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	255106	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

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F 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 requirements of participation in Medicare and Medicaid. 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 F677 was cited. The SA also cited F553, F565, F567, F637, F656, F689, F690, and F880. The census at the time of survey was 217, with a license for 230 beds.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) 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. (ii) 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. (iii) The right to be informed, in advance, of	F 553		6/30/22

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

Electronically Signed | 06/24/2022

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F 553	Continued From page 1 changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: 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 for one (1) of 35 resident care plans reviewed. 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	F 553	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 affectedwith 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	

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F 553	Continued From page 2 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 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.	F 553	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 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.	

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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 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.

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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 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

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F 553	Continued From page 5 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. 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.	F 553		
F 565 SS=F	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for	F 565		6/30/22

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F 565	Continued From page 6 providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, and facility policy review the facility failed to respond and resolve group grievances in resident counsel for six (6) of six (6) months of resident counsel meetings reviewed. Findings Include: Record review of the facility policy titled, "Grievance/Missing Property," dated 08/17, revealed, "Policy; All residents, resident representatives and families also have the right to report property/items that may be missing. Purpose: To provide an opportunity for residents, resident representatives, and/or family to present concerns or grievances to the proper authorities	F 565	1. On 5/24/22 a follow up meeting was held by the Social Services Director for the eleven Residents who attended Resident Council with the State Agency on 5/24/22. Any concerns voiced were addressed. Resident # 59 bedspread and blanket was replaced on 5/24/22. Resident #9, #12, #208 had a meeting with Social Services Director 5/24/22 to address any missing items with items replaced. A letter was drafted and sent to Residents/Resident Representatives on 5/31/22 in regards to missing clothing items and abundance of items that were not labeled and the facility could not determine which Residents the items	

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F 565	Continued From page 7 at the facility and to receive responses to the issue(s) raised. Procedure: A. Grievances may be presented to any staff member....1. Respective Department Head, Executive, Director and/or Grievance Official will follow-up on issues as noted...b. The supervisor will discuss the concerns/grievances and appropriate solutions with the department direction. 2. Supervisory personnel are responsible for reviewing the Grievance form within 10 working days. Department heads are responsible for reviewing, signing and forwarding the completed complaint form to the Executive Director and or Grievance Official. 3. Supervisory personnel shall be responsible for notifying the resident of resolution and so indicate on grievance form...Section 504 Grievance Procedure:...5. If the grievance has not been resolved at this point, the Section 504 Coordinator will forward it to the Vice President of Operations who shall have an additional 30 days to resolve the grievance..." On 05/24/22 record review of the "Resident Council Minutes," dated 05/09/22 revealed "Laundry being returned" and 18 out of 24 residents in attendance revealed, "Was the issue resolved to your satisfaction, No." The form titled, "Resident Council Department Response," dated 05/09/22, stated, "Date response due back to the Resident Council Representative 05/16/22, clothing items not being returned in a timely manner." Record review of "Resident Council Minutes," dated 04/11/22, revealed there were 21 residents in attendance. Review of "Old Business" listed "Laundry" and "Was the issue resolved to your satisfaction? No. Review of "New Business" listed "Laundry" and "Number of residents who share	F 565	belonged to. The Lost/Found Day was scheduled for 6/6/22 and 7/1/22 in the conference room fro Rewsidents/ Resident Representatives to check for missing items. 2. All Residents have the potential to be affected by the deficient practice with missing items located or replaced and grievancies resolved. 3. An inservice was conducted 5/27/22 by the Executive Director for the Social Services Director and the Activity Director on ensuring that the facility responds and resolve group grievances. Nursing staff were inserviced by Social Services starting 5/30/22 regarding labeling resident inventory upon admission and as needed. Social Services Director sent letters to Residents/ Resident Representatives on 5/31/22 regarding completion and updating resident inventory forms, labeling Resident belongings with first and last name with a permanent marker, and Lost and Found day scheduled 6/6/22 to search for missing items. 4. Resident Council meetings were initiated weekly times six weeks starting 6/6/22 by the Social Services Director and the Activity Director for Resident Council to ensure the facility responds and resolves grievancies. Any concerns will be immediately addressed. The Quality Improvement Team initiated rounds weekly starting the week of 6/1/22 times six weeks for residents to identify any	

