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	255146	A. BUILDING _____ B. WING _____	08/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 8/14/23-8/17/23. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation related to F561, F656, F677, F689, F695, F758 and F812. The census at the time of the survey was 139 and the facility is licensed for 155.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to	F 561		9/29/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/04/2023

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F 561	Continued From page 1 participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interview, record review and facility policy review the facility failed to honor the choices of residents for not serving food preferences (Resident #65), not serving double portions (Resident #105) and for not being assisted out of bed (Resident #49 and 123) for four (4) of 139 resident's reviewed during survey. Resident's #49, 65, 105 and 123 Findings include: A review of the facility policy, titled "Residents Rights," revealed, "Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: ...s. Choose and participate in decision making regarding his or her care..." Resident #105 An interview on 08/14/23 at 11:17 AM with Resident #105 revealed he is supposed to get double portions with all his meals, but he usually does not. He stated that he had complained to the nurses and Certified Nurse Assistant's (CNAs) about it, but it has not helped. He stated, "one portion is just not enough food for me". An observation and interview on 8/14/23 at 11:45 AM, with Resident #105 revealed his lunch meal tray had been delivered and set up by the staff, his lunch meal ticket indicated that the resident	F 561	Preparation and submission of the plan of correction by Yazoo City Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirement of state and federal law. 1. On 8/14/23, Certified Nursing Assistant (CNA) went to dietary and corrected Resident # 105□s meal tray to include double portions. On 8/14/23, Resident #65□s meal ticket was reviewed and corrected by dietary manager to remove sausage and grits and replaced with bacon and oatmeal as per resident request. On 8/14/23, Residents #49 and #123 were both gotten up by CNA and placed in wheelchairs. 2. The facility determined that each of the 139 residents has the potential to be affected. 3. Dietary Department staff received a directed in service on 8/14/23 from District manager for on resident choice, food preferences, and ensuring accuracy of meal tickets. All nursing staff received directed in service from Nurse Educator	

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F 561	Continued From page 2 was supposed to receive double portions, but his lunch tray did not have double portions. This observation revealed he had one portion of mashed potatoes, one hamburger steak and one portion of green beans. An interview with the resident at this time confirmed he did not receive double portions on his lunch tray today and stated, "that's normal". An interview and record review on 8/15/23 at 10:00 AM, with the Dietary Manager (DM) revealed that she receives request for "double portions" from the nurses on a request form and then she puts them on the resident's meal ticket. She stated that if the resident's meal ticket indicated "double portions" then the resident should receive "double portions". A record review at this time of Resident #105's meal ticket with the DM confirmed that the resident's meal ticket indicated he was supposed to receive double portions. An interview on 8/15/23 at 10:15 AM, with Registered Nurse (RN) #1 confirmed that if a resident has "double portions" on their meal ticket then it is a preference of the resident, and they should be receiving double portions. An interview on 8/15/23 at 10:30 AM, with the Administrator and the Director of Nurses (DON) confirmed that Resident #105 should be receiving double portions with all of his meals consistently since his meal ticket indicates "double portions" The DON stated that it is not an order but a choice of the resident to receive double portions with his meals. Record review of Resident #105's Admission Record revealed the resident was admitted to the	F 561	beginning 8/25/23 on resident choice and verifying that resident meal tickets match meal tray given to resident. An audit was completed by dietary management From 8/14/23-8/18/23 verifying that the meal ticket matches orders given by Dietician. 9 of 129 residents required clarification. 4. Beginning 9/4/23 Dietary management will observe one meal per day for 7 days, four (4) meals per week for four (4) weeks, and eight (8) meals per month for two (2) months to ensure that the meal ticket matches the meal being served to the resident. Beginning 9/4/23, Registered Nurse Supervisors will choose three (3) residents per day for seven (7) days then four (4) residents per week for four (4) weeks and eight (8) residents per month for two (2) months, who are in bed to ask them if they were asked if they wanted to get up from the bed. A report will be submitted to the Quality Assurance Performance Improvement on 9/20/23 for review and recommendations then monthly for three (3) months. The Dietary Manager and Director of Nursing are responsible for monitoring and compliance.	

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facility on 6/18/21 with medical diagnoses that included Unspecified Polyneuropathy.

Record review of Resident #105's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/22/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicates the resident is cognitively intact.

Resident #49

An observation and interview on 08/14/23 at 11:56 AM, revealed Resident #49 was in the bed wearing a hospital gown. He shared that he had been bathed and placed in a fresh hospital gown by his Certified Nurse Aide (CNA). Resident #49 revealed he wanted to get out of bed more and had not been out of bed in over a week. He said he use to get out of bed when he first admitted to the facility, but the staff stopped getting him up regularly. He said he did not know why the staff does not get him up anymore. He noted he did not want to sit up for a very long time, but he was tired of being in bed all day, every day.

An interview on 8/15/23 at 10:41 AM, with Certified Nursing Assistant (CNA) #7 revealed he had not asked Resident #49 if he wanted to get out of bed. He revealed he had not seen Resident #49 out of the bed and placed in a Geri-chair since early July and was not aware of why he was no longer gotten up out of bed.

An interview on 8/15/23 at 10:55 AM, with the Licensed Practical Nurse (LPN) #6, revealed Resident #49 had not refused to get out of bed. She noted she last remembered him being out of bed sometime in early July. She then confirmed she had not asked Resident #49 if he wanted to

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get out of bed and she was not aware of a reason he needed to stay in bed.

An interview on 8/15/23 at 11:00 AM with CNA #4, revealed she last assisted Resident #49 out of bed into a Geri-chair one (1) day when she worked two (2) weeks ago. She noted she worked as needed (PRN), maybe three (3) days a week, and would get Resident #49 out of the bed at least one of the days when she worked. She revealed she was not aware of a reason why Resident #49 was left in bed most of the time.

