STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255105	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Tupelo	2273 South Eason Boulevard Tupelo, MS 38804

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide dignity to residents, as evidenced by leaving urinary catheter bags uncovered for two (2) of four (4) residents with a catheter. Resident #52 and Resident #190. Findings include: A review of the facility policy, Resident's Rights and Quality of Life dated 05/01/2012, revealed . all residents have the right to a dignified existence, self-determination, and communication with an access to people and services inside and outside the facility. Resident #52 An observation on 09/16/24 at 9:25 AM and again at 10:25 AM, revealed Resident #52 lying in bed, with the bed against the right wall. Resident #52's urinary catheter bag and tubing were exposed with approximately 100 cc (cubic centimeters) of urine in the catheter bag with no privacy covering over the urinary drainage bag. An observation and interview on 09/16/24 at 3:15 PM with the Assistant Director of Nurses (ADON) revealed all urinary catheter bags are to always be in a covered privacy bag. She confirmed that the urinary catheter bag without a privacy bag is a dignity issue, and the resident should have had a privacy bag over it when it was observed uncovered this morning. A record review of Resident #52's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses including Seizures, Urinary Tract Infection, and cognitive communication deficit. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/20/24, revealed under Section H- Bladder and Bowel That Resident #52 had an indwelling catheter. 45598 Resident #190 (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/16/24 at 9:45 AM, an observation in Resident #190's room, revealed a catheter bag hanging on the left side of the bed with no privacy bag covering and it was observed with 350 milliliters (mls) of yellow urine in the drainage bag and it was facing the door. On 09/16/24 at 10:30 AM an observation and interview with Resident #190 revealed a urinary catheter bag hanging on the left side of the bed facing the doorway with no privacy bag in place. There was yellow urine draining into the catheter bag. Resident #190 revealed that therapy staff wheeled her down the hall to physical therapy with the uncovered catheter bag attached to her wheelchair nearly every day. Resident #190 revealed that she worried that other people would stare at her catheter and she stated, It makes me feel nasty. On 09/16/24 at 11:08 AM, an interview with Registered Nurse (RN) Unit Manager revealed that she walked through the facility this morning, saw that Resident #190's catheter bag was not in a privacy bag. RN Unit Manager revealed that having a urinary catheter bag uncovered was a privacy issue and that all catheter bags should be covered. On 09/17/24 at 10:15 AM, an interview with Director of Nursing (DON), revealed that all urinary catheter drainage bags should be covered due to privacy and dignity issues that it may cause the resident. She agreed that not having a privacy bag over Resident #190's urinary catheter bag was a dignity issue. On 09/16/24 at 10:20 AM, an interview with Physical Therapy Assistant (PTA), revealed that she had Resident #190 on her caseload and she received therapy services five days a week. PTA revealed that she transported Resident #190 to therapy in her wheelchair and that she hadn't paid much attention to her catheter bag. She revealed that she normally took the catheter bag from the bed, hooked it on the wheelchair and just went with it during transport to therapy. PTA agreed that transporting a resident with a catheter bag without a privacy bag was a dignity issue and the bag should be covered. She revealed that she would make sure from now on that all catheter bags were covered before transport to therapy. Record review of Resident #190's Admission Record revealed an admitted [DATE] and that she had diagnoses that included Obstructive and Reflux of Uropathy, Rhabdomyolysis, and Paraplegia. Record review of Resident #190's MDS with ARD of 09/13/24 under Section C revealed a BIMS Score of 14 which indicated that she was cognitively intact. Section H revealed that she had an indwelling catheter.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44804 Based on resident and staff interview, record review and facility policy review the facility failed to ensure that all residents were made aware of the resident council meetings each month in order to make the choice to attend (Resident #27 and Resident #50) for two (2) of 16 residents reviewed. The facility also failed to resolve grievances for seven (7) of eight (8) resident council meetings. CROSS REFERENCE F804??????? Findings Include: Review of the facility policy titled Resident Council with an effective date of 5/1/12 revealed under Procedure . #4. Activity Director/SS Designee will provide written answers to questions, requests and grievances to the Resident Council. #5. The Activity Director/SS Designee shall communicate to all residents when and where resident council meetings are held . Record review of the Resident Council Meeting minutes confirmed that food concerns were discussed in the minutes for 9/24, 8/24, 7/24, 6/24, 5/24, 3/24 and 2/24. Food and menu concerns were mentioned and no resolution to the grievances. An interview and record review on 9/16/24 at 10:00 AM, with Residents #27 and Resident #50, Resident #27 stated that the food is terrible and that she has received hashbrowns before that were still frozen inside. She stated that when she ask for an alternate meal then she gets the same meal. Resident #50 confirmed that the same thing had happened to her and that she has complained to the aides, but that's all she knows to tell because that's who brings the meals in to her. Resident #27 stated the chicken is too hard to chew. They both agreed that they never know when the Resident Council Meetings are and Resident #50 stated that she has been here three (3) years, and she has been to one meeting. Resident #27 stated that she has never heard of a Resident Council Meeting. A review of the activities calendar in the resident's room revealed there was no Resident Council Meeting scheduled for September 2024 . An interview and record review on 9/16/24 at 10:10 AM with the Activities Director revealed that she had a Resident Council Meeting on 9/11/24, but confirmed it was not on the September Activities Calendar. She stated that sometimes she is not able to put it on the calendar because she has to coordinate with the dietary manager because they have complaints about food a lot. She revealed when she is not able to put the Resident Council Meetings on the Activities Calendar, then she puts it on a flyer and hangs it in the hall by the large activities calendar. She admitted that if residents did not see the flyer, then the only way they would know when the meeting was scheduled would be by word of mouth from other residents and staff. An interview on 9/16/24 at 10:03 AM, with Resident #43 confirmed that the chicken taste like it's been cooked for weeks and is too hard to chew. He stated he has gone to the cook's multiple times and complained, but nothing has improved. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 9/16/24 at 12:30 PM, with Social Services confirmed that they have had a lot of complaints about the food, wanting a different menu or extra seasoning. She stated she handles grievances but food complaints from the Resident Council Meetings usually do not get put on a grievance form. She stated that she thinks dietary handles the complaints about the food but stated that she wasn't sure. An interview on 9/17/24 at 10:50 AM, with Resident #79 revealed the food is terrible and he has complained about it to the aides and the business office person and the dietician. He stated that the dietician has come and talked with him more than once, but nothing has improved. He stated that he usually does not get food that he likes. An observation of the lunch meal on 9/17/24 at 12:44 PM, revealed that Resident #27 received a hamburger steak with gravy, fried potatoes and a roll. The hamburger patty was approximately an 1/8 inch thick, and the brown gravy was watery and poured over the top of the hamburger patty. An interview on 9/17/24 at 3:00 PM, with the Activities Director revealed that she had not informed all residents of the meeting with the state surveyor for today. She stated that she had just let whoever was at the activities at 2:30 PM stay if they wanted. She stated that she started to put a flyer out but didn't. During the resident council meeting held on 9/17/24 at 3:05 PM Resident #25 revealed the food is terrible and she has complained about it in Resident Council before, but nothing has improved. Resident #3 confirmed they have complained about the food in Resident Council Meetings as well but have not gotten any resolution to their grievances. An interview on 9/17/24 at 3:40 PM, with the Administrator confirmed that all residents should be made aware of the time and date that the Resident Council Meetings are being held, because this is their home and that is their right to participate. She stated that complaints during the Resident Council Meetings do not necessarily get put on a grievance form. She revealed that if for example it was a complaint about the food then the dietary department would meet with the resident or residents that complained. An interview on 09/18/24 at 8:25 AM, with the Administrator confirmed that food has been a concern for a while. We met once a month for a while, but when the dietary manager went out on maternity leave in 3/2024 that committee dwindled away. She stated that residents were allowed to come to the meetings when they had them. An interview on 9/18/24 at 9:30 AM, with the Dietary Manager and the District Dietary Manager they confirmed they have had complaints about food for a while. The Dietary Manager stated that some of the complaints they have received have been wanting the menu changed, too many potatoes, not liking the chicken. The District Dietary Manager revealed most of the complaints have just been personal preferences by the residents. She stated that she was off on maternity leave from 3/24 through 5/24 and confirmed that the food committee meetings that were being held once a month stopped after she left on maternity leave. She admitted that she has gotten complaints from the resident council meetings and if she does not attend then the Activities Director just verbally tells her who complained and what it was about. She revealed that she then goes and talks to that resident. She revealed that she still gets repetitive complaints about food. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 9/18/24 at 11:00 AM, with the Administrator confirmed that food complaints have been ongoing and should have been resolved by now and confirmed that this issue was an unresolved grievance. Record review of the Grievance Log for the last six (6) months revealed there was one grievance regarding disliking the food for Resident #25 on 5/20/24 and that the resident had requested a peanut butter and jelly sandwich with each meal. An interview on 09/19/24 at 8:51 AM, with Resident #25 confirmed she has complained about the food for a long time and recalls filing a grievance in 5/2024. When asked if she was getting her peanut butter and jelly sandwiches with every meal, she stated, I don't know what you are talking about, I don't want all those sandwiches. She stated that she had not received sandwiches of any kind with meals and doesn't want sandwiches. She stated her grievance was about the food and it has not been resolved as of yet. She confirmed that she just picks around on the food and stated, Have you tried it?, If so, then you know what we are going through. Record review of Resident #3's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Cerebral Palsy. Record review of Resident #3's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/3/24 revealed under Section C a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident is cognitively intact. Record review of Resident #25's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Hypertensive Heart Disease without Heart Failure. Record review of Resident #25 MDS with an ARD of 8/6/24 revealed under Section C a BIMS score of 08, which indicated the resident is moderately cognitively impaired. Record review of Resident #27's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Type 2 Diabetes Mellitus. Record review of Resident #27's MDS with an ARD of 7/25/24 revealed under Section C a BIMS score of 15, which indicated the resident is cognitively intact. Record review of Resident #43's Admission Record revealed he was admitted to the facility on [DATE] with medical diagnoses that included Alzheimer's Disease. Record review of Resident #43's MDS with an ARD of 7/23/24 revealed no score for his BIMS score in Section C. Record review of Resident #50's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Chronic Obstructive Pulmonary Disease. Record review of Resident #50's MDS with an ARD of 9/13/24 revealed under Section C a BIMS score of 15, which indicated the resident is cognitively intact. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #79's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Chronic Kidney Disease, stage 3. Record review of Resident #79's MDS with an ARD of 7/15/24 revealed under Section C a BIMS score of 14, which indicated the resident is cognitively intact.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44804 Based on staff and resident interviews, record reviews, and facility policy reviews, the facility failed to ensure advance directives were addressed or correct for three (3) of the 22 sampled residents. Resident #43, Resident #63, and Resident #84 Findings Included: Record review of facility policy titled, Advance Directives, dated [DATE], revealed, Policy Statement, (Proper Name) recognizes the dignity and value of each Resident's right to make health care decisions and to be fully informed of his or her complete health status. Furthermore, (Proper name) recognizes the right of each Resident to issue Advance Directives regarding his or her health care . 8. (Proper name) will provide education and training to its staff regarding its policies and procedures regarding Advance Directives. Resident #43 Record review of Resident #43's Mississippi Physician Orders for Sustaining Treatment (POST) for Advance Directives dated [DATE] revealed Do Not Resuscitate (DNR). The resident did not sign his Advance Directive on admission and the residents Brief Interview for Mental Status (BIMS) score was 09 in ,d+[DATE]. An interview on [DATE] at 3:15 PM, with Minimum Data Set (MDS) Nurse #1 and #2 agreed that if Resident #43 wanted to be a Full Code status then he should be able to make that decision. MDS Nurse #1 stated that the resident did not have a BIMS score on his most recent MDS BIMS because he refused to answer. An interview on [DATE] at 10:30 AM, with Resident #43 revealed he was unaware what DNR (Do Not Resuscitate) meant. The resident stated, What does that mean? Informed the resident that would mean Cardiopulmonary Resuscitation (CPR) would not be performed if needed. He stated, Why?' He confirmed he did not want to be a DNR, that he wanted to have CPR done if he needed it. He stated, Keep me alive if they can. An interview on [DATE] at 11:58 AM, with Social Services revealed that when the resident was first admitted he was very confused and hallucinating, but his cognition has improved and he should be able to make that decision for himself. An interview on [DATE] at 12:10 PM, with the Administrator confirmed that the resident can make medical decisions for himself and he has before. She stated for example that he has requested to go to the emergency room (ER) for different issues and we have sent him. An interview on [DATE] at 3:15 PM, with MDS Nurse #1 and #2 agreed that if Resident #43 wanted to be a Full Code status then he should be able to make that decision. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on [DATE] at 11:10 AM, with the Administrator confirmed that the resident could have been asked after his cognition improved if he wanted to still be a DNR. She stated that they discuss his code status in his care plan meetings but does not think they explained to him what a DNR meant. She revealed that they went to him yesterday and clarified that he wanted to be a full code, and his advance directive/code status was updated. Record review of Resident #43's Admission Record revealed he was originally admitted to the facility on [DATE] with medical diagnoses that included Alzheimer's Disease. Under Advance Directive: DNR. Record review of Resident #43's MDS with an Assessment Reference Date (ARD) of [DATE] revealed no score for his BIMS score in Section C. Resident #63 Record review of Resident #63's Mississippi Physician Orders for Sustaining Treatment (POST) Effective date [DATE] revealed that under Cardiopulmonary Resuscitation (CPR), the resident had chosen Do Not Attempt Resuscitation (DNR), which the Resident signed on [DATE] and the physician signed on [DATE]. During an interview on [DATE] at 11:40 AM, Certified Nurse Aide (CNA) #2 revealed that to find out if a resident is a full code or DNR, we look at the kiosk in the hallway to see their code status. She revealed that, according to the kiosk, Resident #63 is a full code. She revealed that if I went into the resident's room and saw that he wasn't breathing, I would start CPR since I am CPR certified. In an interview on [DATE] at 11:55 AM, Resident #63 revealed that when he was first admitted to the facility, he had signed to be a DNR. He revealed that he now wants to be a full code. He revealed when I first came into the facility, I felt like really there was no hope; he revealed now I can see some improvement and would rather be resuscitated. In an interview on [DATE] at 3:45 PM, the Assistant Director of Nurses (ADON) confirmed that according to his written advance directive, he is supposed to be a Do Not Resuscitate (DNR). She confirmed that the electronic system revealed that he was a full code. She confirmed that the advance directives did not match, and they should. In an interview on [DATE] at 9:25 AM, Licensed Practical Nurse (LPN) #1 revealed she is the admissions nurse and stated, I remember talking with Resident #63 when he was admitted to the facility; he was very sick, and he wanted to be a DNR. She revealed when it was brought to her attention yesterday by the ADON, she went and spoke with Resident #63, and he revealed to her that when he came in, he was sick and wanted to be a DNR, but now he felt he was getting better and wanted to change his status to full code. She revealed that I guess it was just a missed error on our part to make sure the advance directives matched. In an interview on [DATE] at 11:20 AM, the ADM revealed that the Advance Directive Consent Form the resident chose and signed on admission did not match what was in the electronic system and that Resident #63 was able to make his own decisions. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review Resident #63's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included Hypertensive heart disease, Hypokalemia, and Cerebral Infarction without residual deficits. Under Advance Directive: Full Code Record review of Resident #63's MDS with an ARD of [DATE], revealed the resident had a BIMS of 15 and was cognitively intact. Record review of Resident #63's MDS with an ARD of [DATE] revealed that the resident refused to recall words and stated that he was not doing the assessment. Staff interview: After standing and talking to the resident for 5 minutes, he was able to recall that I was there to conduct a memory assessment and repeated that he was not participating. Resident #84 A record review of Resident #84's Mississippi Physician Orders for Sustaining Treatment (POST) revealed only the resident's name and date of birth. The POST form was incomplete and did not reflect Resident #84's advance directives. The consent form had a physician's signature with a date of [DATE] and was signed by LPN #1 for the professional preparing the form. In an interview on [DATE] at 3:52 PM, with ADON, she confirmed that the resident's advance directive was not filled out but did have a doctor's signature on it. She revealed, I honestly can't tell what his code status is by looking at this because it is blank. In an interview on [DATE] at 9:40 AM, LPN #1 confirmed that the consent form for Resident #84 was signed by the Physician Assistant on [DATE]. She revealed that she didn't know what happened with this consent form or why the advance directive was not filled out for the resident and confirmed that it was done in error. In an interview on [DATE] at 11:25 AM, the ADM revealed that the physician doesn't pre-sign any forms. She revealed that when she spoke with the admissions nurse last night, she had stated she had, in error, slid the blank POST form in with the admission paperwork, and it was signed. She confirmed that his code status had not been addressed with the resident upon admission and revealed it was a careless error. Record review of Resident #84's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included Malignant neoplasm of prostate and Hyperlipidemia. Record review of Resident #84's MDS with an ARD of [DATE], under Section C revealed a BIMS score of 14, indicating that the resident was cognitively intact. 46013

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 44804 Based on observation, staff interview and facility policy review the facility failed to ensure resident information was kept confidential and not accessible to the public for one (1) of four (4) survey days. Findings Include: Review of the facility policy titled, Resident Rights and Quality of Life with an effective date of 5/1/2012 revealed under, The resident has the right to .personal privacy and confidentiality of personal and clinical records. An observation on 9/16/24 at 9:04 AM, revealed a medication cart sitting outside the dining room door leading to the B Hall with a visible list of resident names, room numbers, code status and if they were on hospice or dialysis laying on top of the medication cart for anyone to see. An interview and observation on 9/16/24 at 9:06 AM, with the Assistant Director of Nurses (ADON) confirmed the resident list of names was visible on top of the medication cart and would be a violation of the resident's privacy. She stated that the nurse should have put it away so that it could not be seen. She revealed the medication cart was Licensed Practical Nurse (LPN) #2 and she was not sure where she was. An interview and observation on 9/16/24 at 9:10 AM, revealed that LPN #2 walked from the other side of the facility to the medication cart and confirmed that she had left a list of resident names with room numbers and code status laying face up and visible on top of her medication cart. She stated that she had went to get some more medications and leaving the residents names visible would be a privacy issue. She confirmed the list of names should have been put away so no one could see it. An interview on 9/18/24 at 3:02 PM, with the Director of Nurses (DON) confirmed that the residents names and information should not have been left on top of the medication cart and confirmed that was a violation of the resident's privacy and personal information. Review of the list of resident names that was visible on top of the medication cart included all residents on the B Hall, which equaled 22 and four residents from the A Hall. This list included the resident's names, code status, room number and if they were hospice or dialysis.