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F 565	Continued From page 8 the concern, all." Record review of the "Resident Council Minutes," dated 03/07/22, revealed there were 18 residents in attendance. Review of "New Business"revealed, "Rumor about clothes being thrown out. Laundry not being taken back to residents." Review of "Old Business" revealed "Was the issue resolved to your satisfaction? No" Record review of the "Resident Council Minutes," dated 02/14/22, revealed there were 22 residents in attendance. Review of "Old Business" revealed "Was the issue resolved to your satisfaction?" Seven residents marked no and seven residents were marked for sharing the concern for clothing. Record review of the "Resident Council Minutes," dated 01/27/22 revealed, "New Business," Number of residents who share the concern: 18 Laundry." Record review revealed that 23 residents were in attendance for the resident council meeting. Record review of "Resident Council Minutes," dated 12/13/21 revealed 19 residents were in attendance and had concerns with "Missing clothes." On 05/24/22 at 2:00 PM the resident council meeting was held with the State Agency (SA). Eleven residents were in attendance for the meeting and confirmed that every month they have discussed in their resident council meeting that they have missing clothes items and that they are sending items to the laundry and they are not getting them back. All the residents in attendance confirmed that it has been an ongoing problem	F 565	grievances and/or unresolved grievancies. Any concerns will be immediately addressed. The Executive Director will forward the results of the audits to the monthly Quality Assurance Committee. The Quality Assurance Committee will determine the frequency or discontinuation of audits based upon the results achieved.	

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and Resident #9 stated, "You are not well received if you go to the laundry to tell them you have missing items." Interview with Resident #59 during the resident council meeting on 05/24/22 stated that her daughter had brought her a bedspread and a blanket and it has been missing for several months and that she had reported it several times but she has not gotten it back. Resident #12 stated, "I just started getting my family to do my laundry because I was losing so many clothes when the facility did my laundry." Resident #208 stated, "You don't get it back if they lose it and it is not replaced."

Interview with Licensed Practical Nurse (LPN) #4 on 05/25/22 at 8:30 AM, stated that the residents have complained to her about their clothes missing, but they won't let us go back there to laundry to look for them. "They send their clothes to laundry but they don't get them back." The LPN stated that the new Administrator has tried to help to make it better, but it has been a big problem with missing clothes items.

Interview on 05/25/22 at 8:45 AM, with Laundry Employee #1 stated that she has worked here about a month and that they have a lost and found area for clothes but that they have not had time to go through them. An observation in the clean area of the laundry room revealed a large table that was about six foot in length and it was completely covered with clothing items of all types and was mound high about four feet in height on the table. The laundry employee told the SA this was lost/found items. There was also large compartment bins that were built into the wall that had multiple blankets, comforters and bulky items that the laundry staff did not know who they belonged to as well. The laundry employee stated

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that they currently do not have a supervisor for their department, so they are not sure what to do with these items.

Interview with the LMSW on 05/25/22 at 9:00 AM, confirmed that she holds the Resident Council meetings each month. "At one point our environment director got the complaints about missing clothes and other items sent to laundry, but right now we don't have a director for the laundry. I have been here a little over a year and we have had four environment directors since I have been here. So it falls on me to try to find the residents missing items when they report them to me." The LMSW stated that as she gets the complaints from Resident Council that she would give the department manager a form titled, "Resident Council Department Response Form," and they are supposed to address the concerns and give the form back to me on how they handled it within seven days, but that hasn't happened lately because we haven't had a department manager for the laundry department. The LMSW stated that the new Administrator has helped her since she has been here but the prior Administrator was not helping to address these concerns with the residents missing clothes when they were sent to the laundry.