An interview on 8/15/23 at 11:35 AM, with the Administrator, revealed the staff was not honoring Resident #49's choices of wanting to get out of bed more often and should have asked Resident #49 what his choices were regarding getting up or choosing to stay in bed. She confirmed Resident #49 should be gotten out of bed as he chooses to assist in avoiding the possibility of medical/physical decline.

Record review the Departmental Notes for Resident #49 revealed no documentation regarding nursing staff assisting Resident #49 out of bed and no documentation of nursing staff asking Resident #49 his choice to get up or to stay in bed.

Record review of Section F - Preferences for Routine and Activities of the Admissions Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 01/10/2023, for Resident #49, revealed " ... E. How important is to you to choose your own bedtime? 1. Very Important."

Record review of the "Admission Record," for

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Resident #49, revealed an admission date of 01/03/2023, with diagnoses of Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side and Transient Cerebral Ischemic Attack, Unspecified.

Record review of Section C of the Quarterly MDS Assessment, with an ARD of July 6, 2023, for Resident #49, revealed a BIMS score of 14, indicating Resident #49 is cognitively intact.

Resident #123

An observation and interview on 08/14/23 at 11:30 AM, with Resident #123 revealed he was still in bed close to lunch time and was not dressed in street clothes. He revealed he wanted to get out of bed and sit in a wheelchair. He noted he used to get out of bed and sit in a wheelchair but had not been up out of bed for a long time. He shared that he did not want to stay in bed all the time, that he wanted to go out of the room on some days, and that nobody had asked him if he wanted to get out of bed. Resident #123 noted he never use to have to ask to get up and staff would tell him they were going to get him up and put him in the wheelchair.

An interview on 8/15/23 at 11:10 AM, with the Registered Nurse (RN) #2 Charge Nurse, revealed she was not aware of any reason why Resident #123 was not able to get out of bed into a Geri-chair and was not aware of why he stayed in the bed daily. She revealed she was not aware of Resident #123 refusing to get out of bed and was not sure why the Certified Nurse Aides (CNA)s would not get him up.

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An interview on 8/15/23 at 11:15 AM, with CNA #5 revealed Resident #123 did not get out of bed because he did not ask to get up. She noted he can say what he wants and had not told her he wanted to get up. She confirmed she should have asked Resident #123 of his choice to stay in bed or if he would like to get out of bed. She also confirmed she had not asked Resident #123 if he would like to get out of bed. She noted she was not aware of the last time he was up out of bed.

An interview on 8/15/23 at 11:21 AM, with the Licensed Practical Nurse (LPN) #5, revealed it was Resident #123's preference to want to stay in bed and to tell the staff when he wanted to get up. She revealed he had not voiced wanting to get out of bed and she had not asked him.

An interview on 8/15/23 at 11:35 AM, with the Administrator, confirmed that the nursing staff should have asked Resident #123 about his choice to want to get out of bed and not always remain in his room in the bed. She confirmed that Resident #123's choices were not being honored by the nursing facility. She confirmed Resident #123 should be gotten out of bed as he chooses to assist in avoiding the possibility of medical/physical decline.

Record review of the ADL (Activities of Daily Living) Care Plan revealed "Locomotion: Resident requires total assist X1 (times one) staff for locomotion via Geri chair. Resident prefers to stay in bed most of the time".

Record review of the "Departmental Notes," nurses notes, revealed no documentation regarding staff offering to get Resident #123 out of bed or Resident #123 refusing to get out of

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bed.

Record review of Section F - Preferences for Routine and Activities of the Significant Change MDS Assessment, with an ARD of 03/06/2023, for Resident #123, revealed "E. How Important is it to you to choose your own bedtime? 2. Somewhat Important."

Record review of the Admission Record for Resident #123 revealed an admission date of 8/4/22 with diagnoses including Muscle Wasting and Atrophy, Acquired absence of left leg above knee and Cerebral Infarction.

Record review of the quarterly MDS with an ARD of June 1, 2023 revealed in Section C a BIMS score of 09, indicating the resident is moderately cognitively impaired.
Resident #65

An interview with Resident #65 on 8/14/23 at 1:00 PM, revealed he spoke to someone from dietary about a week ago and asked them to stop sending him sausage and grits because he is tired of it and asked for oatmeal and bacon.

A record review of a Nutrition/Dietary Note dated 8/7/2023 for Resident #65, revealed "resident stated that he likes bacon, oatmeal and not grits."

During an interview and observation of the breakfast tray for Resident #65 with Certified Nurse Assistant (CNA) #3 on 8/16/23 at 7:50 AM, she revealed the meal for Resident #65 consisted of a bowl of grits, scrambled eggs, a sausage patty, one slice of bacon, and two biscuits. CNA #3 then revealed the meal ticket listed oatmeal, 2 sausage patties, scrambled eggs, hash browns

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F 561	Continued From page 8 and double portions. CNA #3 confirmed again that Resident #65 did not receive oatmeal on his breakfast tray. An interview with the Assistant Director of Nursing on 8/16/23 8:00 AM, revealed after review of the Resident #65's tray he received grits and sausage and confirmed the facility did not honor his preference's. An interview with the Dietary Manager (DM) on 8/16/23 at 10:30 AM, revealed the dietary aide misread the meal ticket and should not have sent grits on the breakfast tray, she also revealed that the meal ticket was not updated to reflect his preferences for bacon instead of the sausage and confirmed the ticket should have been updated on 8/7/23. The Dietary Manager then revealed Resident #65's food preferences were not being honored and she would ensure the changes were made. Record review of Resident #65's Admission Record revealed that the facility admitted the resident to the facility on 7/8/23 with diagnoses of Protein Calorie Malnutrition and Pressure ulcer of sacral region, left heel, and right heel. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) on 7/15/23, revealed that Resident #65 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated that he was cognitively intact.	F 561		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		9/29/23

