked for one. She revealed "to my understanding, they had stopped going around to each room and offering a snack." Record review of the "Admission Record" revealed Resident #10 was admitted to the facility on 10/04/2024 with medical diagnoses that included anxiety disorder. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/11/24 revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.	F 809		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		12/19/24

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	255216	A. BUILDING _____ B. WING _____	11/06/2024

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RIVERVIEW NURSING & REHABILITATION CENTER	1600 WEST CLAIBORNE AVENUE EXTENDED GREENWOOD, MS 38930

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F 880	Continued From page 58	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 59 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and facility policy review the facility failed to prevent the possibility of the spread of infection during wound care for one (1) of two (2) treatments observed. Resident # 11. Findings Included: Record review of facility policy titled, " Enhanced Barrier Precautions Checklist" revised January 2012 revealed " ...Policy Interpretation and Implementation 1. Staff shall apply Enhanced Barrier Precautions to the care of all residents in high contact care activities regardless of suspected or confirmed presence of infectious disease ..." Record review of facility policy titled "Pressure Ulcer Treatment" revised September 2013, revealed " ... Steps in the Procedure 1. Clean bedside stand. Establish a clean field. 2. Place	F 880	On 11/11/2024, the Treatment Nurse was educated by the Director of Clinical Services on the facility policy of Pressure Ulcer Treatment and Enhanced Barrier Precautions procedures. No residents suffered any ill effects from this deficient practice. On 11/05/2024 Resident #11 was assessed by Registered Nurse with no ill effects noted. All residents with wounds have the potential to be affected by this deficient practice. Starting 11/22/2024, Assistant Director of Nursing educated Treatment Nurse on the facility policy of Pressure Ulcer Treatment and Enhanced Barrier Precautions to ensure proper barriers and proper hand hygiene are utilized. All staff will be in-serviced on Infection Control and	

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F 880	Continued From page 60 the clean equipment on the clean field ...7. Put on clean gloves. Loosen tape and remove soiled dressing. 8. Pull glove over dressing and discard into plastic or biohazard bag. 9. Wash and dry your hands thoroughly ...14. Put on clean gloves .... 16. Cleanse the wound with the ordered cleanser. Use a syringe to irrigate the wound, if ordered. If using gauze, use a clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward) ..." Record review of November 2024 Electronic Treatment Record (ETAR) revealed Resident # 11 had a Stage four (4) pressure ulcer to the right heel with a treatment to clean with wound cleanser, pat dry, apply Collagen with non-boarded super absorbent dressing and wrap with Kerlix and secure with tape daily. Observation of wound care for Resident #11 on 11/5/24 at 10:15 AM, performed by the Treatment Nurse (TN) revealed she failed to perform hand hygiene before gathering wound care supplies after propelling another resident down the hall in a wheelchair. The TN placed the wound care supplies (gloves, dermal wound cleanser bottle, scissors, collagen powder, abdominal pad and gauze packages) on top of the treatment cart without a barrier or cleaning the top of the cart. After entering the resident's room, the TN placed the wound care supplies and open gloves on an overbed table noted to be soiled with a clear substance without cleaning the table or placing a barrier on the table. The TN washed her hands and applied the gloves that had been sitting on the soiled overbed table. She then removed the old dressing and discarded it and began cleaning the wound without performing hand hygiene or	F 880	Enhanced Barrier Precautions on 11/26/2024. Starting on 11/25/2024, the Assistant Director of Nursing will observe Wound Care Nurse completed treatments two times a week times twelve weeks to ensure all residents with wounds have proper barrier, gloves, and proper hand hygiene during treatment. Any adverse findings will be brought to the facility Quality Assurance meeting on 12/18/2024 for review and action as indicated times twelve weeks.	

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changing gloves. She cleaned the wound by wiping over the wound bed with the same four by fours (4x4) four (4) times in a circular motion. Next, she discarded the soiled 4x4's and used a clean 4x4 to pat wound dry and began applying collagen to wound bed using a clean 4x4 , applied a clean 4x4, abdominal pad , gauze and secured the dressing with tape without removing soiled gloves or perform hand hygiene. The TN also failed to follow Enhanced Barrier Precautions (EBP) during wound care. Upon exiting the resident's room, the TN placed the contaminated dermal wound cleanser bottle and scissors on top of the treatment cart then placed them inside cart without sanitizing them.

During an interview on 11/5/24 at 10:20 AM, the TN agreed that she contaminated wound care supplies by placing them on top of treatment cart and on the soiled overbed table without cleaning them or providing a barrier. She agreed that she used gloves that had been contaminated by the soiled overbed table, cleaned wound by wiping over the wound bed with the same 4x4 four (4) times, failed to remove soiled gloves and perform hand hygiene after removing the old dressing and before applying collagen & dressing, placed the dermal wound cleanser and scissors on top of the treatment cart then placed them inside cart without sanitizing them and did not follow EBP while performing wound care. She verified that this failure placed the resident at risk for infection.

An interview with the Assistant Director of Nursing/Infection Preventionist (ADON/IP) on 11/5/24 at 10:25 AM, she verified that the treatment nurse's failure to follow infection control practices during wound care placed the resident at risk for infection.

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F 880	Continued From page 62 Record review of the "Admission Record" revealed that the facility admitted Resident # 11 on 3/19/14 with a diagnoses that included Pressure ulcer of right heel, Stage 4 and Hemiplegia and Hemiparesis following Cerebral Infarction affecting the right dominant side.	F 880		