

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

PRINTED: 04/25/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255109	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF SOUTHAVEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1730 DORCHESTER DR SOUTHAVEN, MS 38671		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The State Agency (SA) conducted an Annual Recertification survey and seven (7) Complaint Investigations (CI MS #27183, CI MS #27690, CI MS #27865, CI MS #28043, CI MS #28193, CI MS #28208 and CI MS#28282) at the facility from 3/17/25 through 3/20/25. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited F 558, F 583, F 584, F 656, F 677, F 689, F 692, F 761, F 842, F 851, F 880, and F 925. The SA identified non-compliance and cited F 584 regarding environmental issues, F 656 for failure to implement a care plan and F 677 for failure to provide Activities of Daily Living (ADL) for CI MS #27183. The SA identified non-compliance and cited F 558 related to inaccessible call lights, F 656 for failure to implement a care plan and F 677 for failure to provide ADL for CI MS #27690. The SA identified non-compliance and cited F 656 for failure to implement a care plan, F 677 for failure to provide ADL care and F 692 regarding hydration for CI MS #28043. The SA identified non-compliance and cited F 656 for failure to implement a care plan and F 677 for failure to provide ADLs for CI MS#28208. The SA investigated CI MS #27865, CI MS #28193 and CI MS#28282 with no deficiencies cited. The census at the time of the survey was 134 and the facility was licensed for 140 beds.	F 000			
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and	F 558		4/16/25	

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

TITLE

(X6) DATE

Electronically Signed

04/10/2025

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 558	Continued From page 1 preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review, and facility policy review, the facility failed to ensure that resident call lights were within reach, which limited a resident's ability to request assistance as needed for two (2) of 134 residents observed on survey. Resident #32 and Resident #42 Findings include: Review of the facility policy with a revision date of October 2022 titled "Call Lights: Accessibility and Timely Response" revealed, "The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance... 5. Staff will ensure the call light is within reach of residents and secured, as needed ...6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room..." Resident # 32 An observation and interview on 3/17/25 at 10:30 AM revealed Resident #32 in bed with the call light wrapped around the side rail on the right side of the bed and hanging out of the resident's reach. When asked how he called the staff for assistance, he stated "I use the call light if I can find it, you can't push what you can't find." An observation of Resident #32's room and	F 558	1. Resident #32's Call light was placed within reach of the resident on 03/17/2025 by certified nursing assistant. Resident #42 call light was placed within reach of the resident on 3/17/2025 by certified nursing assistant. Resident #32 and #42 was assessed by the Director of Nursing on 03/17/2025 and no negative outcome was noted for this resident. 2. All residents using call lights have the potential to be affected by this deficient practice. All residents were reviewed by the Director of Nursing on 03/18/25 to ensure call lights were within reach of all residents. 3. To ensure the deficient practice does not reoccur, on 03/24/2025, the Director of Clinical Education provided an in-service for staff on ensuring call lights are within reach of all residents. 4. To monitor the performance of our corrective action and to ensure sustainability, the Unit Manager or Charge Nurse will audit all residents 3 days a week for 6 weeks, then weekly for 6 weeks starting 03/20/2025 to ensure their call lights are within reach. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of three months beginning 04/14/2025 by the Director of Nursing for review and revision as necessary. The Quality Assurance Performance Improvement Committee will		

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F 558	Continued From page 2 interview with Registered Nurse (RN) #2 and Certified Nursing Assistant (CNA) #2 on 3/17/25 at 10:32 AM, they verified that the call light was wrapped around the side rail on the right side of the bed and hanging out of the resident's reach. CNA #2 stated "that is on me, I just left to throw something away and forgot to put it where he could reach it, I was coming back." RN #2 confirmed that the call light should be kept in the resident's reach because if there was a problem or emergency the resident would not be able to call for assistance. Record review of the "Admission Record" revealed that the facility admitted Resident #32 on 01/31/2020 with diagnoses that included Blindness Right Eye and End Stage Renal Disease. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date of 12/22/24 for Resident #32 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating that the resident is cognitively intact. Resident #42 An observation on 3/17/25 at 10:25 AM revealed Resident #42 lying in bed asleep; the resident's call light was positioned inside the closed drawer of his nightstand, making it inaccessible. An observation on 3/17/25 at 1:20 PM and again at 3:45 PM revealed the call light hanging down on the left side of the nightstand and was not within reach of the resident. An observation on 3/18/25 at 8:30 AM revealed that Resident #42 was lying in bed; his call light	F 558	review the findings and determine if a need to alter our corrective action.		

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F 558	Continued From page 3 was hanging down from the wall and positioned to the right of the nightstand on the floor, and out of reach of the resident. During an interview and observation on 3/18/25 at 11:16 AM of Resident #42's call light position, CNA #4 confirmed the call light was hanging down from the wall and positioned to the right of the nightstand on the floor and was inaccessible to the resident and had not been accessible all morning. She revealed his call light should always be within reach so we can be notified if he needs anything. An interview on 03/18/25 at 2:15 PM, the Director of Nurses (DON) confirmed that staff are expected to ensure call lights are always within residents' reach. The DON stated, "Residents should always have access to their call lights to request assistance. This is a critical aspect of resident safety and care." A record review of Resident #42's Admission Record revealed he was admitted to the facility on 5/15/16 with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side.	F 558			
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(I) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits,	F 583		4/16/25	

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F 583	Continued From page 4 and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to secure electronic health records as evidenced by an Electronic Medication Administration Record (EMAR) visible while the medication cart was unattended on the West unit for two (2) of 58 residents residing on the West Hall. Residents #86 and Resident #104 Findings include: A review of the facility policy with a date of May 1,	F 583	On 3/18/2025 upon discovery that Resident #86 medical information was left visible the computer was closed immediately. On 3/18/2025 upon discovery that Resident # 104 medical information was visible the computer was closed immediately. 2. All residents have the potential to be affected by this deficient practice. All laptops were reviewed by the Director of Nursing on 03/18/25 to ensure that all laptops were closed when not in		

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F 583	Continued From page 5 2012, titled "Residents' Rights Summary," revealed "Privacy and Confidentiality: The resident has the right to personal privacy and confidentiality of his/her personal and clinical records ..." Resident #86 An observation on 3/18/25 at 9:10 AM revealed that a computer located on a medication cart on the West unit was opened with Resident #86's EMAR information visible on the screen. Licensed Practical Nurse (LPN) #1 was away from her medication cart, and the screen was visible to anyone passing the medication cart in the hallway. The visible information included Resident #86's name, medications, and room number. An interview on 3/18/25 at 9:12 AM, LPN #1 confirmed that the EMAR for Resident #86 was visible on the screen to anyone walking by and should be closed when she was away from the medication cart to secure private health information. She stated, "I had to step away from the cart to assist a resident but should have made sure the screen was closed." A record review of Resident #86's Admission Record revealed the resident was admitted to the facility on 03/15/2024. Resident #104 An observation on 3/18/25 at 11:44 AM revealed a medication cart on the West Hall was left unattended, and a computer sitting on the cart was opened with Resident #104's EMAR information visible on the screen and was visible	F 583	attendance and that there was no patient information visible. 3. To ensure the deficient practice does not reoccur, Licensed Practical Nurse #1 was in-serviced on 3/20/2025, 1:1 regarding ensuring resident information is not visible when not directly attending information or screen. On 03/24/2025, the Director of Clinical Education provided an in-service for staff on ensuring resident information is not visible except when in attendance by nursing staff for all residents. 4. To monitor the performance of our corrective action and to ensure sustainability, the Unit Manager or Charge Nurse will audit all laptops 3 days a week for 6 weeks, then weekly for 6 weeks starting 03/20/2025 to ensure patient information is not visible when nursing staff is not in attendance.. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of three months beginning 04/14/2025 by the Director of Nursing for review and revision as necessary. The Quality Assurance Performance Improvement Committee will review the findings and determine if a need to alter our corrective action.		