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, resident and staff interviews, statement on facility letterhead and facility policy review, the facility failed to maintain a clean and safe environment, as evidenced by a dirty wheelchair, (Resident #71) and electrical wires exposed on a bed control (Resident #12) for two (2) of the 22 residents sampled residents. Findings Include: A review of the statement on facility on letterhead signed by the Administrator and dated September 18, 2024, revealed, (Proper Name) utilizes the Embrace Program for our wheelchair cleaning and inspection of bed controls and electrical connections. A review of the facility policy titled Resident's Right and Quality of Life, dated May 1, 2012, revealed, A resident has the right: to receive services in a facility environment that is safe, clean, and comfortable . Resident #12 On 09/16/24 at 10:10 AM, an observation revealed Resident #12's electric bed control in disrepair and laying beside her in bed on her right side. The cord was frayed, and it had an area that measured approximately one-half inch with red, yellow, brown, blue, and black wires exposed. On 09/17/24 at 3:07 PM, an interview with Certified Nursing Assistant (CNA) #5, confirmed that Resident #12's bed control cord was torn with wires exposed and she revealed that she hadn't noticed it before. She revealed that this was an electrical fire hazard and needed to be fixed. CNA #5 revealed that anytime they noticed an issue like that, they reported it to maintenance, and they got right on it. On 09/17/24 at 3:10 PM, an interview with Registered Nurse (RN) Unit Manager, confirmed that Resident #12's bed control cord was frayed and had wires exposed. She revealed that this was a safety hazard, and she would put a work order in for maintenance to fix it. On 09/17/24 at 3:55 PM, an interview with Resident #12 revealed that the bed control cord had been torn since she had been at the facility and stated, That's been over a year. She also revealed that she was concerned that the exposed wires might burn her or cause a fire. On 09/17/24 at 4:00 PM, an observation and interview with Maintenance Supervisor, confirmed the exposed wires on the cord of Resident #12's bed control. He revealed that the wires were coated, and they were low voltage but if the covering came off and the wires touched, the resident could get a little tinge from it. Record review of Resident #12's Admission Record revealed an admitted [DATE] and that she had diagnoses that included Type 2 Diabetes Mellitus, Chronic Kidney Disease, and Need for Assistance with Personal Care. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #12's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/05/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that she was cognitively intact. Resident # 71 On 9/16/24 at 9:25 AM, an observation revealed Resident #71's wheelchair base and wheel spokes with a thick, grayish-dried substance and food crumbs on the wheelchair base. An observation on 9/17/24 at 9:05 AM, revealed Resident #71 sitting in the smoking area in a wheelchair with a thick, grayish-dried substance and food crumbs on the wheelchair base. In an interview on 9/17/24 at 10:50 AM, Resident #71 revealed that his wheelchair is filthy and needs to be cleaned. During an interview on 9/17/24 at 11:05 AM, Certified Nurse Aide (CNA) #1 revealed he normally works the night shift, and they are responsible for cleaning the wheelchairs; there's a list we follow to ensure all the wheelchairs get cleaned. An interview and observation on 9/17/24 at 11:15 AM, the Assistant Director of Nurses (ADON) revealed that the night shift is responsible for cleaning the wheelchairs. She confirmed that Resident #71's wheelchair was dirty and appeared covered in dirt and food particles. She revealed the wheelchair should have been cleaned. A record review of Resident #71's Admission Record revealed he was admitted to the facility on [DATE] with diagnoses that include Cerebral infarction and Need for Assistance with Personal Care. A record review of Resident #71's MDS with an ARD of 07/23/24, revealed a BIMS score of 14, which indicated the resident is cognitively intact. 46013

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 44804 Based on staff interview, record review and facility policy review, the facility failed to ensure that a new employee had a background check completed prior to working for one (1) of five (5) new employee personnel records reviewed. Findings Include: Review of the facility policy titled, (Facilities Proper Name) Background Check Policy with a revision date of 2/13/17 revealed under, Policy .It is the policy of (Facilities Proper Name) Management Services, as part of its hiring procedures, to conduct criminal background checks on all applicants offered employment to support workplace productivity, safety and security. Record review of Registered Nurse (RN) Unit Manager's personnel file revealed she was hired by the facility on 8/13/24 and her background check was completed on 6/10/22 and was outdated. An interview on 9/19/24 at 11:10 AM, with the Administrator confirmed that new staff's background checks have to have been done within the last two years. She stated we have called to see if we could get a more up to date one but have not received an answer. An interview on 9/19/24 at 12:00 PM, with the Assistant Director of Nurses (ADON) revealed that the purpose of a background check is to make sure there are no allegations or disqualifying events that would prevent the staff member from working at this facility. An interview on 09/19/24 12:51 PM, with Human Resources confirmed that she knew that the background check needed to be within 2 years of hire and failed to realize RN Unit Manager's was out of date.