MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61CM	A. BUILDING: _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON NURSING AND REHABILITATION CENTER	355 CROSSGATE BLVD BRANDON, MS 39042

(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and Complaint Investigations, (CI) MS #18656, MS #18654, and MS #18646, at the facility from 5/23/22 through 5/26/22. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm with deficiencies cited at M 500 and M 640. MS #18654 was not substantiated related to neglect, Responsible Representative (RR) not notified of residents change in condition, and left soiled for long periods of time. MS #18656 was not substantiated for personal funds. MS #18646 was substantiated related to resident not groomed and M 610 was cited. The census at the time of survey was 217, with a license for 230 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;	M 500		6/30/22

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M 500	Continued From page 1 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff	M 500		

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M 500	Continued From page 2 and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic	M 500		

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M 500	Continued From page 3	M 500		

purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record);

15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and

16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.

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M 500	Continued From page 4 This Statute is not met as evidenced by: Based on staff interviews, resident interview, and record review, the facility failed to allow a resident to manage her monthly income allotment as evidence by review of monthly trust fund statements for one (1) of three (3) residents. (Resident #30). Findings Include: Review of the "Resident Bill of Rights," the document used by the facility as their policy regarding resident funds, dated 11/17, revealed, "A. Facility resident shall have the right to:...22. Manage his or her financial affairs..." An interview on 05/23/22 at 03:30 PM, with Resident #30, revealed the facility was keeping her $44 monthly income allotment from Social Security, towards her outstanding balance owed to the facility for skilled services, and she did not remember signing an agreement with the facility to give up her money. Resident #30 revealed she was told by a staff member in the front office that she did not have money in a resident fund account when she attempted to get some money several months ago. Resident #30 stated that she was her own Resident Representative (RR), that she had signed herself into the nursing facility, that she handles her own financial business, and that no one from the facility had explained to her how the agreement came to be. An interview on 5/25/22 at 02:30 PM, with the Business Office Manager (BOM), confirmed that Resident #30's $44 monthly income allotment was taken by the facility due to Resident #30's outstanding balance for facility services, and because the facility had not been able to collect	M 500	1. Resident # 30 received a care plan meeting 5/27/22 by Social Services to allow Resident # 30 to have involvement, voice concerns, and make any recommendations to her plan of care. Resident # 30 had no ill effects from this deficient practice as evidenced by an interview by the Director of Nurses 5/27/22. 2. All residents who do not participate in their care planning process have the potential to be affected with resident participating in the plan of care and signing attendance to care plan meeting. 3. The Social Services Director was inserviced 5/27/22 by the Executive Director on ensuring that Residents are allowed to participate in the care plan meeting and sign the care plan signature page. The Interdisciplinary Team was inserviced 6/7/22 by the Director of Nurses to ensure that Residents are allowed to participate in their care planning meeting and sign the care plan sign in sheet. The inservice also included that if the Resident/RP cannot attend or participate, documentation should be noted in the medical record that includes steps taken to include the Resident/Representative. Social Services completed a care plan audit of Residents to see which Residents want to attend care plan meetings when scheduled on 5/30/22 with the right to attend or not attend on scheduled care plan date. Interdisciplinary care plan meetings will be audited weekly by the	