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F 583	Continued From page 6 to anyone passing by the medication cart in the hallway. The visible information included Resident #104's name, medications, and room number. In an interview on 3/18/25 at 11:50 AM, LPN #1 confirmed that Resident #104's EMAR was visible on the screen to anyone walking by. She stated, "I know I shouldn't have left the cart unattended with the resident's information left up; I know I did it earlier this morning, but I usually make sure the screen is closed when I leave the cart." LPN #1 confirmed that this violates the privacy of the residents' medical records. An interview on 3/18/25 at 3:09 PM, the Director of Nursing (DON) confirmed that a resident's information should never be left up on the computer screen while the cart is unattended. He revealed Resident #86 and Resident #104's EMAR should not have been visible while the cart was unattended. He confirmed this is a privacy issue. A record review of Resident #104's "Admission Record" revealed the resident was admitted to the facility on 12/14/2024.	F 583			
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		4/16/25	

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F 584	Continued From page 7 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 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, record review, and facility policy review, the facility failed to provide a safe, clean, and homelike environment for nine (9) of 134 residents residing in the facility. (Residents #14, #17, #32, #70,, #71, #79, #87, #93, and #95).	F 584	1. Resident #14 headboard was replaced on 03/18/2025. Resident #70's dresser drawers were cleaned on 3/18/2025 with riddance of black substance, by Housekeeping. The hole in Resident #79 was replaced and the metal vent cover was secured on 3/18/2025 by		

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F 584	Continued From page 8 Findings include: Review of the facility policy titled, "Room Audit," with an effective date of September 1, 2014, revealed, "Purpose: To assess resident rooms to identify items that should be repaired, replaced, or addressed to ensure a home-like standard that meets acceptable standards...General Room Appearance - Housekeeping issues should be noted and reported to housekeeping. Damaged drywall, furniture, or non-functioning equipment should be noted, a work order created and addressed accordingly to priority..." Resident #14 During an observation of Resident #14's room and interview with the resident on 3/17/25 at 11:10 AM revealed the headboard of the resident's bed was broken on both sides, exposing jagged wood edges. Pieces of the broken headboard were observed lying on the floor behind the bed. He stated the headboard had been broken for a while and confirmed he reported it to staff. A follow-up observation of Resident #14's room on 3/18/25 at 8:58 AM revealed the headboard remained broken with jagged edges exposed. An observation conducted with Registered Nurse (RN) #1 on 3/18/25 at 10:45 AM confirmed the headboard was broken in half on both sides, with jagged edges of wood exposed. She stated that the jagged edges could potentially injure the resident. During an interview with the Administrator on 3/18/25 at 10:55 AM confirmed the broken headboard should have already been identified	F 584	the maintenance director. Resident #17 Air Conditioner was repaired by the Maintenance Director on 3/18/2025 and housekeeping removed the towels and cleaned the area on 3/18/2025. The 3" gap was repaired and towel removed and the screen was placed on the window by the maintenance director on 3/20/2025. The Resident's overbed table was replaced by the maintenance Director on 3/18/2025. Resident #32 bed remote control was replaced on 3/17/2025 by the maintenance director. Resident #71 Bed was repaired by replacing the remote control and the mattress was replaced by the Maintenance director on 3/17/25. Resident #87 curtains were removed and replaced with blinds on , the bed rail was replaced, the wall behind the O2 concentrator was cleaned/painted by the maintenance director on 3/18/25. The boxes on the floor containing tube feeding supplies were removed by central supply on 3/18/2025. The O2 concentrator was cleaned by the unit manager on 3/18/20025. Resident #93 overbed light was replaced on 3/18/2025 by the maintenance director. Resident #95 curtains were removed and replaced with blinds by the maintenance director on 3/18/25. The boxes on the floor containing tube feeding supplies were removed by central supply on 3/18/2025. 2. All residents have the potential to be affected by this deficient practice. Resident #14- The Maintenance Director made rounds in the facility to check and		

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F 584	Continued From page 9 and repaired. She acknowledged the condition could cause concerns for the resident's safety. During an interview on 3/18/25 at 11:10 AM the Maintenance Supervisor revealed he was unaware of the broken headboard in Resident #14's room. He confirmed staff should have reported the issue and entered a work order. He acknowledged the jagged edges of the headboard could be dangerous. Record review of Resident #14's "Admission Record" revealed the resident was admitted on 1/24/24 with diagnoses that included Type II Diabetes Mellitus. Record review of Resident #14's Minimum Data Set (MDS), Section C with an Assessment Reference Date (ARD) of 1/24/25, revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Resident #70 During an interview with Resident #70 on 3/17/25 at 3:08 PM, the resident stated her husband noticed mice droppings inside her dresser drawers while helping her retrieve clothing. Resident #70 stated she reported the mouse droppings to staff. An observation of Resident #70's dresser drawers conducted with Certified Nurse Assistant (CNA) #10 on 3/17/25 at 3:10 PM revealed numerous amounts of black substances approximately the size of rice in the second, third, and fourth drawers. CNA #10 confirmed the presence of the black substances and revealed it appeared to be mice droppings and expressed	F 584	see if any other headboards needed to be replaced. Any negative findings were repaired on 3/18/2025. Resident #70- All resident's rooms were checked for pest by Unit Managers on 3/18/2025. No other evidence of pest was found. Resident #79- The Maintenance Director made rounds in the facility to check and see if holes and vents needed to be repaired. Any negative findings were repaired on 3/18/2025. Resident # 17- The Maintenance Director made rounds in the facility to check and see if there were any other air conditioners that needed repair on 3/18 /2025. The maintenance director checked to see if any other bed side tables needed to be replaced. The maintenance director made rounds on 3/20/2025 to ensure there e were no gaps in windows or any missing screens. The Housekeeping supervisor made rounds in the rooms to ensure there were no towels under the Air Conditioners or areas that needed to be cleaned. Any negative findings were repaired on 3/18/2025. Resident #32- . The Maintenance Director made rounds in the facility to check and see if there were any other bed remote controls that needed repair or replacing on 3/17 /2025. Resident #71- . The Maintenance Director made rounds in the facility to check and see if there were any other beds that needed repair on 3/17 /2025. The Unit managers checked to see if any other mattresses needed to be replaced o 3/17/2025. Any negative findings were repaired or replaced on 3/17/2025. Resident #87- The Maintenance Director made rounds in the		

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F 584	Continued From page 10 concern that mice carry diseases. During an interview with RN #1 on 3/18/25 at 10:45 AM confirmed the presence of what appeared to be mice droppings in Resident #70's dresser drawers. RN #1 stated the resident's clothing would be contaminated with feces and bacteria. During an interview with the Administrator on 3/18/25 at 10:50 AM confirmed the substance that appeared to be mice droppings should have been cleaned immediately upon discovery to prevent health concerns. During an interview with the Maintenance Supervisor on 3/18/25 at 11:10 AM it was revealed that mice droppings in Resident #70's dresser drawers were reported to him on 3/15/25. He confirmed staff should have cleaned the droppings at the time they were discovered to avoid potential health concerns. Record review of Resident #70's "Admission Record" revealed the resident was admitted on 12/10/24 with diagnoses that included Occlusion and Stenosis of an Unspecified Vertebral Artery. Record review of Resident #70's MDS, Section C with an ARD of 2/22/25, revealed a BIMS score of 15, indicating the resident was cognitively intact. Resident #79 An observation of Resident #79's room on 3/17/25 at 11:00 AM revealed a hole in the wall beside the resident's bed, with a metal vent cover hanging out of the hole.	F 584	facility to check and see if there were any curtains that needed to be replaced, bed rails needed to be replaced, and walls needed to be cleaned or painted on 3/18/2025. Central Supply made rounds all the rooms to remove any boxes that contained supplies on 3/18/2025. The Unit managers made rounds to see if any other O2 concentrator needed to be cleaned on 3/18/2025. Any negative findings were repaired or replaced on 3/18/2025. Resident #93 - The Maintenance Director made rounds in the facility to check and see if there were any other over bed lights that needed repair or replacing on 3/18 /2025. Resident #95- The Maintenance Director made rounds in the facility to check and see if there were any curtains that needed to be replaced on 3/18/2025. Central Supply made rounds all the rooms to remove any boxes that contained supplies on 3/18/2025. 3. On 3/24/25, The Director of Clinical Education provided education to staff regarding reporting and creating work orders for repairs needed. The maintenance director or the assistant maintenance director will make rounds in 5 rooms 5 days a week to check for any repairs needed weekly for 4 weeks and then 2 times a week for 8 weeks starting on 03/24/2025. On Resident # 17- 3/17/25 Pest Control Company was contacted by Maintenance to service center due to findings. On 3/24/25 the Director of Clinical Education provided education to staff on notifying Maintenance Director or		

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F 584	Continued From page 11 An observation of Resident #79's room conducted with RN #1 on 3/18/25 at 10:41 AM confirmed there was a hole in the wall and the vent cover was hanging out. She stated the condition posed a potential hazard because the resident could injure himself on the vent cover or stick his arm into the hole. During an interview on 3/18/25 at 10:54 AM the Administrator confirmed the hole in Resident #79's wall was a hazard and should have been identified and addressed. During an interview on 3/18/25 at 11:04 AM the Maintenance Supervisor revealed he was unaware of the hole in Resident #79's wall until today. He measured the hole as approximately four by six inches in diameter and confirmed staff should have identified the damage and submitted a work order. He stated he makes weekly rounds to check for maintenance concerns but did not have documentation of the rounds conducted. Record review of Resident #79's "Admission Record" revealed the resident was admitted on 5/27/24 with diagnoses that included Obstructive Hydrocephalus. Resident #17 An observation and interview on 3/17/25 at 11:30 AM revealed three white bath towels lying on the floor in front of the air conditioner unit in Resident #17's room. Resident #17 revealed that staff change those towels out but was not sure why they were there. Resident #17 stated that the towels may be for the air conditioner but admitted they looked messy. During this observation a thick black substance was noted covering the entire bottom base of the resident's overbed	F 584	Administrator of pest in center, placing in maintenance system (TELS) and in pest control sighting book located at each nurse's station. 4. To monitor the performance of our corrective action and to ensure sustainability. The Nursing Home Administrator or the Director of Nursing will make rounds weekly to ensure all rooms are in good repair and there are no pest control issues starting 03/24/25. The maintenance director or the assistant maintenance director will make rounds in 5 rooms 5 days a week to check for any repairs needed weekly for 4 weeks and then 2 times a week for 8 weeks starting on 03/24/2025. On Resident # 17- 3/17/25 Pest Control Company was contacted by Maintenance to service center due to findings Any negative findings of audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing Home Administrator for review and interventions as necessary beginning with April's Quality Assurance Performance Improvement Committee Meeting on April 14, 2025.		