Interview with the Administrator on 05/25/22 at 2:45 PM, confirmed that she has been the interim Administrator here for about 3-4 weeks and that she was told that the previous housekeeping director was terminated after they found bags and bags of residents clothes in an empty room in the building. She stated that they have worked to try to get the residents missing clothes items back to them and she feels that it has gotten better in the last month but she confirmed that it has been an

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F 565	Continued From page 11 on-going problem. She stated that from now on she will get a copy of the Resident Council meeting minutes after each meeting so that she can follow up on the grievances. The Corporate Director confirmed during the same interview that the previous Administrator wasn't made aware of the Resident Council grievances and was not following up with the residents to ensure that their grievances were resolved.	F 565		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account,	F 567		6/30/22

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F 567	Continued From page 12 interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT 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 reviewed for personal funds. (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	F 567	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 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	

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F 567	Continued From page 13 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 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	F 567	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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F 567	Continued From page 14	F 567		

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.

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

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F 567	Continued From page 15 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.	F 567		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review the facility failed to submit a Significant Change in Status Minimum Data Set (MDS) Assessment for a resident admitted to hospice (Resident #62). Findings include: Record review of facility policy titled, "MDS (Minimum Data Set) Assessment", dated 11/17, revealed, "Policy: The facility shall conduct interdisciplinary assessments using the MDS item sets as defined by Federal/State regulations.	F 637	1. A Significant Change Assessment for hospice services for Resident # 62 was submitted on 6/9/22 by the Minimum Data Set Coordinator. Resident # 62 had no ill effects from the deficient practice. 2. All Resident who receive hospice servcies have the potential to be affected with a significant change assessmenmt completed. 3. An Inservice was given on 5/27/22 by the Director of Nurses for the Minimum	6/30/22

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F 637	Continued From page 16 These assessments provide information on the resident's condition to facilitate development of an individualized plan of care is a means by which the facility can track changes in a resident's status...3. A Significant Change in Status assessment is defined as a change in the resident's baseline status that: a. Impacts on more than one area of the resident's health status, b. Is not self limiting, c. Requires interdisciplinary review/revision of the care plan, or d. When a resident enrolls or discontinues hospice services or changes Hospice provider." Record review of Resident #62's "Face Sheet" revealed she was admitted to the facility on 3/1/21. Diagnoses include: Type 2 Diabetes Mellitus with Diabetic Neuropathy; Hypertensive Chronic Kidney Disease, and Senile Degeneration of Brain. Record review of the 5-day Admission MDS with Assessment Reference Date (ARD) of 1/28/2022, Section O - Special Treatments, Procedures, and Programs, revealed treatment of hospice care was not received. Record review of the Quarterly MDS with an ARD of 3/7/22, Section O - Special Treatments, Procedures, and Programs, revealed hospice care being received. Record review of the "Physician's Telephone Orders", dated 2/12/22, revealed an order to "Admit to (Proper Name of Provider) Hospice. Diagnosis: Senile Degeneration of the Brain." An interview with the MDS Coordinator, on 5/26/22 at 8:13 AM, revealed Resident #62 was placed on hospice in February 2022 and there	F 637	Data Set Coordinator on ensuring that a significant change assessment is completed on Residents for election of hospice service. An inservice was given to the Interdisciplinary Team on 6/7/22 by the Director of Nurses on ensuring that a significant change assessment is completed on Resident election of hospice services. A Hospice audit was completed 5/30/22 by the Director of Nursing to ensure that residents on hospice services had a significant change assessment completed upon initiation of hospice services. 4. The Director of Nurses will audit weekly beginning 5/30/22 times six weeks on ensuring that a significant change assessment was completed on any Resident who elected hospice services. Any concerns will be immediately addressed. The Director of Nurses will forward the results of the audits to the monthly Quality Assurance Committee startimng 6/16/22. The Quality Assurance Committee will determine the frequency or discontinuation of the audits based upon the results achieved.	