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M 500	Continued From page 5 the remainder of the monthly payment from Resident #30's pension. The BOM revealed since Resident #30's pension check was not provided to the facility for the remainder of the outstanding balance, the $44 monthly income allotment was put towards that balance. The BOM confirmed she had not spoken to Resident #30 about her account, confirmed that Resident #30 was her own RR, and confirmed that Resident #30 had not signed a letter to give permission to the facility to take the $44 monthly income allotment. The BOM revealed that there was a letter, in Resident #30's financial folder, that gave the facility permission to take Resident #30's $44 monthly income allotment that was signed by Resident #30's son. The BOM revealed that Resident #30's $44 monthly income allotment from Social Security was being wrongfully withheld by the facility, that the facility was not allowing Resident #30 to represent herself for her financial obligations to the facility, and that the facility should not have allowed the son to sign a letter to give permission to the facility to withhold Resident #30's $44 monthly income allotment. An interview on 5/25/22 at 03:30 PM, with the Interim Administrator, confirmed the facility was wrongfully withholding Resident #30's $44 monthly income allotment from Social Security, that it was being applied to her outstanding balance owed, and that the facility did not have a signed letter, from Resident #30, that gave the facility permission to withhold the $44 monthly income allotment. The Administrator also confirmed the facility should not have allowed Resident #30's son to sign the letter to give the facility permission to withhold Resident #30's $44 monthly income allotment and apply it to her outstanding balance.	M 500	Director of Nursing starting 5/30/22 to ensure Resident and/or Resident Representative has been invited to the care plan meeting with attendance page signed or refusal to attend noted. 4. The Director of Nurses will audit care plan meetings weekly times six weeks starting the week of 5/30/22 to ensure Residents/ Resident Representatives are participating in the care planning process, or refusal to participate is noted on attendance page. Any concerns will be immediately addressed. The Director of Nurses will forward the care plan audits results to the Quality Assurance Committee monthly starting 6/16/22. The Quality Assurance Committee will determine the frequency or discontinuation of audits based upon the results achieved. 1. A request for refund was initiated 5/25/22 by the Business Office Manager to Resident # 30 Trust Fund account. Resident # 30 was reimbursed $792.00 into her Trust Fund account on 6/10/22 by the Business Office Manager. Resident # 30 had no ill effects from the deficient practice after being interviewed by the Director of Nurses on 5/27/22. 2. All Residents who receive a monthly income allotment have the potential to be affected and will be allowed to manage their own personal finances. 3. An inservice was given on 5/27/22 by the Executive Director for the Business	

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M 500	Continued From page 6 Record review of a letter, on the nursing facility's letterhead, dated November 13, 2020, for Resident #30, revealed "RE: Resident #30 (resident's name removed) ... Outstanding balance:(amount removed) ... By signing below I authorize (Proper Name of Nursing Facility) to apply $44.00 from the income allotted my mother, (resident's name removed) by Medicaid be applied toward the outstanding balance beginning immediately ... I understand this will be in force until the account balance is paid in full ... Sign/Print name: (son's name removed) ... Date: 11/3/20." Record review of a letter, on the nursing facility's letterhead, dated 5/25/22, for Resident #30, revealed, "Resident (resident name removed) ... Trust Fund ... (Proper Name of Nursing Facility) started withdrawing $44.00 monthly starting 12/2020 until 5/2022, for the past due balance on her room and board." The letter was signed by the BOM and the Interim Administrator. Record review of Resident #30's "Face Sheet" revealed she was admitted by the facility on 5/5/20. Record review of an Annual Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 2/18/22, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #30 is cognitively intact.	M 500	Office Manager on ensuring that Residents are allowed to manage their allotted monthly income. A Trust Fund account audit was completed 5/31/22 by the Business Office Manager regarding Residents being allowed to manage their monthly personal allotment. Trust FUnd accounts are audited monthly by the Business Office Manager starting 6/10/22 with residents allowed to manage their own trust funds. 4. The Quality Improvement Team initiated rounds weekly times six weeks beginning 6/1/22 for Residents to identify any concerns for Residents in regards to any issues managing their monthly allotted income. Any concerns will be immediately addressed. The Executive Director will forward the results of the audits to the monthly Quality Assurance Committee starting 6/16/22. The Quality Assurance Committee will determine the frequency or discontinuation of results based upon results achieved.	

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Based on facility policy review, resident interview, staff interviews, and record review, the facility failed to allow a resident to participate in the care planning process, as evidenced by no documentation of resident participation in care planning in the medical record and failed to allow a resident to manage her monthly income allotment as evidence by review of monthly trust fund statements for one (1) of 35 residents reviewed for resident rights. Resident #30.