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F 584	Continued From page 12 table. On 3/18/25 at 8:44 AM, an observation revealed no changes in Resident #17's overbed table and the three white bath towels remained lying on the floor in front of the air conditioner unit. During an interview on 3/18/25 at 2:37 PM, Housekeeper #2 revealed that the air conditioner in Resident #17's room leaks, and they change out the towels every day and sometimes two times a day. She revealed it had been reported to the previous administrator. During an observation and interview on 3/18/25 at 2:50 PM, the Director of Nurses (DON) confirmed towels were lying on the floor in front of the air conditioner unit, and the overbed table had a thick black substance over the metal base. During this observation, it was noted that the resident's window had a white towel stuck in the side, and there was a gap of approximately three (3) inches to the remaining top of the window, which exposed the outside elements. There was no screen in the window. Resident #17 revealed they put that towel in there but didn't stop the whole gap. He revealed the window didn't close. The DON confirmed that the window had a gap of approximately 3 inches with a towel positioned in it and was open to the outside elements. He revealed Resident #17 should have a clean, functional room that is free of outside elements. He revealed this is just not acceptable. During an interview on 3/18/25 at 3:00 PM, the Maintenance Supervisor revealed he wasn't aware of the air conditioner unit leaking and didn't have a work order for it and, therefore, wasn't aware of the towels on the floor under the unit.	F 584			

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F 584	Continued From page 13 He revealed he was aware of the gap in the window and that he used to have a helper, and he thought that the helper had repaired the window. A record review of Resident #17's "Admission Record" revealed the resident was admitted on 3/31/2021 with diagnoses that included Unspecified Dementia and Anxiety Disorder. A record review of Resident #17's MDS, Section C, with an ARD of 2/7/25, revealed a BIMS score of 5, indicating severe cognitive impairment. Resident # 32 An observation of Resident #32's bed on 3/17/25 at 10:34 AM, revealed Resident #32 in bed with the bed remote control wrapped around the side rail on the right side of the bed with two (2) inches of wire exposed on the cord. An observation of Resident #32's bed and interview with RN #2 on 3/17/25 at 10:34 AM ,she verified that the wires on the bed remote control were exposed and that they could be a safety hazard because the exposed wires could cause a shock. During an interview on 3/18/25 at 2:00 PM the Maintenance Director stated that he was not notified prior to 3/17/25 that the resident's remote had exposed wires. He confirmed that the wires were exposed and agreed that it could have caused a risk of shock. He revealed that staff were supposed to notify him of maintenance issues by putting in a work order. Record review of the "Admission Record" revealed that the facility admitted Resident #32 on 01/31/2020 with diagnoses that included End	F 584			

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F 584	Continued From page 14 Stage Renal Disease. Record review of the MDS with an ARD of 12/22/24 for Resident #32 revealed a BIMS score of 15, indicating that the resident is cognitively intact. Resident # 71 An observation of Resident #71's room on 3/17/25 at 11:31 AM with CNA #2 revealed the mattress was noted to have a 12 by 12 inch area of sagging to the middle portion of the mattress, as well as a 36 by 12 inch, irregular shaped area in which the top layer of the mattress was peeling off exposing the under layer. The bed was electric, but staff could not raise or lower the head, foot or height of the bed. CNA #2 verified that the mattress was in disrepair and the bed was not working. She stated they had gotten the resident out of bed because of this. She stated she was unsure of how long the mattress had been in disrepair or how long the bed wasn't working stating "We report these things all the time and we can never get anyone to fix them." She stated that they put in a work order to notify maintenance. She agreed that the bed being in disrepair could negatively affect the resident's comfort and positioning. An interview on 3/18/25 at 2:02 PM the Maintenance Director confirmed that staff were to notify him via work order if something needs to be fixed. He stated that he was not notified prior to 3/17/25 that the resident's mattress and bed was in disrepair. He verified that the mattress and the remote control on the bed had to be replaced. He agreed that the bed being in disrepair could negatively affect the resident's comfort and	F 584			

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F 584	Continued From page 15 positioning. Record review of the "Admission Record" revealed that the facility admitted Resident #71 on 3/27/23 with diagnoses that included Systolic Congestive Heart Failure. Resident #87 On 3/17/25, at 10:30 AM, and again on 3/18/25, at 11:10 AM, an observation of Resident #87's room revealed multiple large brown spots on the window curtains and four boxes stacked on the floor containing tube feeding supplies. Further observation revealed a broken left bed rail, and an oxygen concentrator covered in a gray and white powdery substance. The wall behind the oxygen concentrator had a dried yellow substance. During an interview with RN #1 on 3/18/25 at 11:12 AM, she confirmed the presence of the boxes on Resident #87's floor and revealed that she was informed by central supply that the boxes were to be stored in the resident's room. She mentioned that the boxes were previously kept in central supply but was unsure why they were no longer stored there. RN #1 acknowledged that the boxes on the floor posed a potential hazard for staff and visitors. She also revealed that she reported any broken equipment to maintenance but was unaware of Resident #87's broken bed rail. An interview with the Maintenance Director on 3/18/25 at 2:26 PM revealed that he did not conduct routine room rounds, as department heads completed Embrace rounds. He explained that any necessary repairs were documented in	F 584			

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F 584	Continued From page 16 the computer work-order system or reported directly by staff. He revealed he was unaware of Resident #87's broken bed rail. Record review of the "Admission Record" revealed the facility admitted Resident # 87 on 01/04/2025 with a medical diagnosis that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side. Resident #93 An observation and interview on 3/17/2025 at 10:20 AM and again on 3/18/2025 at 11:00 AM revealed Resident #93 lying in bed with his overbed light on. He revealed that his overbed light had been broken for some time and that he had informed the staff about it. This observation revealed that the overhead light lacked a pull string, preventing him from turning it off. An observation and interview with RN #1 on 3/18/2025 at 11:12 AM confirmed that Resident #93's light was broken. She explained that staff members were responsible for reporting broken items to maintenance for repairs. During an interview with the Administrator on 3/18/2025 at 11:50 AM, she confirmed that staff members were responsible for reporting necessary repairs to maintenance, while maintenance was responsible for fixing them. She also acknowledged that Resident #93 should have had functioning equipment in his room. Record review of the "Admission Record" revealed Resident #93 had been admitted to the facility on 5/12/2023 with a medical diagnosis that	F 584			

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F 584	Continued From page 17 included Aphasia following Cerebral Infarction. Record review of the MDS with an ARD of 12/24/2024, indicated that under section C, the BIMS score was 6, which indicated that Resident #93 was severely cognitively impaired. Resident #95 An observation of Resident #95's room on 3/18/2025 at 10:37 AM revealed that the curtains over the windows were stained with large, dark brown marks. Additionally, 10 brown boxes containing various enteral feeding supplies were stacked on the floor. During an interview with RN #1 on 3/18/2025 at 11:12 AM, she confirmed that Resident #95's curtains were dirty and needed to be washed. She also acknowledged that the boxes on the floor had created clutter and posed a fall risk. RN #1 confirmed that the resident should have a clean and clutter-free environment. An interview with the Administrator on 3/18/2025 at 11:50 AM, she confirmed that Resident #95 should have a clean and safe living environment. Record review of the "Admission Record" revealed Resident #95 was admitted to the facility on 2/12/2024 with a medical diagnosis that included Dysphagia following Cerebral Infarction.	F 584			
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	F 656		4/16/25	

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F 656	Continued From page 18 care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care 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	F 656			