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F 637	Continued From page 17 was no Significant Change in Status Assessment for MDS completed. She stated a significant change is required for a hospice status change and/or for a dramatic decline in a resident's condition in two or more areas and since the resident was admitted to hospice, a Significant Change MDS should have been done, but "it was missed". She confirmed an accurate MDS assessment was needed to accurately list the resident's needs and status and the facility failed to do this. An interview with the Administrator on 5/26/22 at 8:20 AM, revealed a Significant Change in Status Assessment was not done for Resident #62's admission to hospice. She stated the purpose of an accurate assessment is to identify a resident's previous condition and the current condition and completing a Significant Change MDS would have accurately updated the resident's status. She confirmed the facility failed to complete a Significant Change MDS assessment for a resident with a hospice admission.	F 637		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		6/30/22

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F 656	Continued From page 18 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. This REQUIREMENT is not met as evidenced by: Based on interviews, observation, record review, and facility policy review, the facility failed to develop a comprehensive care plan (Resident #119) and failed to implement a care plan related to Activities of Daily Living (ADLs) (Resident #9) and feeding assistance (Resident #200) for three (3) of thirty-five (35) resident's care plans reviewed.	F 656	1. A comprehensive care plan was developed on Resident # 119 by the Minimum Data Set Coordinator. A care plan was developed and implemented by the Minimum Data Set Coordinator for resident # 9 for Activities of Daily Living to include one to two physical assistance with showers at least weekly per residents request. A care plan was developed and	

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F 656	Continued From page 19 Findings Include: A review of the facility's policy, "Comprehensive Person Centered Care Plans", dated 3/18, revealed "Policy: Each resident will have a person centered plan of care to identify problems, needs, strengths, preferences and goals that will identify how the interdisciplinary team will provide care...Definitions...Comprehensive Person Centered Care Plan (CCP) contains services provided, preference, ability, goals for admission and desired outcomes, and care level guidelines...Procedure: 1. The comprehensive person centered care plan shall be fully developed with 7 days after the completion of the Admission MDS (Minimum Data Set) assessment..." Resident #119 A record review of the "Face Sheet" revealed Resident #119 was admitted to the facility on 03/25/22 with diagnoses including Chronic Pain, Pressure Ulcer of Sacral Region (Stage 4), History of Pulmonary Embolism, Laceration without Foreign Body of Right Upper Arm, Bundle Branch Block, and Gastrointestinal Hemorrhage. A record review of the MDS Admission Assessment with an Assessment Reference Date (ARD) of 04/07/22 revealed Resident #119 had a Brief Interview of Mental Status (BIMS) of score of 15 which indicated she is cognitively intact. A record review of Resident #119's clinical chart revealed there were no comprehensive care plans completed. The MDS Admission Assessment had been completed on 04/07/22 and the comprehensive care plan should have	F 656	implemented by the Minimum Data Set Coordinator for Resident # 200 for one staff physical assistance with feeding. Resident #119, #9, and #200 had no ill effects based on assessment by the Director of Nurses on 5/27/22. 2. All Residents have the potential to be affected with the plan of care reviewed and revised to meet resdients needs. 3. The Minimum Data Set Coordinator was inserviced on 5/27/22 by the Director of Nursing on development of comprehensive care plans and ensuring that care plans address residents needs including physical assistance with Activities of Daily Living and feeding. An inservice was initiated on 6/7/22 by the Director of Nurses for the Interdisciplinary Team on development of comprehensive care plans to be reviewed and /or revised to meet the residents needs. Care plan audits will be completed weekly by the Director of Nurses on twenty residents with the plan of care reviewed/ revised to meet residents needs. 4. The Director of Nurses will audit twenty care plans weekly times six weeks beginning 5/30/22 to ensure that comprehensive care plans have been developed and care plans address physical assistance with Activities of Daily Living and feeding assistance. Any concerns will be immediately addressed. The Director of Nurses will forward the results of the care plan audits monthly starting 6/16/22 to the Quality Assurance	