Findings Include:

Review of the policy titled, "Interdisciplinary Care Plan Meeting," (ICP) dated 11/17, revealed, "Policy: Interdisciplinary care plan meetings will be held in conjunction with the completion of the RAI (Resident Assessment Instrument) process for all residents to facilitate the provision of necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial well being of the resident and to promote the participation of the resident, and if applicable the resident representative, family, or legal representative in planning care ... Procedure:...2. The Social Service staff will notify the resident and if applicable the resident representative prior to each ICP meeting and encourage them to attend the meeting and solicit their input. If unable to attend, the care plan will

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be reviewed with the resident/resident representative (as applicable) and family if appropriate and their response will be documented ... 5. If the resident/resident representative does not attend or participate with care plan development documentation should be noted in the medical record including the steps taken to include the resident/representative ... 8. An Interdisciplinary Team Care Meeting note will be entered into LTC under Interdisciplinary Notes."

An interview on 05/23/22 at 03:30 PM, with Resident #30 revealed she had not been to a care plan meeting during her entire stay in the facility. Resident presented a care plan invitation letter for the meeting scheduled for 5/24/22 at 10:30 AM. Resident revealed no one had ever come to her room to ask her if she wanted help to get to the care plan meetings, that no one had come to her room to discuss a care plan with her, after the meetings, and that she had not signed any of the care plan sign-in sheets. Resident revealed she is her own Resident Representative (RR) and no one else could attend the care plan meetings for her.

An interview on 5/24/22 at 02:30 PM, with Resident #30, revealed that no staff member had come to her room to discuss the care plan with her, from the care plan meeting that was held today.

Interview on 5/25/22 at 10:00 AM, with the Social Worker (SW), confirmed Resident #30 had been provided invitation letters to attend the care plan meetings and revealed she had not gone to Resident #30's room to ask her if she wanted to attend the care plan meetings. The SW confirmed that Resident #30 had not attended a

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care plan meeting since admission to the nursing facility, and that she had never taken Resident #30's care plan into her room to review and discuss it. The SW revealed Resident #30 had never signed a care plan meeting sign-in sheet, after the care plan meeting. The SW revealed she had not entered any documentation in the medical record regarding interventions attempted to get Resident #30 to attend the care plan meetings nor had entered documentation regarding discussing the care plan with Resident #30. The SW revealed she had not asked Resident #30 if she wanted to discuss her care plan. The SW confirmed that Resident #30 should have been allowed to participate in the care planning process to assist in deciding on the care she received.

An interview on 5/25/22 at 02:30 PM, with the Director of Nursing (DON) revealed the process to review the care plan with a RR, included going to the room of a resident that had signed to be their own RR to discuss the care plan with them if the resident did not attend the care plan meeting. The DON confirmed the care plan should have been taken to Resident #30's room for discussion and review. This process would allow Resident #30 to make suggestions or changes and allow Resident #30 to sign the care plan meeting sign-in sheet acknowledging she was allowed to participate in the care planning process.

An interview and record review of the "Interdisciplinary Care Plan Team Attendance," on 5/25/22 at 02:45 PM, with the Interim Administrator confirmed Resident #30 had not been allowed to participate in the care planning process and revealed the Social Worker should have allowed Resident #30 to participate in the care planning process, by going to the room to

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discuss and review the care plan with the resident. The Administrator confirmed a care plan should not be developed and implemented without participation of the resident and/or the RR.

Record review of the "Interdisciplinary Care Plan Team Attendance," sign-in sheets, for care plan meetings held for Resident #30 revealed, "Resident ... did not attend ... Resident Representative ... own RR," in the signature blocks for the meetings dated for 3/1/22 and 5/24/22.