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F 656	Continued From page 9	F 656		

§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(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

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F 656	Continued From page 10 section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, record review and facility policy review the facility failed to develop a comprehensive care plan for a resident who wanders (Resident # 85) and failed to implement a care plan for a resident who required assistance for activities of daily living (ADL), Resident #22 and #127, for three (3) of 28 comprehensive care plans reviewed. Findings Include: A record review of the facility policy titled, "Care Plans, Comprehensive Person-Centered", revealed Policy Statement, A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Resident #22 Record review of the care plan for Resident #22 revised on 04/25/2023 with a focus revealed, "The resident has an ADL self-care performance deficit r/t (related to) Heart Failure/Angina Pectoris ...Intervention/Tasks: BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary ..." Record review also revealed a care plan revised	F 656	1. On 8/16/23, Resident #22□s nails were cleaned and trimmed by Certified Nursing Assistant, Resident #127□s face was cleaned of facial hair by Certified Nursing Assistant, and Resident #85 was placed on one-to-one monitoring to curb wandering tendencies. 2. The facility determined that each of the 139 residents has the potential to be affected. 3. Registered Nurse Supervisors and Minimum Data Set staff received a directed in service from Nurse Educator beginning 8/25/23 on development and implementation of care plans. An audit was conducted by Minimum Data Set nurse on 9/1/23 on all current residents to ensure that a proper care plan was developed for activities of daily living and that it included nail care and shaving. Care plans for all wander risk residents were either developed or reviewed to ensure accuracy and practicality by Minimum Data Set nurse on 8/18/23. 5 of 141 residents needed adjustments to their individual care plans. 4. Beginning 9/4/23 the Minimum Data Set Coordinator will review any new admissions weekly for three (3) months to	

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F 656	Continued From page 11 on 04/25/2023, "Focus: The resident has a potential risk to skin integrity ...Intervention/Tasks: Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short ..." An observation and interview on 08/14/23 at 12:20 PM, revealed Resident #22 complained that her fingernails needed cut. Resident #22's fingernails are long, approximately one-half inch past her fingertips and dirty with small amounts of a brownish material under the nails. An observation, on 08/15/23 at 11:43 AM revealed the resident continued to have long unclean fingernails. An interview, on 8/15/23 at 3:35 PM with Licensed Practical Nurse (LPN) #8 confirmed Resident #22's fingernails were long and dirty. An interview, on 8/16/23 at 8:20 AM with Certified Nursing Assistant (CNA) #1 confirmed the resident's fingernails were long and dirty. An interview, on 8/16/23 at 1:20 PM, with the Administrator (ADM) revealed if Resident # 22's nails were long and needed cut, her care plan was probably not followed. An interview on 08/17/23 at 08:45 AM, with the Director of Nursing (DON) revealed the purpose of the care plan was for the staff to know how to take care of the residents. She confirmed the care plan for Resident #22 was not being followed. Review of the facilities Admission Record revealed Resident #22 was admitted to the facility	F 656	ensure that Activities for Daily Living and Wandering care plans are developed, accurate and visible on nursing staff's observation and recording tools. A report will be submitted to the Quality Assurance Performance Improvement on 9/20/23 for review and recommendations then monthly for three (3) months. The Material Data Set Coordinator is responsible for monitoring and compliance.	

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on 1/31/2022 with diagnoses that included Hypertensive Heart Disease with Heart Failure, Unspecified Atrial Fibrillation, Anxiety Disorder, and Chronic Obstructive Pulmonary Disease.

Review of the Minimum Data Set (MDS) section C for Resident #22 revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderately impaired cognition.
Resident #127

Record review of the ADL Care Plan revealed Resident #127 was not care planned for refusal of ADL care. The record review did reveal "The resident has an ADL self-care performance deficit r/t (related to) Rhabdomyolysis, Left Knee Effusion and Unilateral Osteoarthritis...Personal Hygiene: The resident requires supervision assistance by (1) staff with personal hygiene ... Date Initiated: 10/19/2022, Revision on 07/03/2023."

An interview and observation on 08/14/23 at 10:50 AM, with Resident #127 revealed him to have a full beard growing half-way down the front of his neck. The hair was approximately 1/3 inch long. Resident revealed he had not had a shave in a while, and no one had offered to shave him. He mentioned he wanted the beard shaved and normally wears a clean face with just a mustache.

An observation and interview on 8/15/23 at 11:10 AM, with Registered Nurse (RN) #2 Charge Nurse, confirmed Resident #127 had a full beard that was growing down the front half of his neck and was approximately 1/3 inch long.

An interview and observation on 8/15/23 at 11:15 AM with CNA #5, revealed she had not asked

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Resident #127 if he would like a shave. She confirmed she had observed his full beard that was grown half-way down the front of his neck and did not ask Resident #127 if he liked having the facial hair. CNA #5 confirmed she should have asked him about his choice for grooming.

An interview on 8/15/23 at 11:35 AM, with the Administrator confirmed that Resident #127's grooming choices were not being honored by the nursing facility.

Record review of the 'Admission Record," for Resident #127, revealed an admission date of 10/05/2022, with diagnoses of Rhabdomyolysis, Effusion, Left Knee, Unilateral Primary Osteoarthritis, Left Knee, and Traumatic Ischemia of Muscle, Subsequent Encounter.