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47874 Based on observation, resident and staff interview, record review, facility policy review, the facility failed to implement a comprehensive care plan related to Activity of Daily Living (ADL) for Resident #58, Resident #59 and for Resident #22 for smoking . For three (3) of 22 care plans reviewed. Findings Include: Facility policy titled, Care Plans, with no date, revealed, Care plans will be developed for all patients and residents based upon the Resident Assessment Instrument (RAI) manual guidelines. Care plans are developed by the interdisciplinary team and revised as needed according to resident and patient status or change. Resident #22 Record review of Resident #22's Care Plans with a date initiated of 5/29/21 revealed , Focus: At risk for smoking related injury related to: Smokes independently .Interventions .Observe patient for unsafe smoking behaviors or attempts to obtain smoking material from outside sources. Immediately inform facility management. Patient is not to have cigarettes or smoking material on person During an observation of Resident #22 on 9/16/24 at 10:00 AM, revealed he was lying in bed. with a cigarette box lying at the foot of the bed in a white and blue pack. Resident #22 revealed he was a smoker and stated, They don't let us keep cigarettes in our rooms. There's not anything in the pack. The box contained 1 cigarette and one-half (1/2) of a used cigarette butt. During an interview with the Administrator on 9/18/24 at 2:40 PM, revealed, the purpose of the care plan was to provide the necessary care and to allow staff to know how to care for the resident. An interview with the Assistant Director of Nursing (ADON) on 9/19/24 at 8:49 AM, confirmed Resident #22's care plan was not followed. Record review of the Admission Record revealed the facility admitted Resident #22 on 2/24/24 with a medical diagnosis that included Personal history of nicotine dependence. Resident #58 Record review of Resident #58's Care Plan revealed that he had an ADL self-care performance deficit r/t (related to) contractures, decreased mobility with interventions initiated on 04/01/24 that included, BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. An observation and interview on 09/16/24 at 10:50 AM with Resident #58 revealed long jagged fingernails approximately one-half to three-fourths inch long on his bilateral hands. Resident #58 stated, They're slow on checking fingernails. He revealed that his shower days were Tuesday, Thursday, and Saturday and he confirmed that they did not take care of his nails like they were supposed to. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation and interview on 09/17/24 at 11:27 AM, with Certified Nursing Assistant (CNA) #2 in Resident #58's room confirmed that he had long jagged fingernails on both hands and that his fingernails should be cut. On 09/18/24 at 9:10 AM, an interview with Minimum Data Set (MDS) Coordinator, revealed that they developed care plans to drive the care needed for the residents. She revealed that the care plans were patient specific. On 09/18/24 at 9:35 AM, an interview with Licensed Practical Nurse (LPN) #2, revealed that the Certified Nursing Assistants were supposed to check fingernails with every bath and as needed. She agreed that nail care was included in the care plan and if they left their fingernails long and dirty, they did not follow the care plan. An interview with Administrator (ADM) on 09/18/24 at 11:15 AM, confirmed that nail care was included in Resident #58's care plan and agreed that the staff did not follow the care plan for nail care. Record review of Resident #58's Admission Record revealed an admitted [DATE] and that he had diagnoses that included Cervical Disc Disorder with Myelopathy, Need for Assistance with Personal Care, and Muscle Weakness. Record review of Resident #58's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/01/24 under Section C revealed a Brief Interview for Mental Status Score (BIMS) of 15 which indicated that he was cognitively intact. Under Section GG revealed that he required partial to moderate assistance with showering and bathing himself and required substantial/maximal assistance with personal hygiene. Record review of Resident #58's Task Care Record revealed that a staff member signed that he received his shower on Saturday evening, 09/14/24. Resident #59 Record review of Resident #59's Care Plan initiated on 06/13/24 revealed that he had self care deficit related to history of CVA (Cerebrovascular Accident), decreased functional abilities, hemiplegia to left nondominant side, weakness. Interventions included, Nail, hair, and oral care daily and as needed and Provide cueing, supervision, and assistance with ADLs as needed. An observation and interview on 09/16/24 at 10:40 AM, with Resident #59 revealed long jagged fingernails on both hands and he had three fingernails on his right hand with brown substance underneath. He revealed that the aides helped with his baths every other day but they had not checked his fingernails in a while. Resident #59 revealed that he couldn't see that well and he needed help to keep them cleaned and trimmed. On 09/18/24 at 11:20 AM an interview with Administrator (ADM) revealed that nail care was included in Resident #59's care plan and she agreed that they did not follow their care plan for nail care. Record review of Resident #59's Admission Record revealed an admitted [DATE] and that he had diagnoses that included Hemiplegia, Cerebral Infarction, and Generalized Muscle Weakness. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #59's MDS with ARD of 09/09/24 under Section C revealed a BIMS Score of 15 which indicated that he was cognitively intact. Section GG revealed that he required setup or clean up assistance with personal hygiene needs. Section B revealed that his vision was highly impaired. Record review of Resident #59's Task Care Record revealed that a staff member signed that he received his shower on Monday evening, 09/16/24. 45598

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47874 Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to ensure that a resident's comprehensive care plan was revised and updated for one (1) of 22 sampled residents. Resident #33 Findings Include: Record review of the facility policy titled, Care Plans with a revision date of 10/21 revealed under, Policy: . Care plans are developed by the interdisciplinary team and revised as needed according to resident and patient status or change. An observation of Resident #33 on 9/16/24 at 9:38 AM and on 09/17/24 at 8:30 AM revealed, she was lying in bed with a raised perimeter air mattress intact to the bed. An interview with the Director of Nursing (DON) on 9/17/24 at 10:30 AM revealed, Resident #33 had a raised perimeter air mattress to keep her from rolling out of the bed. Record review of Resident #33's Fall Care Plan revealed, the care plan was not revised to add the secured perimeter air mattress. An interview with the Administrator (ADM) on 9/18/24 at 2:40 PM, revealed the purpose of the care plan was to provide the necessary care and to allow staff to know how to care for the resident. She confirmed the care plan should have been revised to add the mattress to the fall prevention care plan. Record review of the Admission Record revealed the facility admitted Resident #33 on 12/4/20 with a medical diagnosis that included Huntington's Disease.