Record review of a copy of the "Resident Bill of Rights" dated 11/17, that was provided to Resident #30 upon admission to the nursing facility, revealed, "Facility resident shall have the right to:...7. Participate in the development and implementation of his or her person-centered plan of care, including but not limited to: a. The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings, and the right to request revisions to the person-centered plan of care. b. The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency and duration of care, and any other factors related to the effectiveness of the plan of care. c. The right to be informed, in advance, of changes to the plan of care. d. The right to receive the services and/or items included in the plan of care. The right to see the care plan, including the right to sign after significant changes to the plan of care."

Record review of the "Face Sheet" for Resident #30 revealed an admission date of 5/5/20.

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Record review of the "Departmental Notes" in the electronic medical record for 3/1/22 and 5/24/22 revealed lack of documentation from the Social Worker indicating the care plan was reviewed and discussed with Resident #30 after a care plan meeting.

Record review of an Annual Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 2/18/22 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #30 is cognitively intact.

PERSONAL FUNDS

Review of the "Resident Bill of Rights," the document used by the facility as their policy regarding resident funds, dated 11/17, revealed, "A. Facility resident shall have the right to:...22. Manage his or her financial affairs..."

An interview on 05/23/22 at 03:30 PM, with Resident #30, revealed the facility was keeping her $44 monthly income allotment from Social Security, towards her outstanding balance owed to the facility for skilled services, and she did not remember signing an agreement with the facility to give up her money. Resident #30 revealed she was told by a staff member in the front office that she did not have money in a resident fund account when she attempted to get some money several months ago. Resident #30 stated that she was her own Resident Representative (RR), that she had signed herself into the nursing facility, that she handles her own financial business, and that no one from the facility had explained to her how the agreement came to be.

An interview on 5/25/22 at 02:30 PM, with the Business Office Manager (BOM), confirmed that

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M 500	Continued From page 12 Resident #30's $44 monthly income allotment was taken by the facility due to Resident #30's outstanding balance for facility services, and because the facility had not been able to collect the remainder of the monthly payment from Resident #30's pension. The BOM revealed since Resident #30's pension check was not provided to the facility for the remainder of the outstanding balance, the $44 monthly income allotment was put towards that balance. The BOM confirmed she had not spoken to Resident #30 about her account, confirmed that Resident #30 was her own RR, and confirmed that Resident #30 had not signed a letter to give permission to the facility to take the $44 monthly income allotment. The BOM revealed that there was a letter, in Resident #30's financial folder, that gave the facility permission to take Resident #30's $44 monthly income allotment that was signed by Resident #30's son. The BOM revealed that Resident #30's $44 monthly income allotment from Social Security was being wrongfully withheld by the facility, that the facility was not allowing Resident #30 to represent herself for her financial obligations to the facility, and that the facility should not have allowed the son to sign a letter to give permission to the facility to withhold Resident #30's $44 monthly income allotment. An interview on 5/25/22 at 03:30 PM, with the Interim Administrator, confirmed the facility was wrongfully withholding Resident #30's $44 monthly income allotment from Social Security, that it was being applied to her outstanding balance owed, and that the facility did not have a signed letter, from Resident #30, that gave the facility permission to withhold the $44 monthly income allotment. The Administrator also confirmed the facility should not have allowed Resident #30's son to sign the letter to give the	M 500		

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M 500	Continued From page 13 facility permission to withhold Resident #30's $44 monthly income allotment and apply it to her outstanding balance. Record review of a letter, on the nursing facility's letterhead, dated November 13, 2020, for Resident #30, revealed "RE: Resident #30 (resident's name removed) ... Outstanding balance:(amount removed) ... By signing below I authorize (Proper Name of Nursing Facility) to apply $44.00 from the income allotted my mother, (resident's name removed) by Medicaid be applied toward the outstanding balance beginning immediately ... I understand this will be in force until the account balance is paid in full ... Sign/Print name: (son's name removed) ... Date: 11/3/20." Record review of a letter, on the nursing facility's letterhead, dated 5/25/22, for Resident #30, revealed, "Resident (resident name removed) ... Trust Fund ... (Proper Name of Nursing Facility) started withdrawing $44.00 monthly starting 12/2020 until 5/2022, for the past due balance on her room and board." The letter was signed by the BOM and the Interim Administrator. Record review of Resident #30's "Face Sheet" revealed she was admitted by the facility on 5/5/20. Record review of an Annual Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 2/18/22, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #30 is cognitively intact.	M 500		
M 610	45.21.2 Activities of daily living	M 610		6/30/22