Record review of Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of June 27, 2023, for Resident #127, revealed a Brief Interview for Mental Status (BIMS) score of 08, indicating Resident #127 is moderately cognitively impaired.
Resident #85

A record review of Resident # 85's care plan, with an onset date of 7/31/23 ,revealed, Focus: I have been evaluated as a wandering risk related to specify: (decreased safety awareness, confusion, wandering/exit seeking behaviors secondary diagnoses Unspecified Dementia, Unspecified Severity, with Other Behavioral Disturbance).
Goal: I will remain free of injuries associated with wandering behaviors through this review period.
Interventions/Tasks: May reside on secure unit two (2) ...
Wander Bracelet r/t wandering/exit seeking

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behaviors ...Nurse to check placement q shift including skin check under bracelet. Location of bracelet on resident: Right Wrist. Check my location frequently. Encourage me to participate in activities of my preference. Engage me in diversional activities when indicated. Evaluate the need for me to utilize a wandering bracelet device to alert staff of me approaching and exit door. Observe me for signs and symptoms of agitation, pacing, repetitive verbalizations of wanting to leave/go home, restlessness, report increased behaviors to nurses for further interventions. Provide me re-orientation, as needed, re-evaluate continued need for wander bracelet ... and Focus: "Proper name of Resident #85", is an elopement wanderer related to Resident wanders aimlessly, significantly intrudes on the privacy or activities. Goal: The resident's safety will be maintained through the review date. Interventions/Tasks: Apply wander guard to alert staff of attempts to elope. Nurse to check placement and function q (every) shift using device tester. If missing or inoperable, replace as soon as available./ I will be monitored q (every)15 minutes until bracelet in place. Assess for fall risk. Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. WANDER ALERT: Device ...

On 8/15/23 at 8:15 AM Resident # 85 was observed ambulating in the hall and walking up to different resident doors.

Resident # 85 was observed on 8/15/23 at 9:15

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AM, riding the elevator from the first floor to the second floor without the supervision of staff.

Resident # 85 was observed on 8/16/23 at 9:10 AM, in the second-floor dining room walking up to another resident who was sitting in a Geri chair and picked up his arm using his shirt sleeve then putting the other resident's arm down.

Record review of the facilities Wander Data Assessment-V 1, dated 7/31/23, revealed that Resident # 85 had a score of 25 , which indicated that he is High Risk for Wandering. Question number four (4), Does the wandering significantly intrude on the privacy or activities of others, was answered yes.

During an interview with the Director of Nursing (DON) on 8/16/23 at 9:35 AM, she agreed that Resident # 85's care plan did not adequately reflect the resident's risk for accident hazards related to wandering and interfering with other resident's privacy or activities. She also agreed that there were no interventions to prevent accident hazards related to resident's wandering and interfering with the privacy or activities of others. She agreed that failure to develop the care plan puts the resident at risk for accidents and injury from other residents.

A record review of Admission Record revealed Resident # 85 was admitted to the facility on 3/7/2019, with diagnoses that include Unspecified Dementia, Unspecified severity, with Other Behavioral Disturbance and Attention-Deficit Hyperactivity Disorder, Unspecified Type.

A record review of Resident # 85's Quarterly Minimum Data Set (MDS) Assessment, with an

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F 656	Continued From page 16 Assessment Reference Date (ARD) of 7/24/2023, Section C, Cognitive Patterns revealed Resident #85 has a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition.	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 observations, staff and resident interview, record review and facility policy review the facility failed to assist a resident out of bed and provide nail care for resident's that require assistance with Activities of Daily Living (ADLs) for two (2) of 139 residents reviewed during survey. Resident #22 and #127. Findings include: Review of the facility policy titled, "Activities of Daily Living (ADL), Supporting", revealed residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming ,and personal and oral hygiene. The policy interpretation and implementation revealed under #2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in	F 677	1. On 8/16/23, Resident #22□s nails were cleaned and trimmed and Resident #127□s face was cleaned of facial hair by Certified Nursing Assistant and verified by Registered Nurse Supervisor. 2. The facility determined that each of the 139 residents has the potential to be affected. 3. All nursing staff received a directed in service from the Nurse Educator beginning 8/25/23 on providing nail care and shaving all residents who need to have that activity of daily living performed in according to care plan and documentation of care to include any refusals. Observations were conducted by Registered Nurse Supervisors on 8/21/23 inspecting all residents for proper nail care and shaving practices. 4. Beginning 9/4/23, Registered Nurse Supervisors will observe five (5) residents	9/29/23

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F 677	Continued From page 17 accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care). Resident #22 An observation and interview, on 08/14/23 at 12:20 PM revealed Resident #22 complained that her fingernails needed cut. Resident #22's fingernails are long, approximately one-half inch past her fingertips and dirty with small amounts a brownish material under the nails. She stated her granddaughter cut them last time and she thinks her family is waiting to see if the staff cuts them. She stated that she thought maybe someone was going to cut them today. She stated her toenails are fine because the podiatrist comes and cuts them. On 08/15/23 at 11:43 AM, an observation and interview revealed Resident #22 continued to have long unclean fingernails. She stated that no one had offered to cut her nails. An observation and interview on 8/15/23 at 3:35 PM, with Licensed Practical Nurse (LPN) #8 confirmed she had seen the resident's fingernails and they were long and dirty. She stated the resident could damage her skin by scratching. Resident #22 stated that she does itch on her back and shoulders and scratches her shoulders. LPN #8 assessed the resident's skin, and no scratches or open areas were noted. An interview on 8/16/23 at 8:20 AM, with Certified Nursing Assistant (CNA) #1 stated she was assigned to Resident #22 yesterday. She confirmed the resident's fingernails were long and	F 677	per week for three (3) months to ensure that shaving and nail care are being performed in accordance with orders, care plan, and Kardex in Point of Care on Point Click Care. A report will be submitted to the Quality Assurance Performance Improvement on 9/20/23 for review and recommendations then monthly for three (3) months. The Assistant Director of Nursing is responsible for monitoring and compliance.	