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F 656	Continued From page 19 by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to implement an activities of daily living (ADL) care plan for resident's dependent on staff assistance (Residents #12, #111, and #118) and failed to implement a care plan related to fluid restriction for (Resident #32) for four (4) of 45 resident care plans reviewed. Findings include: Review of the facility policy titled, "MDS (Minimum Data Set) and Care Plans," with an effective date of August 2019, revealed, "Policy: Care plans will be developed per the RAI (Resident Assessment Instrument) guidelines." Resident #12 A record review of Resident #12's "Care Plan" revealed that he had a self-care deficit related to (Cerebral Vascular Accident) with left hemiplegia, impaired cognition, and immobility with interventions that included Nail, hair, shave and oral care daily and as needed. An observation on 3/17/25 at 12:05 PM and again on 3/18/25 at 9:20 AM of Resident #12's mouth and gums revealed a thick white substance that was adhered to the upper and lower gum lines. During an interview and observation on 3/18/25 at 11:00 AM, Certified Nurse Aide (CNA) # 6 confirmed that Resident #12's teeth were bed and had a lot of gunk on them. She admitted that it	F 656	1. Resident #12 received mouth care by assigned certified nursing assistant on 03/18/2025. On 03/18/2025, resident #12's care plan was reviewed by the Director of Nursing Services (DNS) to ensure it reflected oral care. The resident was assessed by the Director of Nursing on 03/18/2025 and no negative outcome noted for this resident. Resident #111's fingernails was cleaned and trimmed on 03/18/2025 by certified nursing assistant as addressed in the resident's care plan. On 03/18/2025, resident #111's care plan was reviewed by the DNS, to ensure it reflected that is fingernails are to be trimmed and cleaned. The resident was assessed by the Director of Nursing on 03/18/2025 and no negative outcome was noted for this resident. Resident #32's water pitcher was removed on 03/18/2025, by certified nursing assistant fluid needs will be provided by dietary and nursing. Resident #32 was assessed by the Director of Nursing on 03/18/2025 and no negative outcome noted for this resident. Resident #118's fingernails was cleaned and trimmed on 03/18/2025 by certified nursing assistant as addressed in the resident's care plan. On 03/18/2025, resident #118's care plan was reviewed by the DNS to ensure it reflected that is fingernails are to be trimmed and cleaned.		

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F 656	Continued From page 20 looked like it had been a long time since his teeth had been taken care of. During an interview on 3/18/25 at 3:26 PM, the Director of Nurses (DON) revealed that all residents are to be adequately groomed, including oral care. He revealed that his care plan was not followed if the resident was not provided with oral care as he should have been. A review of the "Admission Record" for Resident #12 revealed he was admitted to the facility on 9/5/23 with diagnoses that included Alzheimer's Disease, and Hemiplegia and Hemiparesis following Cerebral Infarction affecting the Left Dominant Side. Resident #111 Record review of Resident #111's "Care Plan" revealed that she had an ADL self-care performance deficit related to Dementia, Parkinson's, abnormal gait and mobility with interventions that included Bathing/Showering: Check nail length and trim and clean ...daily as needed on bath day and as necessary. Report any changes to the nurse. An observation and interview on 3/17/25 at 10:54 AM revealed Resident #111's fingernails were long, jagged and had a brown substance under each nail. Resident #111 stated that his nails were sharp and needed cut and cleaned. An observation and interview on 3/18/25 at 9:05 AM Resident #11 revealed no change in the appearance of her fingernails. She stated that she got cleaned up last night, but they did not do	F 656	Resident #118 was assessed by the Director of Nursing on 03/18/2025 and no negative outcome was noted for this resident. 2. All residents who require assistance with oral care have the potential to be affected by this deficient practice. All residents who require assistance have the potential to be affected by not having their fingernails trimmed and cleaned. All residents who have orders for fluid restrictions have the potential to be affected by this deficient practice. All residents were reviewed by the Director of Nursing on 03/18/25 to ensure that all residents who require assistance with oral care was done. All residents and their orders who require fluid restrictions were reviewed by the Director of Nursing on 03/18/2025 with no negative findings. All residents were checked by the Unit Managers on 03/18/2025 to ensure that all resident's fingernails were trimmed and clean. 3. To ensure the deficient practice does not reoccur, The Director of Nursing or the Director of Clinical Operation on 3/20/25 began reviewing all the residents care plans that require assistance with oral care, fingernails trimmed and cleaned and fluid restrictions to ensure care plans are updated. The Director of Clinical Education began in-services with staff on 3/20/25 to ensure they are aware of residents needing assistance with oral care, fingernails trimmed and cleaned and fluid restrictions. 4. To monitor the performance of our corrective action and to ensure		

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F 656	Continued From page 21 anything with her nails. During an interview on 03/18/25 at 2:00 PM, the DON confirmed that residents should receive assistance with their ADLs, including proper nail care. He revealed that if the resident's fingernails were not adequately groomed, their care plan was not being followed, and it should have been. A review of the "Admission Record" for Resident #111 revealed she was admitted to the facility on 3/21/24 for diagnoses which included Type 2 Diabetes Mellitus and Parkinson's Disease. A review of the MDS with an ARD of 3/13/25 revealed Resident #111 had a BIMS of 15, indicating the resident was cognitively intact. Resident #32 A record review of the "Care Plan " for Resident #32 revealed "Focus: [Resident Proper Name] has alteration in Kidney Function Due to End Stage Renal Disease (ESRD), evidenced by hemodialysis, left nephrostomy tube. Goal: I will reduce short term complications associated with impaired renal function through review date. Interventions: one liter (1L) fluid restriction. Nursing to provide: 150 cc on 7-3 shift, 150 cc fluids on 3-11 shift, 100 cc fluids on 11-7 shift. Dietary to provide: 12 oz fluids on breakfast tray, 4 oz fluids on lunch tray, 4 oz fluids on dinner tray." A record review of Resident #32's "Electronic Medication Administration Record" (eMAR) documentation of fluid intake revealed the resident was on a 1-liter fluid restriction daily and there were 9 days out of the last two weeks that	F 656	sustainability, the Unit Manager or Charge Nurse will conduct audits 3 days a week for four (4) weeks and then weekly for 8 weeks to ensure oral care is being performed, and fingernails are trimmed and clean. The Director of Nursing will audit weekly all residents with orders for fluid restrictions and will audit all new admits during clinical start up. Findings of audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing Home Administrator for review and interventions as necessary beginning with April's Quality Assurance Performance Improvement Committee Meeting on 04/14/2025.		

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F 656	Continued From page 22 indicated fluid intake exceeded 1 liter within a 24-hour period. Those days were 3/3/25, 3/5/25, 3/8/25, 3/9/25, 3/10/25, 3/12/25, 3/13/25, 3/14/25, and 3/17/25. During an interview and record review of Resident #32's documented fluid intake with Licensed Practical Nurse (LPN) #1 on 3/18/25 at 8:47 AM, she stated that Resident #32 was on a 150-cc fluid restriction for the 7:00 AM-3:00 PM shift. She clarified that this did not include his fluid intake from breakfast or lunch, only the fluids administered by the nursing staff during her shift. She admitted that she did not check his meal trays to verify that dietary provided the ordered amount of fluid for breakfast and lunch, nor did she monitor or document his fluid intake from those meals. After record review, LPN #1 verified that it was hard to tell from the documentation how much the resident was actually getting but appeared that the resident may have went over the one liter limit a few day. On 3/18/25 at 8:50 AM, during an interview and record review with the DON, he admitted that Resident #32 may have exceeded the one liter daily limit for multiple days. During an interview on 3/20/25 at 9:30 AM, with the MDS Nurse stated that the care plan is formulated as a guideline for resident care based on their needs. She agreed that the interventions are to be followed by staff in order for the residents to reach their goals. She stated that the staff's failure to accurately monitor and document Resident 32's fluid restriction was a failure to implement his current care plan. A record review of the "Admission Record"	F 656			

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F 656	Continued From page 23 revealed that the facility admitted Resident #32 on 01/31/2020 with a diagnosis of End-Stage Renal Disease. Resident #118 Review of the care plan for Resident #118 titled, "I have ADL self-care performance deficit r/t (related to) weakness, impaired cognition," with a revision date of 2/24/2025 revealed interventions: "Personal Hygiene: The resident requires limited assistance x (1) one staff with personal hygiene and oral care." An observation and interview with Resident #118 on 3/17/2025 at 10:15 AM revealed the residents' fingernails were long, jagged with a dark brown substance present underneath the nail beds. Resident #118 stated that he did not like his fingernails to be long and could not recall the last time they had been trimmed. An observation on 3/18/2025 at 10:48 AM was conducted with RN #1 who confirmed that Resident #118's fingernails needed cut and cleaned and looked like it had been a while since they were taken care of. During an interview with the DON on 3/18/2025 at 11:10 AM, he confirmed after review of the ADL care plan for Resident #118 that staff did not implement the care plan related to personal hygiene. He stated the purpose of the care plan is to direct staff on how to care for the residents. He also stated that concerns from staff not implementing care plans are that the residents may not receive the care they need. A review of the "Admission Record" for Resident #118 revealed he was admitted on 1/21/2025,	F 656			