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M 610	Continued From page 14 Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure Activities of Daily Living (ADL) assistance was provided for residents who were dependent for assistance with showering for two (2) of twelve (12) residents reviewed for ADL assistance. (Resident #129 and Resident #9). Findings include: A review of the facility's policy "Bath/Shower-Dependent" dated 8/11, revealed, "Policy: A bath (shower/tub) for cleanliness and comfort is scheduled at least weekly for each resident. Responsibility: Nursing Assistants or Licensed Nurses Monitored by Charge Nurse..." Resident #129 In an observation and interview on 05/23/22 at 3:07 PM, Resident #129 stated that he has not had a shower in a month and that they get "wash offs" here. The resident did not have a body odor	M 610	1. Resident #9 and #129 were interviewed on 5/27/22 by the Director of Nursing in regards to assistance being provided with showers and shower preferences. Resident # 9 is receiving physicial assistance of one to two person with showers per her request at least weekly. Resident # 129 is receiving showers at least weekly with one to two person physical assistance. Resident # 9 and #129 had no ill effects from this deficient practice. 2. All Residents who require assistance with showers have the potential to be affected and will be provided physical asssitance with showers at least weekly. 3. An inservice was initiated 5/27/22 by the Director of Nurses for nursing staff regarding providing physical assistance with showers at least weekly for dependent Residents. Shower/ bath audits will be completed by Unit Managers at least weekly starting week of 6/1/22 to ensure residents are getting showers /	

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M 610	Continued From page 15 but did have oily hair and flaky skin. The SA reviewed the "3-11 Shower" schedule and confirmed that Resident #129 is on a schedule to receive baths every Monday, Wednesday, and Friday every week on the 3 PM-11 PM shift. Record review of Resident #129's "Bathing Report" for 4/18/22 - 5/26/22 revealed documentation indicated a shower was given on 4/18/22, 5/9/22 and 5/25/22. The "Self-Performance" of the Bathing Report revealed he required total dependence for showers. On 05/26/22 at 9:08 AM, the State Agency (SA) conducted an interview with CNA #2 who stated that the CNAs have a shower book to reference which days the residents are supposed to receive baths. She revealed that Resident #129 is on the list for Mondays, Wednesdays, and Fridays on the 3pm-11pm shifts to receive his bath. She confirmed that to her knowledge, the resident has not refused a shower and is very verbal/cognitively intact in what he needs. She revealed that the only time a resident does not go to shower is when they are not able to sit in a shower chair or lay out chair. On 05/26/22 at 09:42 AM, in an interview with the Director of Nursing (DON) revealed that the family is very active in his care and has not complained about care. She stated that she will consider changing his shower days. She said that the CNA should follow the bath schedule and the nurse should check behind them to ensure it has been done. If the resident refuses their shower the nurse should try to encourage the resident or get someone in the resident's family to convince the resident to take the shower. She also stated	M 610	baths with physical assistance per their request. 4. The Quality Improvement Team initiated rounds weekly times six weeks beginning 6/1/22 to identify any concerns from Residents related to not receiving assistance with showers. Any concerns will be immediately corrected. The Executive Director wil forward the results of the audits to the monthly Quality Assurance Committee starting 6/16/22. The Quality Assurance Committee will determine the frequency or discontinuation of audits based upon the results achieved.	

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M 610	Continued From page 16	M 610		

that cleanliness is important.