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dirty. She stated that they should have already been cut.

An interview, with the Administrator (ADM) on 8/16/23 at 8:30 AM, revealed nail care should be done at least once a week. She stated that residents could scratch themselves if their nails were too long.

An interview on 08/17/23 at 08:42 AM, with the Director of Nursing (DON) revealed that the staff should be cutting nails. The CNA's cut nails unless the resident is diabetic, then the nurse cuts them. The DON stated nails should be cut to prevent skin impairments.

Review of the facility Admission Record revealed Resident #22 was admitted to the facility on 1/31/2022 with diagnoses that included Hypertensive Heart Disease with Heart Failure, Unspecified Atrial Fibrillation, Anxiety Disorder, and Chronic Obstructive Pulmonary Disease.

Review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 7/6/23 revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated moderately impaired cognition.
Resident #127

An observation and interview on 08/14/23 at 10:50 AM with Resident #127 revealed him to have a full beard growing half-way down the front of his neck. The hair was approximately 1/3 inch long. Resident revealed he had not had a shave in a while, and no one had offered to shave him. He mentioned he wanted the beard shaved and normally wears a clean face with just a mustache.

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An observation and interview on 8/15/23 at 11:10 AM with Registered Nurse (RN) #2 Charge Nurse, confirmed Resident #127 had a full beard that was growing down the front half of his neck and was approximately 1/3 inch long. She revealed there are Certified Nurse Aides (CNA)s in the building that are not always assigned to the floor that assist with shaving residents and a person that comes to the beauty shop that could have shaved Resident #127. RN #2 Charge Nurse shared that she was not aware of why he had not been shaved in a while. She noted she had no knowledge of Resident #127 refusing to be shaved. RN #2 Charge woke Resident #127 and asked him if he wanted a shave. Resident #127 was witnessed informing the RN Charge Nurse he did want to shave, but to come back later to do it.

An interview and observation on 8/15/23 at 11:15 AM with CNA #5, revealed she had not asked Resident #127 if he would like a shave. She confirmed she had observed his full beard that was grown half-way down the front of his neck and did not ask Resident #127 if he liked having the facial hair. CNA #5 confirmed she should have asked him about his choice for grooming. She revealed that all the nursing facility CNAs can shave their assigned residents and revealed a box of disposable razors that were stored at the nursing desk for the CNAs to use to shave the residents.

An interview on 8/15/23 at 11:35 AM with the Administrator confirmed that the nursing staff should have inquired about and documented Resident #127's choices for grooming, should have honored his resident right for the choice of wanting to have his facial hair shaved, and should

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F 677	Continued From page 20 have offered to shave him. She confirmed that Resident #127's grooming choices were not being honored by the nursing facility. Record review of Resident #127's admission photo revealed he was wearing a mustache and did not have a full beard. Record review of the medical record for Resident #127 revealed no staff documentation of Resident #127 being asked about his grooming choices or him refusing to be shaved. Record review of the 'Admission Record," for Resident #127, revealed an admission date of 10/05/2022, with diagnoses of Rhabdomyolysis, Effusion, Left Knee, Unilateral Primary Osteoarthritis, Left Knee, and Traumatic Ischemia of Muscle, Subsequent Encounter. Record review of Section C of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of June 27, 2023, for Resident #127, revealed a Brief Interview for Mental Status (BIMS) score of 08, indicating Resident #127 is moderately cognitively impaired.	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	F 689		9/29/23

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by:
Based on observation, resident and staff interview, record review and a facility policy, the facility failed to provide adequate supervision in order to reduce the risk of an accident hazard for two (2) of 139 residents reviewed in the facility. Resident #29 and 85.

Findings include:

A review of a statement on facility letter head dated 8/16/23 and provided to the State Agent (SA), revealed, "The facility does not have a policy on Accidents and Hazards."

A record review of the facility policy, titled "Wanderer Management, Monitoring System & Resident Elopement Protocol", revealed under Policy...It is the policy of this facility that all residents are afforded adequate supervision to provide the safest environment possible ..."

Resident #29

An observation and interview with Resident #29 on 8/14/23 at 2:41 PM, revealed a large bottle of Women's One a Day multivitamin and a large bottle of Vitamin C on a table visible upon entering the room. Resident #65 revealed these were her vitamins she must take daily.

An observation of Resident #29's room with Licensed Practical Nurse (LPN) #1 on 8/15/23 at 9:20 AM, confirmed there was a large bottle of Women's One a Day Multivitamins and a large bottle of Vitamin C sitting on Resident #29's table. LPN #1 revealed Resident #29 does not have an order to self-administer medications and confirmed she should not have any medications

1. On 8/14/23, Vitamins were immediately removed from Resident #29□s possession by the Registered Nurse Supervisor and given to Director of Nursing Services. Resident #29 was placed on 72 hour observation for signs and symptoms of any adverse effects with none noted. Registered Nurse Supervisor verified that no other medications were located in the room. On 8/16/23, Resident #85 was redirected by Certified Nursing Assistant and placed on individual monitoring which consisted of redirecting away from other resident's rooms and engaging the resident in other activities.