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F 656	Continued From page 20 been completed by 04/14/22. On 05/25/22 at 03:18 PM, the State Agency (SA) conducted an interview with Licensed Practical Nurse (LPN) #3, who is also the MDS Coordinator. The interview revealed that there was no comprehensive care plan completed for Resident #119. She confirmed that a baseline care plan was completed within twenty-four (24) hours for the resident, but the comprehensive care plan that should have been completed within twenty-one (21) days of admission was not. LPN #3 agreed the care plan should have been completed timely to ensure the residents are accurately taken care of. The proper care cannot be given if the comprehensive care plan is not in place. On 05/26/22 at 09:52 AM, in an interview with the Director of Nursing (DON), she confirmed the MDS Coordinator should create a comprehensive care plan within 21 days of admission to the facility. The the care plan is used to help the Certified Nurse's Aide (CNAs) and nurses provide care to the residents. The care can be done without a care plan, but the care plan shows the details. She verified that the MDS Coordinator is responsible for the assessments and completion of the comprehensive care plan. The MDS Coordinator should be checking and making sure the comprehensive care plans are completed. Resident #9 An interview with Resident #9 on 5/24/22 at 1:30 PM, revealed she usually gets showers three (3) times a week. She stated she is unable to do her	F 656	Committee. The Quality Assurance Committee will determine the frequency or discontinuation of audits based upon the results acheived.	

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own care and she requires the assistance of the staff.

An interview with LPN #4 on 5/25/22 at 2:30 PM, revealed Resident #9 is scheduled for showers three (3) days each week.

An interview on 5/26/22 at 11:45 AM with CNA #4, she stated Resident #9 is care planned to receive showers 3 times a week.

An interview with CNA #5 on 5/26/22 at 11:47 AM, she stated Resident #9 is care planned to get showers three (3) times a week.

Interview with the DON on 5/26/22 at 12:14 PM revealed Resident #9 should have a shower three (3) times each week and she requires assistance with bathing. She confirmed the facility failed to ensure the resident received proper personal hygiene with baths and showers three (3) times each week as care planned and the facility failed to follow the developed care plan for showers three (3) times each week.

Record review of Resident #9's care plan revealed a "Problem/Onset" date of 6/25/2019. The "Problem/Need" is listed as "Self care deficits related to impaired mobility, diagnoses of Paraplegia, Polyneuropathy, Anxiety Disorder, and requires extensive assist for bed mobility, transfers and toileting." Approaches included to "assist with showers 3 times weekly."

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 and need for assistance with personal care.

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Record review Resident #9's MDS with an Assessment Reference Date (ARD) of 5/2/22, Section C - Cognitive Patterns, revealed a Brief Interview for Mental Status (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.

Resident #200

The nursing facility provided documentation on the nursing facility's letterhead, dated May 26, 2022, and signed by the Interim Administrator, that revealed " (Formal Name of Facility) does not have specific policies that address Implementation Care of Care Plan ... (Formal Name of Facility) does not have specific policies that address feeding assistance."

An observation and interview on 05/23/22 at 12:45 PM, revealed Resident #200 had his lunch tray in front of him, Observed noodles on the napkin that was on his chest, as a cover. The SA asked Resident #200 if he was finished eating. He quickly answered, "no." Resident #200 revealed he needed help eating his meals and had difficulty due to the amount of arthritis in his hands. Resident #200 was demonstrated how difficult it was to use the regular sized utensil. Resident #200 dropped the fork, in his lap, before he could reach his mouth. Resident #200 revealed he had asked the nursing staff for help and was able to feed himself.

An observation and interview on 5/24/22 at 12:45 PM, of Resident #200 with the lunch meal,

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revealed Resident #200 was again attempting to feed himself. Resident #200 confirmed he needed help eating.

An interview on 5/25/22 at 09:30 AM, with the LPN#6, confirmed that the CNAs had not been providing assistance to Resident #200. LPN#6 stated Resident #200 was noted to be able to feed himself, and was not aware he needed help with meals. LPN #6 revealed Resident #200 had not been assessed for feeding assistance and had not been assessed for the need for built up utensils. LPN #6 revealed Resident #200 would benefit from feeding assistance.