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F 656	Continued From page 24 with diagnoses including a Need for Assistance with Personal Care and Urinary Tract Infection.	F 656			
F 677 SS=E	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 interview, record review, and facility policy review, the facility failed to provide activities of daily living (ADL) care for resident's dependent on staff assistance for three (3) of five (5) residents reviewed for ADL's. (Residents #12, #111, and #118). Findings include: Review of the facility policy titled "ADLs," effective August 2021, revealed the following: "Policy: Ensure ADLs are provided in accordance with accepted standards of practice, the care plan, and reasonable accommodation of the resident's choice and preferences." ... Resident #12 An observation on 3/17/25 at 12:05 PM and again on 3/18/25 at 9:20 AM revealed that Resident #12's upper and lower teeth were covered in a thick white substance that adhered to the upper and lower gum lines. During an interview and observation on 3/18/25 at 11:00 AM, Certified Nurse Aide (CNA) #6	F 677	1. Resident #12 received mouth care by assigned certified nursing assistant on 03/18/2025. On 03/18/2025, resident #12's care plan was reviewed by the Director of Nursing Services (DNS) to ensure it reflected oral care. The resident was assessed by the Director of Nursing on 03/18/2025 and no negative outcome noted for this resident. Resident #111's fingernails were cleaned and trimmed on 03/18/2025 by certified nursing assistant as addressed in the resident's care plan. On 03/18/2025, resident #111's care plan was reviewed by the DNS, to ensure it reflected that his fingernails are to be trimmed and cleaned. The resident was assessed by the Director of Nursing on 03/18/2025 and no negative outcome was noted for this resident. Resident #118's fingernails was cleaned and trimmed on 03/18/2025 by certified nursing assistant as addressed in the resident's care plan. On 03/18/2025, resident #118's care plan was reviewed by the DNS to ensure it reflected that his fingernails are to be trimmed and cleaned.	4/16/25	

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F 677	Continued From page 25 confirmed Resident #12's teeth were bad and had a bunch of gunk on them. She revealed she honestly thought they looked like it had been quite some time since his mouth had been tended to. During an interview on 03/18/25 at 2:10 PM, Registered Nurse (RN) #3 revealed that Resident #12 has a hospice aide that comes twice a week and provides personal hygiene but admits that it is all of their responsibility to make sure the residents oral care is taken care of. She stated that there is no excuse for a residents' daily oral care to not be completed. During an interview on 3/18/25 at 3:26 PM, the Director of Nurses (DON) revealed that all residents are to be adequately groomed, including oral care. A record review of Resident #12's "Admission Record" revealed he was admitted to the facility on 9/5/23 with diagnoses that included Alzheimer's Disease, and Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Dominant Side. Resident #111 An observation and interview on 3/17/25 at 10:54 AM revealed Resident #111's fingernails to be one and one-half (1.5) inches long past the tip of the fingers, jagged in appearance with a brown substance under the nail beds. Resident #111 stated, "I am a diabetic, and the nurse has to cut them. They are sharp, and I don't like them this long. I'm not sure when the last time they were cut and cleaned."	F 677	Resident #118 was assessed by the Director of Nursing on 03/18/2025 and no negative outcome was noted for this resident. 2. All residents who require assistance with oral care have the potential to be affected by this deficient practice. All residents who require assistance with activities of daily living have the potential to be affected by not having their fingernails trimmed and cleaned. All residents were reviewed by the Director of Nursing on 03/18/25 to ensure that all residents who require assistance with oral care was done. All residents were checked by the Unit Managers on 03/18/2025 to ensure that all resident's fingernails were trimmed and clean. 3. To ensure the deficient practice does not reoccur, the Director of Clinical Education began in-services with staff on 3/20/25 to ensure they are aware of residents needing assistance with activities of daily living according to their plan of care; including oral care and fingernails trimmed and cleaned. 4. To monitor the performance of our corrective action and to ensure sustainability, the Unit Manager or Charge Nurse will conduct audits 3 days a week for four (4) weeks and then weekly for 8 weeks starting 03/20/2025 to ensure the residents who require assistance with activities of daily living receive services as directed in their plan of care. Findings of audits will be presented to the Quality Assurance and Performance Improvement Committee for a minimum of three months for review and		

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F 677	Continued From page 26 An observation and interview on 3/18/25 at 9:05 AM with Resident #111 revealed she got cleaned up last night by the bath girl but admitted that she didn't get her fingernails cut. Her fingernails remain long and jagged. She revealed the girl who gave her a bath couldn't cut her fingernails because she is diabetic, and the nurse had to cut them. She stated, "I don't know when I will get my fingernails trimmed, but they need them." An interview and observation on 3/18/25 at 11:10 AM CNA #5 revealed she was assigned to the resident today and confirmed that the resident's nails were long and jagged. She revealed that she couldn't cut them since the resident is diabetic, but we are supposed to notify the nurses when we notice the fingernails are long and need to be cut. She revealed she had not reported it to the nurse. During an interview and observation on 3/18/25 at 11:15 AM, Licensed Practical Nurse (LPN) #3 confirmed that the resident is diabetic, and the nurses are responsible for trimming the resident's fingernails. She confirmed Resident #111's nails were long and jagged and needed to be trimmed. Resident #111 stated, "I would like my fingernails cut." During an interview on 03/18/25 at 2:00 PM, the DON confirmed that Resident #111 should receive assistance with their ADLs, including proper nail care. A record review of the "Admission Record" for Resident #111 revealed she was admitted to the facility on 3/21/24 with diagnoses which included Type 2 Diabetes Mellitus and Parkinson's Disease.	F 677	interventions as necessary by the Nursing Home Administrator /Director of Nursing Services beginning on 04/14/25.		

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F 677	Continued From page 27 A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/13/25 revealed Resident #111 had a Brief Interview of Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Resident #118 An observation of Resident #118 on 3/17/2025 at 10:15 AM revealed the resident had jagged fingernails approximately one-half (½) inch in length with a dark brown substance present underneath the nail beds. During an interview conducted at the time of the observation, Resident #118 verbalized he did not like his fingernails to be long and could not recall the last time they had been trimmed. A subsequent observation and interview on 3/18/2025 at 10:48 AM was conducted with RN #1, she confirmed that Resident #118's fingernails were long, jagged, and visibly soiled with a dark brown substance under the nail beds. RN #1 further acknowledged the nails appeared untrimmed for a prolonged period and required attention. RN #1 expressed concern that the resident could potentially scratch himself, increasing the risk of skin breakdown or infection due to the dirty nails. During an interview with the DON on 3/18/2025 at 11:10 AM he confirmed that Resident #118 was dependent on staff assistance for personal care and should have already received nail care. A record review of the "Admission Record" for Resident #118 revealed he was admitted on 1/21/2025, with diagnoses including A Need for	F 677			

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F 677	Continued From page 28 Assistance with Personal Care. Record review of the MDS with an ARD of 1/28/25 revealed Resident #118 had a BIMS score of 09, indicating the resident had moderate cognitive impairment.	F 677			
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, Safety Data Sheet review, and facility policy review, the facility failed to safely store and lock hazardous cleaning chemicals on two (2) of three (3) housekeeping carts observed during survey. Findings include: Review of facility policy titled "Environmental Services Chemical Use/Dilution and Hazards" revealed "Overview of proper chemical use ...6. Each housekeeping cart has a lockbox. All chemicals are to be stored in the lock box. Do not leave your cart unattended..." An observation and interview on 3/17/25 at 10:50 AM revealed an unattended housekeeping cart on the west hall that was unlocked. An interview at this time with Housekeeper #5 confirmed that	F 689	1. On 3/17/25 the lock on the West Wing housekeeping cart was replaced by the area housekeeping manager. On 3/17/2025 the lock was replaced and the key given to the housekeeper on the rehabilitation housekeeping cart by the area housekeeping manager. 2. All residents have the potential to be affected by this deficient practice. All housekeeping carts were checked by the housekeeping supervisor to ensure the locks were working properly and that all housekeepers had keys to their carts so that their chemicals could be stored properly on 3/18/2025. 3. To ensure the deficient practice does not recur, on 03/20/24 the Director of Clinical Education provided an in-service to staff on ensuring all chemicals were	4/16/25	

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F 689	Continued From page 29 the housekeeping cart was not locked. She then stated that the door on the side of the cart and the roll cabinet on the top of the cart did not lock. Further observation of the cart with Housekeeper #5 revealed that the following chemicals were stored on the cart: Crew Bathroom Disinfectant Cleaner, Virex Plus One-step disinfectant cleaner & deodorant, and Crew clinging Toilet bowl cleaner. Housekeeper #5 stated that she was not sure how long the lock had not worked and at one point someone had used tape to keep the door shut, but they really needed new ones. She stated that the cart is supposed to be locked to keep the chemicals away from the residents because they are dangerous and could hurt them if they drank it or got it on them. An observation and interview on 3/17/25 at 11:00 AM with Housekeeper #4 revealed that the rehabilitation hall housekeeping cart was locked but the following chemicals were stored outside the cart, within resident reach: Crew Bathroom Disinfectant Cleaner, Virex Plus One step disinfectant cleaner & deodorant, and Crew clinging Toilet bowl cleaner. Housekeeper #4 stated that he stored the chemicals there because he did not have a key to unlock the cart. He stated that he has worked at the facility for about a month. He stated that the cart is supposed to be locked to keep the chemicals away from the residents because they are dangerous and could hurt them if they drank it or got it on them. An interview with the Housekeeping Supervisor on 3/18/25 at 9:07 AM, he stated that he was not aware that the west housekeeping cart was not locking. He stated he knew that there had been a previous issue with it not locking but stated that	F 689	stored and locked according to policy and procedure. On 03/20/24 the Housekeeping Supervisor in-service the housekeeping staff on storing their chemicals in the locked storage area of their carts, on making sure that all locks work properly, on notification of any lock not working properly and ensuring that every housekeeper has a key to their cart. 4. To monitor the performance of our corrective action and to ensure sustainability, the Unit Manager or Charge Nurse will conduct audits 3 days a week for four (4) weeks and then weekly for 8 weeks starting on 03/20/25 for any chemical that is not stored under lock and key. The house keeping supervisor will audit all housekeeping carts 5 days a week for 8 weeks and then weekly thereafter for 6 weeks to ensure the housekeeping staff are storing their chemicals in the locked storage area of their cart, ensuring all locks work properly, on notification of any lock not working properly and ensuring that every housekeeper has a key to their cart starting on 3/25/25. Findings of audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing Home Administrator for review and interventions as necessary beginning on 04/14/2025.		