2. The facility determined that each of the 139 residents has the potential to be affected.

3. Nursing staff received a directed in-service from Nurse Educator beginning 8/23/23 on procedures and protocols for self-administration and storage of medication in resident's room. from Nursing Educator. Beginning 9/1/23, all staff received a directed in service from Nurse Educator on Wandering and how to redirect residents with dementia. Observations were conducted by Registered Nursing Supervisors of all resident's rooms in the facility looking for medication. 0 out 88 rooms had unauthorized medication in them.

4. Beginning 9/4/23, the Registered Nurse Supervisor will choose two (2) rooms per day for seven (7) days, three

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F 689	Continued From page 22 in her room. LPN #1 confirmed the concerns of Resident #29 having medications in her room would be she could accidentally take too many pills causing possible gastric distress and toxicity. An interview the Director of Nursing (DON) on 8/15/23 at 9:32 AM, revealed after review of the medical record, Resident #29 does not have a self-administration of medication evaluation or a physician's order to self-administer any medications. The DON confirmed Resident #29 should not have the medications in her room and she would remove them immediately and confirmed possible concerns from having the vitamins in the room is the resident could take extra and have side effects from the medications. A record review of the Order Summary Report dated 8/15/23 for Resident #29, revealed no order for Resident #29 to self-administer medications. Record review revealed two orders dated 10/09/2020 for One-A-Day Women's Tablet (Multiple Vitamins-Minerals) Give 1 tablet by mouth one time a day related to VITAMIN DEFICIENCY, UNSPECIFIED ...Vitamin C Tablet (Ascorbic Acid) Give 1 tablet by mouth one time a day related to VITAMIN DEFICIENCY, UNSPECIFIED ..." An interview with the Minimum Data Set (MDS) Nurse on 8/16/23 at 2:33 PM, revealed she is unaware of any residents wanting to self-administer medications and revealed if a resident voiced interest the Interdisciplinary Team (IDT) would meet and evaluate the resident. Record review of the Admission Record revealed that the facility admitted Resident #29 to the facility on 5/03/2017 with diagnoses of Paranoid	F 689	(3) rooms per week for two (2) weeks and five (5) rooms per month for the next two (2) months to look for unauthorized medications. Beginning 9/4/23, two (2) residents that are high risk for wandering will be selected three (3) times a week for three (3) months by Registered Nurse Supervisor to observe if staff is redirecting. A report will be submitted to the Quality Assurance Performance Improvement on 9/20/23 for review and recommendations then monthly for three (3) months. The Assistant Director of Nursing is responsible for monitoring and compliance.	

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Schizophrenia, Major Depressive disorder, and Anxiety Disorder.

Record review of the MDS Section C with an Assessment Reference Date (ARD) on 7/10/23, revealed that Resident #29 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated that she was cognitively intact.
Resident #85

On 8/15/23 at 8:15 AM an observation revealed Resident # 85 ambulating in the hall and walking up to different resident doors. Resident #85 was wearing a wander alert device on his right wrist.

An observation of Resident # 85 on 8/15/23 at 9:15 AM, revealed that he was riding the elevator from the first floor to the second floor without staff supervision.

On 8/16/23 at 9:10 AM, Resident # 85 was observed in the second-floor dining area walking up to another resident, who was sitting in a Geri chair and picking up the other resident's arm using his shirt sleeve then putting the other resident's arm down.

Record review of a facility investigation conducted for an incident that occurred on 7/14/23 revealed that Resident #85 had gone into another resident's room and went through his clothing looking for a shirt. The resident who lives in that room became angry and hit Resident #85 in the head with a wet floor sign.

Record review of the Wander Data Assessment-V 1, dated 7/31/23, revealed that Resident #85 had a score of 25 , which indicated that he is High Risk for Wandering. Question

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number four (4), Does the wandering significantly intrude on the privacy or activities of others, was answered yes.

A record review of the August 2023 "Medication Administration Record" revealed that Resident #85's behavior monitoring does not include monitoring or supervision for wandering or intruding on the privacy or activities of others.
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A record review of Resident # 85's "Progress Notes *New*" for the time frame of 7/14/23 through 8/14/23 revealed there is no documentation that the resident received monitoring or supervision for wandering or intruding on the privacy or activities of others.

During an interview with Social Worker (SW) #1 on 8/15/23 at 2:00 PM, when asked what interventions were provided to keep Resident #85 from intruding on other residents and to keep him safe, she stated that she educated other residents that Resident #85 was not aware of what he was doing. When asked what interventions were provided to protect Resident #85 from cognitively impaired residents, that could not understand teaching, she stated that the nurses and certified nursing assistants perform close monitoring of Resident # 85 to keep the resident safe. She clarified that close monitoring means keeping the resident on his hall.

In an interview with LPN #5 on 8/15/23 at 3:00 PM, she stated that Resident #85 does wander up and down the hall, but only goes into the rooms of the residents to socialize with them.

In an interview with the Activities Director (AD) on

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8/15/23 at 3:10 PM, she stated that the resident does wander. She stated that the resident comes to and from activities on his own. The AD stated she does not leave any type of activity for Resident # 85 as a diversion to prevent the resident from intruding on others privacy and activity during the evening or at night.

Interview with Certified Nursing Assistant #3 (CNA) on 8/15/23 at 4:00 PM, she stated that she is very familiar with Resident # 85. CNA #3 stated that Resident # 85 wanders, but only goes into residents' rooms that he knows.

In an interview with Licensed Practical Nurse # 4 (LPN) on 8/16/23 at 8:50 AM, she stated that Resident # 85 ambulates up and down the hall socializing with staff and other residents. She states he likes to help other residents and if he sees them in the hall he will go up to the wheelchair and start pushing it. She stated that Resident # 85 has had a physical altercation with another resident when he went into the other resident's room looking for a shirt the other resident got mad and hit Resident # 85 in the head with a wet floor sign. She verified that Resident #85 goes to and from activities on the first floor by himself.