The record review of the "Face Sheet" revealed that Resident #129 was admitted on 4/11/22 with diagnoses including Candidiasis of skin and nail and Epileptic syndrome.

Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/10/22 revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated Resident #129 had severe cognitive impairment.

Resident #9

An interview on 5/23/22 at 2:24 PM, with Resident #9 revealed she prefers her showers in the mornings or afternoons, but if the staff come to do her bath/shower after 8 PM she is too tired and will sometimes go without her bath.

An interview with Resident #9 on 5/24/22 at 1:30 PM, revealed she usually gets showers three times a week. She stated she is unable to do her own care and she requires the assistance of the staff.

An interview on 5/25/22 at 2:00 PM, with Resident #9 revealed she is on the shower list for Monday, Wednesday, and Friday. She stated she had not mentioned to the staff that she prefers a morning or afternoon shower.

Record review of Resident #9's "Bathing Report" for May 2022 revealed the resident had documentation of receiving a shower or bath on 5/2/22, 5/3/22, 5/5/22, 5/8/22, 5/11/22, 5/14/22, 5/16/22, and 5/18/22. For the dates of 5/19/22 through 5/26/22, the report lists, "Activity Did Not Occur".

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M 610	Continued From page 17 An interview with Licensed Practical Nurse (LPN) #4 on 5/25/22 at 2:30 PM, revealed the resident is scheduled for showers 3 days each week. She stated the resident will let the staff know when she wants her showers. She stated there is a shower team on some days and the showers are done on 7-3 shift and 3-11 shift and when there is not a shower team the Certified Nursing Assistants (CNA) bathe the residents. She stated this resident will usually let the staff know when she would like her shower and the staff try to work times out with the residents. She stated Resident #9 is total care with her bathing care and does not refuse care. An interview with the Resident #9 on 5/26/22 at 8:40 AM, revealed she should have received a shower yesterday, but she did not remind the staff and it was so late when they came to do her bath and at that point, she was too tired. An interview with LPN #4 on 5/26/22 at 10:15 AM, revealed the resident had not mentioned to her that she would like her showers on day shift. She stated at times around 2:30 PM the resident will tell her she wants a shower, so she passes this information to the oncoming shift. An interview with LPN #5 on 5/26/22 at 10:18 AM, revealed the resident is scheduled for a shower 3 times a week and does not refuse care. She stated she was unaware the resident had a preference on the time. An interview with CNA #6 on 5/26/22 at 11:22 AM, revealed the resident is scheduled for a shower on 3 PM - 11 PM shift on Monday, Wednesday, and Friday. She stated on some day and evening shifts, they had a shower team and on those	M 610		

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M 610	Continued From page 18	M 610		

days, the resident would occasionally get her shower on the day shift. She stated the resident had never told her that she would prefer to have her shower on one shift over another shift. She stated the CNAs receive a shower list assignment of the residents scheduled for showers that day and once it is done, it is charted in the computer. She stated she has never known the resident to refuse her shower.

An interview with CNA #5 on 5/26/22 at 11:47 AM, revealed the resident "loves her showers and never refuses them". She stated the resident was scheduled to get showers 3 times a week and she did not know that the resident had a preference for the shower time. She stated the resident would usually let the staff know when she wanted to receive her care.

Interview with the Director of Nursing (DON) on 5/26/22 at 12:14 PM, revealed the resident should have a shower 3 times each week. She stated this resident is "prim and proper" and she likes to have her showers and be dressed nicely, and she requires assistance with bathing. She stated for the time on the bathing report from 5/19/22-5/26/22, the resident should have received showers, but no one marked that these as completed. She stated bathing is needed for personal hygiene and for skin protection. She confirmed the facility failed to ensure the resident received proper personal hygiene with baths and showers three times each week.

Record review of Resident #9's Face Sheet revealed the resident was admitted to the facility on 6/18/2019 with diagnoses including Paraplegia, Polyneuropathy, Primary Osteoarthritis of left shoulder, and Need for Assistance with personal care.