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F 689	Continued From page 30 he had used it about a month ago and it was locking with no issue. He further stated that Housekeeper #4 had just recently started using the rehabilitation housekeeping cart and he had forgotten to tell him to come and get his key. He confirmed that it was important to keep the cleaning chemicals secure because they were caustic and could cause injury if the residents got them on them or drank them. An interview with the Administrator on 3/18/25 at 2:45 PM, she stated she was not aware of the issues with the housekeeping cart and that it was her expectation that she would have been notified if the housekeeping cart was not locking or if an extra key was needed. Record review of the Safety Data Sheets (SDS) review for Crew Bathroom Disinfectant Cleaner, Virex Plus One step disinfectant cleaner & deodorant, and Crew clinging Toilet bowl cleaner revealed: Crew Bathroom Disinfectant Cleaner, "Hazard Statement: None ...4. First Aid Measures, Eyes: Rinse with plenty of water, if irritation occurs or persists, get medical attention ..." Virex Plus One step disinfectant cleaner & deodorant: "Hazard Statement: combustible liquid. Causes severe skin burns and serious eye damage. Harmful if swallowed. May cause damage to organs through prolonged or repeated exposureFirst Aid Measures, Eyes: If in eyes rinse cautiously with water for several minutes ...Continue rinsing for at least 15 minutes." Crew clinging Toilet bowl cleaner: "Hazard Statement: Causes severe skin burns and serious eye damageFirst Aid Measures, Eyes: If in eyes rinse cautiously with water for several minutes ...Continue rinsing for at least 15 minutes ..."	F 689			

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F 692 F 692 SS=D	Continued From page 31 Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews, and facility policy reviews, the facility failed to accurately monitor and document fluid intake for one (1) of six (6) residents receiving dialysis. Resident #32. Findings Include: Review of a statement, on company letter head, dated 3/19/25 and signed by the Administrator (ADM) revealed " Standards of Practice, the expectation set forth by (Proper name of facility) management is that the nurses comply with	F 692 F 692	1. Resident #32 fluid restrictions were reviewed with Nurse Practitioner by Director of Nursing Services(DNS) on 3/20/2025. The fluid restrictions were placed on Medication Administration Record(MAR) and care plan by DNS. Resident #32 was assessed by the Director of Nursing Services on 3/20/2025 with no complications noted related to fluid restriction. 2. All residents with fluid restrictions have the potential to be affected by the deficient practice. By 4/3/2025 all		4/16/25

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F 692	Continued From page 32 current standards of practice in terms of following physician's orders and fluid restriction documentation." A record review of the "Order Summary Report" for Resident #32 revealed an order for a one liter (1L) fluid restriction. Nursing was to provide 150 cubic centimeters (cc) on the 7:00 AM-3:00 PM shift, 150 cc on the 3:00 PM-11:00 PM shift, and 100 cc on the 11:00 PM-7:00 AM shift. Dietary was to provide 12 ounces (oz) of fluids on the breakfast tray, four (4) oz on the lunch tray, and four (4) oz on the dinner tray. A record review of Resident #32's "Electronic Medication Administration Record" (eMAR) documentation of fluid intake from the last two weeks revealed the resident exceeded 1 liter fluid intake daily on the following days; 3/3/25, 3/5/25, 3/8/25, 3/9/25, 3/10/25, 3/12/25, 3/13/25, 3/14/25, and 3/17/25. On 3/18/25 at 8:47 AM, during a review of the eMAR documentation of Resident #32's fluid intake with Licensed Practical Nurse (LPN) #1, she verified that the resident was on a one (1) liter per 24-hour fluid restriction. She confirmed that she only documented the 150 cc she administered during her shift and was unaware of how other nurses documented the resident's intake. She admitted that she did not know if the resident was adhering to the fluid restriction. Upon further review of the eMAR, she was unable to determine the resident's total 24-hour fluid intake. She acknowledged that it appeared the resident may have exceeded the one (1) liter fluid restriction on multiple days but was unsure of the accuracy due to inconsistent documentation. She agreed that accurately monitoring fluid intake is	F 692	residents with fluid restrictions had been reviewed by Nurse Practitioner and Registered Dietician to determine restriction amount and orders obtained, placed on MAR for monitoring. 3. The Director of Clinical Education and the Director of Nursing Services began in-service on 3/20/25 with nurses to ensure following and documentation of each resident's fluid restrictions daily. 4. To monitor the performance of our corrective action and to ensure sustainability, the Unit Manager or Director of Nursing Services will audit 3 residents 3 times per week x 6 weeks, then weekly for 6 weeks starting 03/20/2025, to ensure fluid restrictions are followed and documented. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of three months beginning 04/14/2025 by the Director of Nursing for review and revision as necessary. The Quality Assurance Performance Improvement Committee will review the findings and determine if a need to alter our corrective action.		

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F 692	Continued From page 33 essential for a resident on dialysis to prevent fluid overload. On 3/18/25 at 8:50 AM, during an interview and record review of the eMAR documentation of Resident #32's fluid intake with the Director of Nursing (DON), he confirmed that he was unable to determine if the resident was adhering to his fluid restriction. He agreed that it appeared the resident may have exceeded one (1) liter on multiple days but was unsure how staff were documenting fluid intake. The DON stated that he was uncertain whether the 7:00 AM-3:00 PM and 3:00 PM-11:00 PM shifts included the fluid the resident received with his meals. During an interview and record review of Resident #32's eMAR fluid intake documentation with the Nurse Practitioner (NP) on 3/18/25 at 10:00 AM, she stated that based on the documentation, it appeared the resident was not adhering to his fluid restriction. However, she could not be certain due to the inconsistent and unclear documentation. She agreed that failure to accurately monitor fluid intake could exacerbate the residents' medical conditions. A record review of the "Admission Record" revealed that the facility admitted Resident #32 on 01/31/2020 with a diagnosis of End-Stage Renal Disease.	F 692			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		4/16/25	

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F 761	Continued From page 34 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility policy review the facility failed to ensure a medication cart was locked and medications were secured for one (1) of four (4) survey days. Findings include: Record review of the facility policy titled, "Medication Storage" with a revision date of 04/23 revealed ..."It is the responsibility of the facility to keep the medication cart locked and secure at all times when not in use... Medications or sharps cannot be stored on top of the medication cart. All safety measures must be taken to protect the residents from accessing medications and other objects that could potentially harm the resident or	F 761	1. On 3/18/2025, West Wing Medication cart was locked by Licensed Practical Nurse #1. Medication left on top of cart was removed on 3/18/2025, by LPN #1. 2. All residents have the potential to be affected by the deficient practice. 3. Licensed Practical Nurse #1 was in-serviced 1:1 by Director of Nursing and Administrator on 3/20/25, on the deficient practice of leaving the medication cart unlocked and medication unsecure. The Director of Clinical Education began in-service on 3/20/2025 to Nurses on the standard to always lock medication cart when not attending and ensure medication is secure under lock when not		

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F 761	Continued From page 35 others..."	F 761	attending. 4. To monitor the performance of our corrective action and to ensure sustainability, the Unit Manager or Director of Nursing will audit 3 medication carts 3 times per week x 6 weeks, then weekly for 6 weeks starting 03/20/2025, to ensure medication carts are locked when unattended and there is no medication not stored under lock. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of three months beginning 04/14/2025 by the Director of Nursing for review and revision as necessary. The Quality Assurance Performance Improvement Committee will review the findings and determine if a need to alter our corrective action		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F 842		4/16/25	

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F 842	Continued From page 36 (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or	F 842			

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F 842	Continued From page 37 unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review the facility failed to ensure accurate documentation of the care and services provided for a resident with a Peripherally Inserted Central Catheter (PICC) for one (1) of three (3) residents receiving IV (Intravenous) therapy. Resident #430 Findings Include: Record review of the facility policy titled "Purpose of the Patient Record" revealed "Process; clinical records are maintained to provide complete and accurate patient information for continuity of care..."	F 842	1. On 3/19/2025, The Unit Manager obtain orders for flushing the Peripherally Inserted Central Catheter Line and changing the dressing to the Peripherally Inserted Central Catheter line site for Resident #430. Resident was assessed by the Unit Manager and there were no complications to the Peripherally Inserted Central Catheter site of resident #430. 2. All residents with a Peripherally Inserted Central Catheter line have the potential to be affected by the deficient practice. All residents with a Peripherally Inserted Central Catheter line were reviewed and orders in place for flushing		