An interview on 05/25/22 at 02:30 PM, with the DON confirmed that Resident #200 had been assessed for assistance with feeding and was care planned for assistance with feeding. She stated that Resident #200's care plan should have been followed by the nursing staff and that Resident #200 should be provided feeding assistance.

Record of the "Face Sheet" for Resident #200 revealed an admission date of 1/6/22 and included an admission diagnosis of Nutritional Deficiency, Unspecified.

Record review of the Significant Change MDS Assessment revealed Section C- BIMS score of 05, indicating Resident #200 has severely impaired cognition. Section GG - Functional Abilities and Goals, with and Assessment Reference Date (ARD) of 4/21/22, revealed 03 ... Eating ... 03 Partial/moderate assistance ... 03. Partial/moderate assistance - Helper doe LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than

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F 656	Continued From page 24 half the effort. Record review of the nutrition care plan for Resident #200 revealed, "Problem onset: 03/23/2022 with the Problem/Need listed as "Resident at nutritional risk ... Approaches included, "Assist resident with meals as needed."	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff 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	F 677	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	6/30/22

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F 677	Continued From page 25 had a shower in a month and that they get "wash offs" here. The resident did not have a body odor 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	F 677	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 / 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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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 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.

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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".

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

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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 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

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F 677	Continued From page 29 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. 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.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident	F 689	1. Resident # 18 is being secured in	6/30/22

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F 689	Continued From page 30 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. 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	F 689	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 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	

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F 689	Continued From page 31 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 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.	F 689	discontinuation of audits based upon the results achieved.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		6/30/22

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F 690	Continued From page 32 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review the facility failed to ensure a suprapubic catheter was secured by a leg strap for one (1) of (1) residents observed with catheters. Resident #18 Findings Include: Record review of the facility's policy, "Catheter Care", with a revision date of 5/22, revealed, "...Procedure...5. Secure the urinary catheter with	F 690	1. Resident # 18 suprapubic catheter was secured with a catheter strap on 5/25/22 by Licensed Practical Nurse # 1. Resident # 18 had no ill effects from this deficient practice. Licensed Practical Nurse # 1 was inserviced by the Director of Nurses on 5/27/22 on ensuring that leg straps are in place to secure suprapubic catheters. 2. All Residents who require suprapubic	

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F 690	Continued From page 33 a catheter strap..." On 05/24/22 at 08:17 AM, during an observation and interview Resident #18 was sitting in a wheelchair. The State Agency (SA)observed a catheter bag hanging beside wheelchair. Resident #18 stated she has a suprapubic catheter and it came out a few weeks ago. Resident #18 pulled up her gown and pointed to the catheter site. The SA did not see a leg strap in place. The SA asked Resident #18 if she usually has a leg strap on. Resident #18 responded "no". Observation on 5/25/22 at 04:03 PM, revealed Licensed Practical Nurse (LPN) #1 provided suprapubic catheter care for Resident #18. The SA observed there was not a leg strap in place prior to LPN #1 beginning catheter care. LPN #1 did not place a leg strap on Resident #18's leg after the catheter care was completed. Interview on 5/25/22 at 4:52 PM, with LPN #1 revealed that without the leg strap holding the catheter in place it could cause dislodging of the catheter. Interview on 5/26/22 at 9:52 AM, with the Director of Nursing (DON) she confirmed that there should be a leg strap placed on Resident #18's leg to prevent the catheter tubing from causing trauma to Resident #18. She stated the nurse should have obtained one to put on the resident at the time she completed the catheter care. Record review of the "Face Sheet" revealed an admission date of 1/22/19, with medical diagnoses of Uninhibited neuropathic bladder and Presence of urogenital implants.	F 690	catheters have the potential to be affected with catheter straps applied to secure suprapubic catheters in place. 3. An inservice was conducted by the Director of Nurses for the nursing staff starting on 5/30/22 to ensure that catheter leg straps are utilized for Residents who require a suprapubic catheter. A catheter audit was completed 5/30/22 by the Director of Nursing to ensure catheter leg straps are secure in place to prevent the catheter from causing trama. Unit Nurse Managers and the Director of Nurses are completing suprapubic catheter audits for residents with catheters three times weekly starting 5/30/22 to ensure that residents catheter leg straps are in place to prevent trauma. 4. The Director of Nurses and/or Charge Nurse will observe at least three residents with suprapubic catheters three times per week times six weeks to ensure that leg straps are in place to secure suprapubic catheters starting 5/30/22. Any concerns will be immediately addressed. The Director of Nurses 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 audits based upon the results achieved.	