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 47874 Based on resident and staff interview, record review, and facility policy review, the facility failed to follow nursing standards of practice for a resident with a physician order for intravenous (IV) antibiotics for one (1) of 22 sampled residents. Resident #20 Findings Include: Record review of a typed statement on facility letterhead, dated September 19, 2024, and signed by the Administrator revealed (Proper name of facility) does not have a policy on Standards of Practice. Record review of the August 2024 Medication Administration Record (MAR) for Resident #20 revealed, an order dated 8/4/24, Meropenem Intravenous Solution Reconstituted 500 MG (milligrams) use 500 MG (milligrams) intravenously every day shift for infection Urinary Tract Infection (UTI) for 5 (five) days in sodium chloride 0.9% (percent) 100 ml (milliliters) IVPB (intravenous piggyback). The MAR was initialed as administered on 8/5/24 and 8/7/24, with no documentation to support medication was administered on 8/6, 8/8, and 8/9 with the MAR left blank. An interview with Resident #20 on 9/19/24 at 8:35 AM, revealed she could not recall if she had an IV (intravenous therapy) recently or if she got all her IV antibiotics for the full 5 days. An interview and record review with the Registered Nurse (RN) Unit Manager #3 on 9/19/24 at 8:55 AM, revealed she would have been the nurse responsible for giving Resident #20's IV (intravenous therapy) antibiotic on 8/6/24, 8/8/24, or 8/9/24. RN Unit Manager #3 reviewed the MAR and confirmed it was not initialed as given. She revealed she would not have documented it under the progress notes. She stated, I know it was given. She confirmed that without documentation, it was not done. Record review of the Progress Notes for Resident #20 revealed, there was no documentation that the resident received the IV medication Meropenem for the dates of 8/6/24, 8/8/24, or 8/9/24. An interview with Licensed Practical Nurse (LPN) #5 on 9/19/24 at 11:00 AM revealed, Resident #20 returned from the hospital with a physician order for IV antibiotics for a UTI. She confirmed the antibiotic ordered on the MAR was not initialed for 8/6/24, 8/8/24, or 8/9/24 and revealed it looks like it was not done. She revealed not receiving the antibiotic could result in the infection worsening and sepsis. LPN #5 explained that the resident had a lot of urinary tract infections. An interview with the Director of Nursing (DON) on 9/19/24 at 11:26 AM, confirmed if the medication was not documented, then it was not done. She revealed it was the Unit Manager's responsibility to ensure the resident got the medication. Record review of the Admission Record revealed the facility admitted Resident #20 on 6/23/24 with medical diagnoses that included Urinary tract infection and Dependence on renal dialysis. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/9/24, revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #20 was cognitively intact.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47874 Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide the necessary assistance with Activities of Daily Living (ADL) care for a resident requiring nail care (Resident #58, #59) and incontinent care (Resident #7) for three (3) of 22 sampled residents. Findings Include: Review of the facility policy ADL's (Activities of Daily Living) dated August, 2021, revealed, Policy: Ensure ADL's are provided in accordance with accepted standards of practice, the care plan, and reasonable accommodation of the resident's choices and preferences. An observation on 9/17/24 at 8:15 AM, revealed Resident #7 was lying in bed with eyes open, alert but confused and it was noted a very strong odor of urine in the room. An observation and interview with Certified Nurse Aide (CNA) #7 on 9/17/24 at 8:18 AM, confirmed the strong odor of urine in the room and confirmed the resident was incontinent and explained that she had not made a round on the resident since her shift started at 7 AM. The CNA revealed the last round would have been done on the 11-7 shift. The CNA pulled back the top cover and checked to see if the resident was wet. An observation revealed the resident had on two (2) blue incontinent briefs. The top brief was heavily saturated in urine. CNA #7 confirmed the resident was not supposed to have on 2 briefs and agreed it gives the impression that staff were not rounding and providing incontinent care, as they should be. She revealed she normally made rounds with the 11-7 shift, but she did not do it this morning and confirmed she should have. An interview with CNA #8 on 9/17/24 at 8:22 AM, revealed they were supposed to round on the residents every 2 hours or more if needed. She revealed they were required to make rounds with the off going shift to ensure the residents were clean and dry. An interview with the Director of Nursing (DON) on 9/17/24 at 11:00 AM, revealed not providing incontinent care timely and wearing 2 briefs could cause an increased risk for skin breakdown. She explained that using 2 briefs on a resident made it look like they were not wanting to make rounds on the residents. An interview with the Administrator on 9/17/24 at 11:10 AM, revealed the aides were responsible for making rounds on the resident every 2 hours, and if the resident was a heavy wetter, they were to increase their rounds to hourly or every 30 minutes. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/13/24 revealed under, bladder and bowel in section H, Resident #7 was always incontinent of bladder. Also revealed under section GG, the resident was dependent on staff for toileting hygiene. Record review of the Admission Record revealed the facility admitted Resident #7 on 2/19/23 with a medical diagnosis of Unspecified Dementia. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #58 On 09/16/24 at 10:50 AM, an observation and interview with Resident #58 revealed long jagged fingernails approximately one-half to three-fourths inch long on his bilateral hands. Resident #58 stated, They're slow on checking fingernails. He revealed that his shower days were Tuesday, Thursday, and Saturday and he confirmed that they did not take care of his fingernails like they were supposed to. On 09/17/24 at 9:07 AM, an observation in Resident #58's room revealed long jagged fingernails on both of his hands. He revealed that he had his shower on Saturday night and revealed that they had not provided nail care. On 09/17/24 at 11:27 AM, an observation and interview with CNA#2 in Resident #58's room confirmed that he had long jagged fingernails on both of his hands. She revealed that long jagged fingernails could scratch him on his skin and cause a possible infection. On 09/18/24 at 9:35 AM, an interview with Licensed Practical Nurse (LPN) #4, revealed that the CNAs were supposed to check fingernails with every bath and as needed. On 09/17/24 at 11:45 AM, the Assistant Director of Nursing (ADON) confirmed that Resident #58's fingernails were long and jagged and needed to be cut. On 09/18/24 at 11:15 AM an interview with Administrator (ADM) revealed that nail care was supposed to be done during resident baths and showers. She revealed that the CNAs were also supposed to be checking nails every day and cleaning them as needed. She revealed that ADL concerns had been on-going and they were working on trying to fix issues. ADM confirmed that they should have identified these ADL concerns regarding the nails and fixed the problem. Record review of Resident #58's Admission Record revealed an admitted [DATE] and that he had diagnoses that included Cervical Disc Disorder with Myelopathy, Need for Assistance with Personal Care, and Muscle Weakness. Record review of Resident #58's MDS with ARD of 07/01/24 under Section C revealed a BIMS Score of 15 which indicated that he was cognitively intact. Record review of Resident #58's Task Care Record revealed that a staff member signed that he received his shower on Saturday evening, 09/14/24. Record review of Resident #58's MDS with ARD of 7/01/24 under Section GG revealed that he required partial to moderate assistance with showering and bathing himself and required substantial/maximal assistance with personal hygiene. Resident #59 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/16/24 at 10:40 AM, an observation and interview with Resident #59 revealed long jagged fingernails on both hands and he had three fingernails on his right hand with brown substance underneath. He revealed that the aides helped with his baths every other day but they had not checked his fingernails in a while. Resident #59 revealed that he couldn't see that well and he needed help to keep them cleaned and trimmed. On 09/17/24 at 11:25 AM, an interview with CNA #2 revealed that they had scheduled times for resident baths or showers and that they were supposed to check, clean and clip fingernails during that time. She revealed that personal hygiene included mouth care, nail care, peri-care and shaving. She confirmed that Resident #59's fingernails were long and jagged and should have already been taken care of. An observation and interview on 09/17/24 at 11:33 AM, with Registered Nurse (RN) #1 confirmed that Resident #59 had long jagged fingernails and brown substance underneath three fingernails on his right hand. She revealed that fingernails carried germs and could cause infection if Resident #59 scratched himself. Record review of Resident #59's Admission Record revealed an admitted [DATE] and that he had diagnoses that included Hemiplegia, Cerebral Infarction, and Generalized Muscle Weakness. Record review of Resident #59's MDS with ARD of 09/09/24 under Section C revealed a BIMS score of 15 which indicated that he was cognitively intact. Section B revealed that his vision was highly impaired. Section GG revealed that he required setup or clean up assistance with personal hygiene needs. Record review of Resident #59's Task Care Record revealed that a staff member signed that he received his shower on Monday evening, 09/16/24. 45598

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Diversicare of Tupelo	2273 South Eason Boulevard Tupelo, MS 38804

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47874 Based on observation, resident and staff interview, and facility policy review, the facility failed to ensure that a residents' environment was free from accident hazards, as evidenced by, medications left at bedside and smoking paraphernalia in rooms for two (2) of 22 sampled residents. Resident #22 and #34 Findings include: Review of the facility policy titled Safe Smoking with an effective date of 11/1/16 revealed under, Purpose: 1. To maximize our ability to provide a safe environment for all residents/patients who smoke, while taking into account non-smoking residents . Record review of a typed statement on facility letterhead, dated September 17, 2024, and signed by the Administrator revealed (Proper name of the facility) does not have a policy for Medication Left at Bedside. The center utilizes the Medication Administration Clinical Competency. An observation of Resident #22 on 9/16/24 at 10:00 AM, revealed he was lying in bed. with a cigarette box lying at the foot of the bed in a white and blue pack. Resident #22 revealed he was a smoker and stated, They don't let us keep cigarettes in our rooms. There's not anything in the pack. The box contained 1 cigarette and one-half (1/2) of a used cigarette butt. An interview with the Director of Nursing (DON) on 9/17/24 at 11:00 AM, revealed the Administrator keeps the cigarettes locked up in her office and distributes 2 cigarettes in a zip lock baggie to each resident that was going to smoke at each break. She revealed, we tell the families that the residents can't have them and if they buy them, they must leave them with the Administrator. She revealed Resident #22 did go out with a friend and could be getting them that way. The DON explained that the aides and nurses know that when they see cigarettes' or a lighter on a resident, they cannot have it. An interview with the Administrator (ADM) on 9/17/24 at 11:10 AM, revealed the facility did not allow the residents to keep smoking paraphernalia and Resident #22 knew that. She revealed the resident had one friend that he went out of the facility with, but he knew the resident could not have them. She stated, I use the honor system. I can't go into his room and search or shake him down. She confirmed the resident could set something on fire in the building by keeping smoking materials. An interview on 9/19/24 at 10:50 AM, with the ADM revealed, she spoke to Resident #22 about having cigarettes in his room and the resident stated, When I go out to smoke, I need my cigarettes. She revealed all she could do to control the issues was the honor system. She explained on the weekends, if cigarettes were brought into the facility by families, they were given to the nurses and locked up. The ADM revealed the nurses give 2 cigarettes to the aides for smoke break, so the residents do not have access to the materials. Record review of the Admission Record revealed the facility admitted Resident #22 on 2/24/24 with a medical diagnosis that included Personal history of nicotine dependence. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/10/24 revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 14, which indicated Resident #22 was cognitively intact. Resident #34 An observation of Resident #34's bedside dresser on 9/16/24 at 10:15 AM, revealed a bottle of Rolaids Antacid Ultra Strength #72 count, Magnesium 200 mg (milligrams) #60 count and a bottle of Multivitamin tablets #200 count. An interview with the resident revealed, he brought them from home and stated, I just take them when I think about it. An observation and interview with Registered Nurse (RN) #2 on 9/16/24 at 10:30 AM, revealed Resident #34 should not have medication in his room because he did not have an order to self-administer the medication. She confirmed anything could happen with the resident having bottles of medication at bedside. She revealed we could be double dosing him, causing a medication error. An interview with the ADM on 9/17/24 at 12:10 PM, revealed the facility was not aware Resident #34 had the medication in his room and was taking it. She revealed the resident did not have an order to self-administer meds, and confirmed he could potentially get overmedicated if he was receiving the same medications by the nurses. Record review of the Admission Record revealed the facility admitted Resident #34 on 1/11/24 with a medical diagnosis that included Atherosclerotic heart disease. Record review of the MDS with an ARD of 7/9/24 revealed, under section C, a BIMS summary score of 15, which indicated Resident #34 was cognitively intact.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47874 Based on observation, staff interview, record review, and facility policy review, the facility failed to ensure residents were properly assessed and consent obtained for bed rails for two (2) of 22 sampled residents. Resident #33 and #60 Findings Include: Record review of the Facility policy titled, Restraint with an effective date of 11/28/16 revealed Process: . When a patient/resident is determined to need a restraint, an evaluation will be completed at least on a quarterly basis or with a significant change in the patients/residents condition. This evaluation will assist in determining continued need or possible reduction/elimination . Resident #33 An observation of Resident #33 on 9/16/24 at 9:38 AM, revealed, she was lying in bed, arousable with one-half (1/2) side rails that were up on both sides of the bed and a raised perimeter air mattress was intact to the bed. An observation on 9/17/24 at 8:30 AM, revealed Resident #33 was lying in bed with her eyes closed with one-half (1/2) side rails up on both sides of the bed with a raised perimeter air mattress to the bed. An interview with the Director of Nursing (DON) on 9/17/24 at 10:30 AM, revealed Resident #33 was having falls, so they applied the raised perimeter air mattress. She explained the resident was not supposed to have bed rails also on her bed and revealed she was not aware that the resident