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M 610	Continued From page 19 Record review of the MDS with an ARD of 5/2/22, Section C - Cognitive Patterns, revealed a BIMS score of 15, which indicated the resident was cognitively intact. Section G - Functional Status, revealed the resident required physical help in part of bathing activity with one person physical assist.	M 610		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level II Based on observation, staff and resident interviews, and facility policy review the facility failed to properly secure a resident in a sit to stand lift while being transferred from wheel chair to bed for one (1) of two (2) residents observed (Resident #18). Findings Include: Review of the facility's policy, "Subject: Invacare Sit-To-Stand Lift" with a date of 8/16 revealed, "...Procedure:...5. Transfer Sling a....place sling behind resident and fasten waist belt in a comfortable manner..." On 05/25/22 at 03:50 PM, the State Agency (SA) observed Certified Nurses Assistant #1 (CNA), bring Resident #18 into her room via wheelchair.	M 640	1. Resident # 18 is being secured in safety sling in the sit to stand lift while being transferred from wheelchair to bed. Resident # 18 was assessed by the Director of Nurses on 5/26/22 and had no ill effects. Certified Nursing Assistant/ Nursing Assistant # 1 and Licensed Practical Nurse # 2 were inserviced on 5/26/22 by the Director of Nurses regarding properly securing a resident with a safety sling on the sit to stand lift while being transferred. 2. All Residents that require transfers with the sit to stand lift have the potential to be affected and will be secured with safety sling during transfer. 3. An inservice was initiated on 6/7/22 by	6/30/22

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M 640	Continued From page 20 CNA #1 and Licensed Practical Nurse (LPN) #2 connected the transfer sling to the sit-to-stand mechanical lift with the straps, but failed to secure the waist belt by fastening it to Resident #18. The waist belt ensures that the resident is secure from the possibility of falling during the transfer. The two continued to move the resident towards the bed and eased her down onto the bed. On 05/25/22 at 04:52 PM, an interview with LPN #1 confirmed that CNA #1 did not secure the waist belt for the sit-to-stand lift and that it should have been secured. She confirmed that the resident could have been hurt if the belt is not fastened and she is responsible for securing the buckle before transferring the resident. On 05/25/22 at 05:01 PM, an interview with CNA #1 stated that she is conscious that she made a mistake by the waist belt not being fastened to the resident when she used the lift. She agreed that the resident could have been injured by not having the belt buckled. She stated that she should have never used the lift without the waist belt being fastened and she knows exactly what she did wrong. 05/26/22 at 09:52 AM, in an interview with the Director of Nursing (DON), she confirmed that CNA #1 and LPN #1 should have fastened the waist belt when using the sit-to-stand lift. She admitted that the person assisting should have helped with that part of the transfer if they could see that it was not being done correctly. She confirmed the resident could have been injured during the transfer. Record review of Resident #18's "Face Sheet" revealed an admission date of 1/22/19 with medical diagnoses including Multiple Sclerosis	M 640	the Director of Nursing for nursing staff to ensure Residents are properly secured with sit to stand lifts during transfers. Unit managers are completing sit to stand lift audits starting 5/30/22 observing the Certified Nursing Assistants/Nursing Assistants securing at least ten residents with safety sling in sit to stand lift three times weekly. 4. The Director of Nurses and/or Charge Nurse will observe transfers three times weekly times eight weeks beginning 5/30/22 to ensure that Residents who are transferred utilizing the sit to stand lift are secured. Any concerns will immediately be addressed. The Director of Nurses will forward the results of the audits monthly starting 6/16/22 to the Quality Assurance Committee. The Quality Assurance Committee will determine the frequency or discontinuation of audits based upon the results achieved.	

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M 640	Continued From page 21 and Muscle Spasms. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/1/2022, revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #18 was cognitively intact. Review of section G revealed she required a two person physical assist with transfers.	M 640		