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(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 690	Continued From page 34 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.	F 690		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control 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 §483.70(e) 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	F 880		6/30/22

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	255106	A. BUILDING _____ B. WING _____	05/26/2022

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F 880	Continued From page 35 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct 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 observations, staff interviews, and record reviews, the facility failed to ensure soiled linen was discarded in a manner to prevent the	F 880	1. Resident # 18 was assessed on 5/26/22 by the Director of Nurses with no soiled linen utilized to provide care or	

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F 880	Continued From page 36 spread of infection and ensure a contaminated object did no come in contact with a clean area for two (2) of four (4) days of survey (Resident #18 and Resident #119). Findings Include: Resident #18 Observation on 5/25/22 at 3:50 PM revealed Certified Nursing Assistant (CNA) #1, assisted by Licensed Practical Nurse (LPN) #1, bring Resident #18 in the room via wheelchair. The State Agency (SA) observed two white sheets and a blanket on the floor upon entering the room. She knocked the white heel protector from the from the bed on to the floor, picked it up, and placed it on Resident #18's bed. The resident adjusted herself in the bed and CNA #1 put the heel protectors onto her feet. CNA #1 placed a blanket on top of the pile of linen on the floor. She continued to pick the blanket up from the floor, fold it, and place it in the chair by the head of Resident #18 ' s bed. CNA #1 also picked up the other two sheets and blanket and placed them in the resident's wheelchair then exited the room. Interview on 5/25/22 at 4:52 PM, during an interview with LPN #1 revealed CNA #1 let a few things hit the floor, including the covers, blankets and heel protector boots. Those items should have been placed into a bag and carried out of the room. She stated that things that have been on the floor can be contaminated and that is an infection control issue. On 05/25/22 at 05:01 PM, the SA conducted an interview with CNA #1. She admitted she should	F 880	services. Resident # 119 is being provided wound care with no contamination of the wound with an external object. Resident # 18 and # 119 had no ill effects from this deficient practice. The Director of Nurses inserviced Licensed Practical Nurse # 1 and Certified Nursing Assistant # 1 on 5/26/22 ensuring that soiled linen was discarded in a manner to prevent the spread of infections and ensure that a contaminated object did not come into contact with a clean area. 2. All Residents have the potential to be affected with linen handling and wound care treatments provided in a manner to prevent the spread of infection. 3. An inservice was conducted on 6/7/22 by the Director of Nurses for nursing staff to ensure that soiled linen are discarded in a manner to prevent the spread of infections and contaminated objects did not come into contact with a wounds clean area during treatments. Infection Control rounds are being conducted by the Unit Nurse Managers and Director of Nurses to ensure that linen is being handled in a manner to prevent the spread of infection starting 5/30/22. Wound care observation rounds are being completed three times weekly by Unit Nurse Managers starting 5/30/22 to ensure that wound care treatments are being provided in a manner to prevent spread of infection and the clean wound does not come into contact with a contaminated object. The Root Cause	