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F 842	Continued From page 38 On 3/19/25 at 9:18 AM, an observation of Registered Nurse (RN) #4 revealed she flushed Resident #430's PICC located on the right upper arm with 10 ML (milliliters) normal saline and started Vancomycin (antibiotic) infusing via dial a flow. There was a transparent dressing over the residents' PICC line dated 3/14/25. Record review of Resident #430's Electronic Medication Administration Record (EMAR) revealed the resident did not have an order to flush the PICC or to change the dressing. An interview with RN #5 on 3/19/25 at 9:45 AM, confirmed Resident #430 did not have a physician's order to flush the PICC or to change the dressing. She confirmed the resident should have an order to keep the line patent and prevent it from becoming occluded. She stated, "We just do it." An interview with the Director of Nursing on 3/19/25 at 9:56 AM confirmed Resident #430 should have PICC care orders to ensure the line remained patent and free from complications. Review of the "Admission Record" revealed the facility admitted Resident #430 on 2/27/25 with medical diagnosis that included Aftercare following Explantation of the Knee Joint Prosthesis.	F 842	and Peripherally Inserted Central Catheter line dressing change by the Director of Nursing Services on 3/19/2025. 3. The Director of Clinical Education began in-service to Nurses on 3/20/2025, of standard of practice to obtain Peripherally Inserted Central Catheter line orders for flushing and dressing changes upon initiation or admittance with a Peripherally Inserted Central Catheter line. 4. To monitor the performance of our corrective action and to ensure sustainability, the Unit Manager or DNS will audit all Peripherally Inserted Central Catheter lines upon admission or initiation to ensure flush orders and dressing changes are ordered beginning 03/20/2025. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of three months beginning 04/14/2025 by the Director of Nursing for review and revision as necessary. The Quality Assurance Performance Improvement Committee will review the findings and determine if a need to alter our corrective action.		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format.	F 851		4/16/25	

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F 851	Continued From page 39 Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from	F 851			

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F 851	Continued From page 40 agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, Payroll-Based Journal (PBJ) staffing data report review, and facility policy review, the facility failed to accurately submit staffing data into the PBJ system for one (1) of four (4) quarters reviewed. First Quarter 2025 (October-December 2024) Findings Include: Review of the facility policy titled "Payroll Based Journal Entry Submission" unrevised, revealed under, "Policy: CMS (Centers for Medicare and Medicaid Services) regulations for Payroll Based Journal (PBJ) entries submission are adhered too." Record review of the "PBJ Staffing Data Report" revealed the facility submitted excessively low weekend staffing data for the 1st quarter 2025 (October 1-December 31).	F 851	The center addressed the corrective action by performing a complete audit on 3/20/2025 of the Payroll Based Journal data submitted for the quarter October 1-December 31, 2024, that was submitted incorrectly to Centers for Medicare and Medicaid Services by the Nursing Home Administrator, Human Resource Coordinator, and Workforce Manager. Human Resource Coordinator and Workforce Manager were notified of the incorrect data submission on 3/20/2025. The center identified that Diversicare of Southaven's nursing home star rating, quality measures, and all residents at the center are at risk for the deficient practice. To avoid recurrence of the deficient practice, the Administrator, Human Resource Coordinator and the Workforce Manager was educated on 3/20/2025 by Regional Director of Operations on		

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F 851	Continued From page 41 An interview with the Regional Human Resource on 3/18/25 at 11:30 AM revealed the facility's payroll system handled late clock-ins and shifts that crossed midnight as counting toward the next shift. He revealed if a staff member clocked in late, it would automatically transfer over to the next shift because of the federal overtime laws in place. He revealed he was unsure if the department heads that worked the weekend were captured on the payroll-based journal (PBJ). An interview with Human Resources on 3/19/25 at 9:00 AM, she revealed the facility's corporate office submitted the payroll-based journal (PBJ). She confirmed that with the payroll system that they use, if someone clocks in late, the hours will automatically transfer over to the next shift. She confirmed that she did not manually correct the employee hours in the system. An interview with the Administrator (ADM) on 3/19/25 at 10:37 AM revealed every morning she went over the PPD (Patient Per Day) and looked at call ins from the day before to ensure the PPD was accurate. She revealed they had not had any low staffing. She revealed that on the weekends, they have an on-call person, and they come in and work as a CNA or nurse or whatever was needed to ensure that they met that PPD. Furthermore, she explained that they had the current payroll system for about a year and had not worked out all the kinks yet. She confirmed that no one manually corrected payroll. She revealed that she had compared the workforce manager's schedule with the human resources report and saw for herself that the hours were not captured correctly. The ADM revealed that if someone came in 2 hours late, their hours would not be captured that shift. She confirmed this	F 851	submitting complete and accurate licensed nurse staffing data and daily audit during daily Workforce Management meetings for accuracy. The center plans to monitor the effect of the systemic changes to make sure solutions are sustained by licensed nurse staffing data being reviewed during daily Workforce Management meetings beginning 3/20/2025 for accuracy. The Administrator, Human Resource Coordinator and the Workforce Manager will audit licensed nurse staffing data weekly for four weeks effective 3/20/2025, then monthly for three months for accurate data submission to Payroll Based Journal. Any negative findings will be brought to the Quality Assurance Performance Improvement meeting monthly for a minimum of three months beginning 4/14/2025, by the Administrator for review and revision as necessary to ensure compliance is sustained.		

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F 851	Continued From page 42 could cause a discrepancy with the hours submitted in the payroll-based journal.	F 851			
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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;	F 880		4/16/25	

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F 880	Continued From page 43 (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 contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to implement infection prevention and control practices when the facility failed to properly dispose of and contain contaminated garbage and resident belongings for one (1) of two (2) resident's on contact isolation (Resident #125)	F 880	1. Resident #4 was assessed on 3/19/2025 by the Director of Nursing Services (DNS) with no signs and symptoms of infection noted. Resident #118 was assessed on 3/19/2026 by the Director of Nursing Services with no signs and symptoms of infection noted.		

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F 880	Continued From page 44 and utilize Enhanced Barrier Precautions (EBP) for two (2) of 32 resident's requiring EBP (Resident #4 and Resident #118) Findings include: Review of the facility's "Infection Control Guide" revealed under, "Environmental Cleaning: Cleaning, disinfection and sterilization are important measures used to prevent and reduce the spread of infections in the healthcare setting. The oversight and monitoring of cleaning, sterilization and disinfection practices are the responsibility of the infection control care team which should include the Administrator, Director of Nursing Services, Clinical Educator, Infection Control Preventionist, Housekeeping Supervisor and Dietary Manager." Additionally, revealed under, "Transmission Based Precautions: Transmission Based Precautions (TBP) are used to help stop the spread of germs from one person to another. The goal is to protect residents, their families, visitors, and healthcare workers - and stop germs from spreading across a Healthcare setting..." Record review of the facility policy "Implementing the Use of Enhanced Barrier Precautions (EBP) in Skilled Long-Term Care (LTC) Nursing Facilities" revealed, "Enhanced Barrier Precautions...EBP should be used for residents with any of the following: Colonization or infection with targeted Multi Drug Resistant Organisms (MDROs). Chronic wounds (e.g. pressure ulcers, diabetic foot ulcers) or indwelling devices (e.g. central venous catheters, indwelling urinary catheters, tracheostomy, feeding tube) that increases their risk of acquiring MDROs."	F 880	Resident #125□s was equipped with biohazard receptacles on 3/17/2025 by Infection Preventionist. Resident #125 was assessed on 3/19/2025 by Director of Nursing Services and no complications noted from the lack of biohazard trash disposal and proper chemicals used to clean the room. Assessment of other residents on the hall did not reveal signs or symptoms of infection related to resident #125. On 3/18/2025, resident #125□s room was cleaned with chemicals labeled to kill Clostridioides difficile. 2. All residents have the potential to be affected by this deficient practice. 3. To ensure the deficient practice does not recur, on 3/20/2025, the Treatment Nurse, CNA #4 , CNA #1were educated 1:1 by the Director of Nursing/ the Director of Clinical Education(DCE) on contact precautions, enhanced barrier precautions to be used when providing care to a resident with precautions and location of personal protective equipment(PPE). The DCE provided education to the staff on enhanced barrier precautions, isolation precautions and location of PPE. The area housekeeping manager provided chemicals to be used to clean rooms with Clostridioides difficile with in-service to housekeeping staff on 3/18/2025, on use. 4. To monitor the performance of our corrective action and to ensure sustainability, the Unit Manager or Charge Nurse will audit to ensure enhanced barrier precautions and isolation receptacles are in place 3 days a week for 6 weeks, then weekly for 6 weeks starting 3/20/2025. Housekeeping manager will		