During an interview with Resident # 85 on 8/16/23 @ 8:50 AM, he attempted to hug this State Agent (SA), then began repetitively tapping SA on the shoulder and stated "you my wife" over and over. He was unable to answer any questions.

During an interview with the Director of Nursing (DON) on 8/16/23 at 9:30 AM, she agreed that keeping the resident on his hall was not considered close monitoring. She also agreed

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F 689	Continued From page 26 that there is no documentation showing that resident has received supervision related to wandering or interfering with others privacy or activities. She agreed that failure to provide supervision puts the resident at risk for accidents and injury from other residents. A record review of Admission Record revealed Resident # 85 was admitted to the facility on 3/7/2019, with diagnoses that include Unspecified Dementia, Unspecified Severity, with Other Behavioral Disturbance and Attention-Deficit Hyperactivity Disorder, Unspecified Type. A record review of Resident # 85's Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 7/24/2023, Section C, Cognitive Patterns revealed Resident #85 has a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review, and facility policy review the facility failed to post oxygen in use signage outside the	F 695	1. On 8/15/23, an □Oxygen in use□ sign was placed on the door of Resident #290□s room by Registered Nurse	9/29/23

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F 695	Continued From page 27 resident's room entrance door for one (1) of 15 residents reviewed receiving oxygen. Resident #290 Findings Include Review of the facility policy titled, "Oxygen Administration," with a revised date of February 2023, revealed, "Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration. ... Steps in the Procedure ... 2. Place an "Oxygen in Use" sign on the outside of the room entrance door. ... 3. Place an "Oxygen in Use" sign in a designated place." An observation on 08/14/23 at 11:23 AM, with Resident #290 revealed there was no oxygen (O2) signage outside the room entrance door. An observation and interview on 8/15/23 at 11:10 AM, with Registered Nurse (RN) #2, Charge Nurse, confirmed there was no O2 signage outside the room entrance door to Resident #290's room and she had not noticed this. She confirmed there should have been O2 in use signage placed outside Resident #290's room entrance door to alert all who entered the room that there was O2 in use. An interview on 8/15/23 at 11:35 AM, with the Administrator confirmed there should have been an O2 in use sign on the outside of Resident #290's room entrance door to allow all who entered his room to know there was O2 being used in the room. An interview on 8/16/23 at 08:30 AM, with Licensed Practical Nurse (LPN) #7, revealed the steps in the process for setting up O2 for a	F 695	Supervisor. 2. The facility determined that 22 of the 139 residents has the potential to be affected. 3. A directed in service was conducted by Nurse Educator beginning 8/23/23 on ensuring that proper signage is on the door of every room where oxygen is used. An audit was completed by Registered nurse supervisors on 8/21/23 to ensure that signage was on every resident door who receives oxygen via concentrator. 4. Beginning 9/4/23, Registered Nurse Supervisors will select three (3) residents per week for three (3) months with orders for continuous oxygen to observe that proper signage is on the door outside of that resident's room. A report will be submitted to the Quality Assurance Performance Improvement on 9/20/23 for review and recommendations then monthly for three (3) months. The Assistant Director of Nursing is responsible for monitoring and compliance.	

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F 695	Continued From page 28 resident, but she did not reveal that O2 in use signage should be placed on the outside of the room entrance door. Record review of the "Order Summary Report," for Resident #290, revealed " ... O2 at 2 liters per minute via nasal cannula continuously ... Order Status: Active; Order Date: 07/28/2023; Start Date: 07/28/2023 Record review of the "Admission Record," for Resident #290, revealed an admission date of 07/28/2023, with diagnoses of Chronic Atrial Fibrillation, Unspecified, Unspecified Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure, and Shortness of Breath. Record review of Section C on the Admission Minimum Date Set (MDS) Assessment, with an Assessment Reference Date (ARD) of August 4, 2023, for Resident #290, revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating Resident #290 is cognitively intact.	F 695		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a	F 758		9/29/23

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F 758	Continued From page 29 resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to provide a stop date for a psychotropic medication ordered	F 758	1. On 8/15/23, the order for Resident #9□s Lorazepam Concentrate was discontinued per physician directive by	

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F 758	Continued From page 30 as needed (PRN) for one (1) of four (4) residents reviewed for psychotropic medication review. Resident #9 Findings include: Review of the facility policy titled, "Psychotropic / Psychoactive Medication Policy", revised 01/2023 revealed a psychotropic drug is any drug that affects the brain activities associated with mental processes and behavior... These drugs include, but are not limited to, drugs in the following categories: (i) Antipsychotic; (ii) Antidepressant; (iii) Anti-anxiety; and (iv)Hypnotic. Other medications which affect brain activity will also be subject to psychotropic medication requirements if documented use is a substitution for a psychotropic medication rather than the approved or original indication. Policy implementation revealed residents will not receive as needed (PRN) doses of psychotropic medications unless that medication is necessary to treat a specific condition that is documented in the clinical record. The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order. Record review of Resident #9's Order Summary Report dated 8/15/23 revealed an order dated 7/29/2023 for Lorazepam Concentrate 2 milligrams (MG)/milliliter (ML). Give 0.5 ml by mouth every 6 hours as needed for Anxiety related to Anxiety Disorder, Unspecified. The order does not have a stop date. An interview, on 8/15/23 at 1:30 PM, with the Director of Nursing (DON) revealed the as	F 758	Assistant Director of Nursing Services. 2. The facility determined that all the 139 residents have the potential to be affected. 3. A directed in service was conducted by Nurse Educator beginning 8/23/23 with all Register Nurses and Licensed Practical Nurses on ensuring that all as needed psychotropics have a stop date that is 14 days after the start date and documentation for the physician justifying the need to continue the as needed psychotropic. Audits were conducted by Registered Nurse Supervisors on 8/21/23 on all as needed psychotropics to ensure all were following policy by Registered Nurse Supervisors. 1 of 6 as needed psychotropic order was need of a stop date and was corrected by Registered Nurse Supervisor. 4. Beginning 9/4/23, the Registered Nurse Supervisor will check as needed psychotropic on three (3) residents per week for three (3) months. A report will be submitted to the Quality Assurance Performance Improvement on 9/20/23 for review and recommendations then monthly for three (3) months. The Assistant Director of Nursing is responsible for monitoring and compliance.	