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F 880	Continued From page 37 have thrown the dirty linen in a bag to discard. She stated that she knows that there are germs on the floor and could cause infection. She stated that she knows that it is an infection control issue. On 05/26/22 at 09:52 AM, in an interview with Director of Nursing (DON), confirmed that holding linen against the body, picking it up off the floor, and putting it on clean surfaces is an infection control issue. She agreed that doing so spreads germs and that the resident could be at risk for infections. She stated that the linen should have been put in a dirty linen barrel and never been put on the floor. A record review of Resident #18's "Face Sheet" revealed that the resident was admitted on 01/22/19 with a diagnoses including Multiple Sclerosis and Pressure Ulcer of the heel. A record review of Resident #18's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/01/22, revealed that the resident has a Brief Interview for Mental Status (BIMS) score of 14, which indicated she is cognitively intact. A record review of the facility's "Educational In-Service Record" dated 09/22/20 revealed "Title: Infection Control and Handwashing" was signed by CNA #1 as being in attendance. Resident #119 Record review of the "Physician Orders" for the month of May 2022 revealed an order dated 5/25/22 for "Santyl ointment clean sacral with normal saline, pat dry, apply Santyl with moist	F 880	Analysis was completed 6/24/22 by Infection Preventionist, Executive Director, Assistant Executive Director, Director of Nurses, and the Governing Body with use of the Five Whys- Infection Control- Non- Compliance. The Director of Nursing/ Unit Managers will make infection control rounds three times weekly times six weeks starting 5/30/22 to observe infection control technique handling soiled linen and wound care treatments without contamination by an external object. The Staff Development Coordinator/ Unit Managers will be be completing competencies with nursing staff to ensure proper linen handling and wound care treatments without contamination of wounds three times weekly times four weeks to prevent the spread of infection starting 5/30/22. Linen Handling audits and wound care observation audits will be completed three times weekly times six weeks starting 5/30/22. Sparkling Surfaces- CDC video inservices were started 6/15/22 for all staff to view and sign upon completion of watching video. Executive Director verified that all staff will have viewed Sparkling Surfaces - CDC Video by close of business 7/5/22. The employee roster with the date and signature that the Sparkling Hands-CDC-video was viewed will be submitted to Electronic Plan of Correction by close of business 7/5/22. 4. The Director of Nurses and/or Charge Nurse will observe ten staff three times a week times six weeks starting 5/30/22 to ensure that soiled linen is handled to	

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F 880	Continued From page 38 gauze and cover with foam dressing daily." On 05/26/22 at 08:25 AM, the State Agency (SA) observed wound care for Resident #119 with LPN #2, assisted by CNA #3. The resident was lying on her left side, on an incontinence pad, wearing a brief. The CNA unfastened the residents right side of her brief to expose the wound. During wound care, LPN #2 cleaned the wound with normal saline, and left the bedside to wash her hands. While she was washing her hands, CNA #3 pulled the contaminated brief and the incontinence pad over the cleaned wound bed to provide privacy, causing the contaminated brief to come in contact with the cleaned wound bed. When LPN #2 returned from washing her hands, CNA #3 pulled the brief and incontinence pad back down to expose the wound. LPN #2 then applied the Santyl and moistened gauze and covered the wound with a foam dressing. On 05/26/22 at 10:00 AM, in an interview with CNA #3, she confirmed she used the resident's brief and incontinence pad to cover the wound after it was cleaned by the LPN. She said she covered the wound on the sacrum to provide privacy for the resident. On 05/26/22 at 10:03 AM, in an interview with LPN #2, she confirmed she had cleaned the wound and went to wash her hands. When she returned, she realized the CNA had taken the contaminated brief and covered the cleaned wound. She stated that allowing the contaminated brief to touch the cleaned wound bed could have caused the wound to become infected. On 05/26/22 at 10:26 AM, in an interview with the	F 880	prevent the spread of infection and contaminated objects do not come into contact with a clean area during treatments. The Director of Nurses 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 audits based upon the results achieved.	

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F 880	Continued From page 39	F 880		

Director of Nursing (DON), she stated she expects wound care to be provided without contamination and using the contaminated brief to cover the cleaned wound was not providing care without contamination.

Record review of the "Face Sheet" revealed the facility admitted Resident #119 on 3/25/22 with diagnoses including Chronic Pain and Pressure Ulcer of Sacral Region.

Record review of Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/26/22 revealed Resident #119 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated she is cognitively intact.