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F 880	Continued From page 45 Resident #4 On 3/19/25 at 9:04 AM, the Treatment Nurse (TN) and Certified Nursing Assistant (CNA) # 4 were observed entering Resident #4's room to provide wound care. Resident #4 had EBP signage located on the resident room door that instructed staff to wear a gown and gloves during high contact resident care activities such as changing briefs or assisting with toileting and wound care for chronic wounds. CNA #4 and the TN were observed performing hand hygiene then CNA #4 uncovered Resident #4, unfastened her brief, and positioned her on her right side. She did not wear a gown. The TN provided Resident #4's wound care but did not wear a gown. An interview with the TN and CNA #4 on 3/19/25 at 9:10 AM, they stated that they did see the EBP sign on the door and knew that they should have worn a gown to provide care. The TN stated that she forgot because there was no Personal Protective Equipment (PPE) on the door. The TN stated that EBP was used for residents with wounds to prevent the spread of infection. On 3/20/25 at 9:35 AM, during an interview, the Infection Control Nurse stated that PPE for EBP was kept in a central location on each unit and they are readily available for all staff. She verified that EBP should be followed during wound care to prevent the spread of infection, and the TN and CNA should have worn a gown. Record review of the "Admission Record" revealed that the facility admitted Resident #4 on 8/23/19 with a diagnosis of Diabetes Mellitus. Resident #118	F 880	audit to ensure proper disinfectant is used for cleaning in all isolation rooms 3 days a week for 6 weeks, then weekly for 6 weeks starting 3/20/2025. Findings of audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing Home Administrator for review and interventions as necessary beginning on 4/14/2025.		

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F 880	Continued From page 46 An observation and interview on 3/19/25 at 9:35 AM with CNA #1 performing Foley catheter care for Resident #118 revealed there was no observation of CNA #1 applying a gown as part of EBP. In a continued interview with CNA #1 she confirmed after seeing the EBP sign on the resident's door that she failed to wear a gown as part of EBP and confirmed that she should have worn the gown to reduce the risk of transmission of bacteria between the staff and resident. During an interview with the Infection Preventionist on 3/19/25 at 10:36 AM she revealed the purpose of EBP is to place a layer of protection between staff and residents to reduce the risk of spread of infection. She revealed that all residents who have devices like indwelling catheters, wounds, and other devices should be on enhanced barrier precautions. During an interview with the Director of Nursing (DON) on 03/19/25 11:30 AM he revealed if staff failed to use EBP for a resident during catheter care they increased the risk of the spread of infection between the staff and the residents. Record review of the "Order Summary Report" for Resident #118 revealed an order with an onset date of 1/22/25 to clean Foley catheter with warm soapy water, rinse with clean water and pat dry every shift. ... A review of Resident # 118's "Admission Record" revealed that he was admitted on 1/21/2025, with a diagnosis of Need Assistance with Personal Care and Urinary Tract Infection. Resident #125 On 3/17/25 at 3:25 PM, an observation outside	F 880			

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F 880	Continued From page 47 Resident #125's room door revealed a sign announcing contact isolation precautions and a 3-compartment drawer containing PPE. Further observation inside the room revealed a regular trash receptacle with disposed of yellow gowns and gloves inside. There were no biohazard containers for the linen or trash. An interview with Licensed Practical Nurse (LPN) #5 on 3/17/25 at 3:30 PM revealed Resident #125 was on contact precautions due to Clostridium Difficile infection (C. diff). She revealed staff should be dressing out in gloves and gowns and dispose of the PPE in a biohazard container before leaving the room. She confirmed the resident did not have biohazard barrels in the room and should have. An interview with the Administrator on 3/18/25 at 11:50 AM, confirmed biohazard containers should have been in Resident #125's room to prevent the spread of the pathogen to other residents and staff. An interview with Housekeeping #2 on 3/19/25 at 11:25 AM revealed she used Virex disinfectant to wipe down the bedside tables, bed rails, mattress, overhead lights, dressers, knobs, and she wiped down everything in the bathroom. She revealed she mopped the floor with Stride cleaner. She confirmed they (housekeeping services) used these products for all resident rooms in the facility, including Resident #125. Review of the Environmental Protection Agency (EPA) Registered list of antimicrobial products effective against C. diff spores revealed Virex and Stride were not listed as effective.	F 880			

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F 880	Continued From page 48 An interview with the Housekeeping Supervisor on 3/19/25 at 12:07 PM confirmed he was aware housekeepers were using Virex and Stride to clean Resident #125's room. He confirmed these solutions were not effective against C. diff spores and revealed they should be using Clorox. He stated, "I knew we had an isolation but did not know what kind." The Housekeeping Supervisor confirmed not using the appropriate chemicals could cause a nasty spread of infection in the building. An interview with the Infection Preventionist (IP) on 3/19/25 at 12:12 PM revealed when the facility had a resident on transmission-based precautions (TBP), it was her responsibility to notify the other departments so the necessary equipment such as the biohazard barrels could be placed in the rooms. She confirmed she did not let anyone know about placing the biohazard barrels in Resident #125's room. She revealed she did not directly speak to the housekeeping supervisor to notify him that the resident had C. diff, but they all attended the stand-up meeting where it was discussed. The IP confirmed failing to handle the resident's clothing and trash in the proper manner and using ineffective cleaning products could spread the infection to staff and residents. Record review of the "Order Summary Report" for Resident #125 revealed an order dated 3/14/25, "Vancomycin oral capsule 125 MG (milligrams) by mouth four times a day related to Enterocolitis due to Clostridium Difficile." Review of the "Admission Record" revealed the facility re-admitted Resident #125 on 3/14/25 with a medical diagnosis that included Enterocolitis	F 880			

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F 880	Continued From page 49 due to Clostridium Difficile.	F 880			
F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, the facility failed to maintain an effective pest control program to address and eliminate the presence of mice droppings in the resident's dresser drawers, posing a potential risk of contamination and health hazards for one (1) of 134 resident's rooms observed (Resident #70). Findings include: Review of the facility's policy titled "Pest Control," with an effective date of September 1, 2014, revealed the policy stated: "Purpose: It is the policy of this center to maintain an effective pest control program..." During an interview with Resident #70 on 3/17/25 at 3:08 PM, the resident stated that her husband noticed mice droppings inside her dresser drawers while assisting her with retrieving clothing. Resident #70 further stated she reported the presence of the mouse droppings to staff. An observation of Resident #70's dresser drawers, conducted with Certified Nurse Assistant (CNA) #10 on 3/17/25 at 3:10 PM, revealed numerous amounts of what black substances the size of pieces of rice in the second, third, and	F 925	1. Resident #70's dresser drawers were cleaned on 3/17/2025 with riddance of black substance, by Housekeeping. 2. All residents of the center have the potential to be affected by the deficient practice. All resident's rooms were checked for pest by Unit Managers on 3/17/2025. No other evidence of pest was found. 3. On 3/17/25 Pest Control Company was contacted by Maintenance to service center due to findings. On 3/24/25 the Director of Clinical Education provided education to staff on notifying Maintenance Director or Administrator of pest in center, placing in maintenance system (TELS) and in pest control sighting book located at each nurse's station. 4. To monitor the performance of our corrective action and to ensure sustainability. The Housekeeping Department will audit 5 rooms 5x/week x 6 weeks, then weekly and the Unit Managers will audit 5 rooms 3xweek x 6 weeks and weekly thereafter. or until substantial compliance achieved, to ensure residents rooms are free of pest beginning 3/20/25. Any negative findings		4/16/25

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F 925	Continued From page 50 fourth drawers. CNA #10 confirmed the presence of the black substance and stated it appeared to be mice droppings and stated that mice carry diseases, expressing concern regarding the findings. During an interview with Registered Nurse (RN) #1 on 3/18/25 at 10:45 AM, RN #1 confirmed the presence of mice droppings in Resident #70's dresser drawers. RN #1 stated the resident's clothing would be contaminated with feces and bacteria as a result. During an interview with the Administrator on 3/18/25 at 10:50 AM she confirmed that the droppings could cause potential health concerns. During an interview with the Maintenance Supervisor on 3/18/25 at 11:10 AM, he stated the mice droppings in Resident #70's dresser drawers had been reported to him through a work order dated 3/15/25. Review of the work order, provided by the Maintenance Supervisor, revealed staff reported "mice and mice dropping in (Resident #70's room number removed)," entered on 3/15/25 at 12:07 PM. Record review of Resident #70's "Admission Record" revealed the resident was admitted on 12/10/24 with a diagnosis of Occlusion and Stenosis of an Unspecified Vertebral Artery. Record review of Resident #70's Minimum Data Set (MDS), Section C with an Assessment Reference Date (ARD) of 2/22/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact.	F 925	of audits will be addressed in Quality Assurance and Performance Improvement Committee meeting for a minimum of three months by the Nursing Home Administrator or Director of Nursing for review and corrective action as necessary beginning with April's Quality Assurance Performance Improvement Committee Meeting on April 14, 2025		

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