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needed Lorazepam should have a 14 day stop date. An assessment should be done by the doctor and if the medication is not needed it can be discontinued or reordered for a specified number of days. She stated that without a stop date the resident could continue to get the medication and it could possibly lead to dependency or side effects.

An interview, on 08/16/23 at 08:31 AM, with the Administrator (ADM) confirmed that the nursing staff should catch that there is not a stop date when they put in the order for as needed psychotropic medications.

Record review of the July and August 2023 Electronic Medication Administration Record (EMAR) revealed the resident had not received any doses of Lorazepam.

An interview, on 08/16/23 at 10:35 AM, with the Nurse Practitioner confirmed she was aware of the need for stop dates on psychotropic as needed medications. She stated that they could do better on that.

An interview, on 08/17/23 at 08:47 AM with the Director of Nursing (DON) revealed she had spoken with the nurse practitioner concerning as needed psychotropic medications and she had reviewed and corrected all of the orders that needed a stop date.

Review of the facility Admission Record for Resident #9 revealed an admission date of 7/27/23 with diagnoses that included Unspecified Dementia, Anxiety Disorder, and Cognitive Communication Disorder.

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F 758	Continued From page 32 Review of the Minimum Data Set (MDS) for Resident #9 with an Assessment Reference Date (ARD) of 8/3/23 revealed a Brief Interview for Mental Status (BIMS) score of 7 which indicated the resident had severely impaired cognition.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review the facility failed to properly thaw raw chicken for meal preparation for one (1) of three (3) kitchen tours. Findings Include Review of the facility policy titled, "Food: Preparation," with a revised date of 9/2017,	F 812	1. On 8/14/23, Dietary Manager immediately discarded the chicken from the sink. 2. The facility determined that the 139 residents have the potential to be affected. 3. A directed in service was conducted	9/29/23

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F 812	Continued From page 33 revealed "Policy Statement: All foods are prepared in accordance with the FDA Food Code. Procedures: ... 5. The Cook (s) thaws frozen items that requires defrosting prior to preparation using one of the following methods: ... Completely submerging the item under cold water (at a temperature of 70 degrees F (Fahrenheit) or below) that is running fast enough to agitate and float off loose ice particles." An observation, during the initial tour, on 08/14/23, at 10:14 AM revealed a clear bag containing raw chicken in a metal strainer in the double-sided sink to thaw. The chicken was not observed to be submerged in a pan of cold water and was not under a stream of cold running water. The strainer holding the chicken was not under the faucet and was located near the front wall of the sink. An observation and interview on 8/14/23 at 10:20 AM, with the Dietary Kitchen Aide #2, confirmed the clear bag of raw chicken was thawing in the sink in a strainer near the front wall of the sink. She shared the proper way to thaw raw meat was to stop up the sink, place the raw meat in the sink, fill the sink with water, and let the meat sit in the water until it thaws. An observation and interview on 8/14/23 at 10:23 AM, with Assistant Dietary Manager #3, confirmed the clear bag of raw chicken was in a strainer placed at front wall of the sink to thaw for meal preparation. She confirmed that raw meat was to be thawed in a deep pan that will allow it to be submerged in cold water, while a constant stream of cold water is running over it into the pan. She noted the raw chicken was not being properly thawed in the sink.	F 812	by the District Manager on 8/14/23 on proper thawing procedures and protocol with all dietary staff. 4. Beginning 9/4/23, Dietary Manager will observe three (3) thawing procedures for Potentially Hazardous Food (PHF) per week for the next three (3) months. A report will be submitted to the Quality Assurance Performance Improvement on 9/20/23 for review and recommendations then monthly for three (3) months. The Director of Nursing is responsible for monitoring and compliance.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YAZOO CITY REHABILITATION AND HEALTHCARE CENTER	925 CALHOUN AVENUE YAZOO CITY, MS 39194

(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 812	Continued From page 34 An observation and interview on 8/14/23 at 10:30 AM, with the Dietary Manager #1, confirmed the clear bag of raw chicken was in a strainer at the front wall of the sink, that there was no cold water running over it, and it was not thawing properly. She added that she had placed the clear bag of raw chicken in the strainer for thawing, was aware she should have submerged it in a deep pan of cold water and placed it under a constant stream of running water. The Dietary Manager revealed she was aware that thawing raw meat the wrong way could cause a resident to get sick. An interview on 8/16/23 at 02:00 PM, with the Administrator, confirmed the raw chicken was not thawed correctly and improper thawing of raw meat could be a possible health hazard for the residents. Record review of the Dietary Department In-services revealed "Healthcare SERVICES GROUP Associate In-Service Record ... Date 5-13-23 ... Topic: Correct Thawing Methods ... Thawing in the sink: the frozen item must be completely submerged under cold water, at a temperature of 70 degrees F or below, that is running fast enough to agitate and float off loose ice particles."	F 812		