did. Record review of the Clinical Health Status Evaluation revealed .Evaluation: The resident will not utilize side rails at this time . An interview with Licensed Practical Nurse (LPN) #5 on 9/19/24 at 8:15 AM, revealed Resident #33 has Huntington's disease, and the resident used to try to get up, but no longer tried due to an overall decline in her health. She revealed the resident would frequently have her head up against the rails. An interview with the Assistant Director of Nursing (ADON) on 9/19/24 at 8:49 AM revealed, a side rail consent was not signed for Resident #33's bed rails. She revealed the resident was on hospice and when they delivered a new bed it had bed rails, and the staff did not recognize that the resident was not supposed to have them, and they had failed to complete the siderail assessment. Record review of the Admission Record revealed the facility admitted Resident #33 on 12/4/20 with a medical diagnosis that included Huntington's Disease. Resident #60 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 09/16/24 at 9:40 AM and again at 10:55 AM, revealed Resident #60 lying in bed with 1/2 side rails up at the middle of both sides of the bed. An observation on 09/16/24 at 12:05 PM revealed Resident #60 lying in bed with bilateral 1/2 side rails. An observation on 09/16/24 at 3:25 PM, revealed Resident #60 lying in bed with her head covered and propped up on the right-sided bed rail. An observation on 09/17/24 at 8:44 AM and again at 3:45 PM revealed Resident #60 lying in bed with 1/2 bed rails bilaterally centered in the middle of the bed that were raised. During an interview and observation on 09/18/24 at 8:50 AM, Registered Nurse (RN) #1 revealed she was assigned to the B hall today to give medications and revealed I'm not sure if (Proper name of Resident #60) is supposed to have side rails. RN #1 looked at the computer and stated, Let's go down there and look. RN #1 confirmed that the 1/2 bed rails were positioned in the middle of both sides of the resident's bed and that the resident's bed rails were not supposed to be in that position but rather used as an enabler at the top of the bed. In an interview on 09/18/24 at 10:46 AM, the DON confirmed that Resident #60 does not have a consent for side rails and revealed they were not supposed to be positioned down the sides of the resident's bed. She revealed that the resident is bedbound but can move about in the bed. In an interview on 09/18/24 at 3:11 PM, the Administrator revealed that Resident #60 is not supposed to have her rails used in the position of a bed rail. She stated, The staff should have caught that. Record review of the Clinical Health Status Evaluation revealed .Side Rail Assessment Screen dated 8/15/24 revealed .Resident has poor safety awareness due to decreased cognitive functioning . Based upon the above assessment findings: The Resident will not utilize side rails at this time . Record review of the Admission Record revealed Resident #60 was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus, Abnormalities of gait and mobility, and Mixed Receptive-Expressive Language Disorder. 46013

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44804 Based on observation, staff interview and facility policy review the facility failed to ensure that medications were stored securely in a locked medication cart or locked storage room for two (2) of four (4) medication carts used in the facility. Findings Include Record review of a typed statement on facility letterhead, dated September 18, 2024 and signed by the Administrator revealed (Proper name of facility) does not have a policy for Storage of Medications on top of the medication cart. An observation on 9/16/24 at 9:04 AM, revealed an unattended medication cart sitting outside the dining room near the beginning of the B Hall. The top of the cart contained a medicine cup full of a red liquid, a bottle of magnesium, Colace and calcium sitting on the top of the medication cart. An observation and interview on 9/16/24 at 9:06 AM, with the Assistant Director of Nurses (ADON) confirmed there was a medicine cup full of a red liquid, and three bottles of over-the-counter medication that included magnesium, Colace and a bottle of calcium. She stated that medication should never be left out on the medication cart while there is no nurse at the cart. She stated this is to prevent other residents from ingesting the medication that could lead to an accident or harm. She revealed that this medication cart belonged to Licensed Practical Nurse (LPN) #2 and she was not sure where she was. An interview and observations on 9/16/24 at 9:10 AM, revealed LPN #2 walked from the other side of the facility to her medication cart and confirmed that there was a medicine cup full of a red liquid, a bottle of magnesium, a bottle of Colace and a bottle of calcium sitting on top of the cart. She stated that she left the medication on top of the medication cart and went to get some more medication that she needed. She revealed that the red liquid was a protein supplement. She confirmed that all medications should have been put away because anyone coming by could have taken any of the medications that were left unsecured. An interview on 9/18/24 at 9:10 AM, with the Director of Nurses (DON) confirmed that medication should never be left on top of a medication cart unattended. She stated that any resident could have come by and drank or took that medication. An interview and record review on 9/19/24 at 12:25 PM, with the DON reviewed that the facility has four medication carts in the building. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 09/17/24 at 12:40 PM, revealed Registered Nurse (RN) #1 standing at the B wing medication cart. RN #1 had medication cards in her hand. She opened the red narcotic binder and placed the medication cards inside the binder. RN #1 then closed the top of the binder, left the cart, and went down the hall. The medication card edges were visible and accessible to anyone passing the medication cart. RN #1 returned to the unattended medication cart at 12:43 PM. She confirmed four (4) medication cards, including Baclofen, Buspar, Augmentin, and Cyproheptadine, were left on the medication cart unattended and unsecured. She revealed she should not have left the medication on the cart unattended and confirmed it could have been a hazard for other residents who could have gotten into the medications. 46013

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47874 Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to serve food that met the residents' choices and failed to serve the food in an attractive and palatable manner for four (4) of twelve residents reviewed for dining. Resident #20, #27, #43, and #50. Findings Include: CROSS REFERENCE F565 Record review of the facility policy Menus revised 10/2022 revealed Menus will be planned in advance to meet the nutritional needs of the residents .6. Menus will be served as written, unless a substitution is provided in response to preference . Resident #20 An interview on 9/16/24 at 10:57 AM, with Resident #20 revealed, she did not like the food that she was served. An observation of the lunch meal on 9/16/24 at 12:50 PM revealed, Resident #20's meal ticket read, Renal and listed the foods as, Baked chicken breast on a bun, grilled cheese sandwich, garden pasta salad, green peas, apple crisp, soup, unsweetened tea 8 ounces. The food on the tray was untouched, and the resident revealed she could not eat it. Resident #20 reported the food did not look appealing and revealed she had the same thing every day. An observation of the chicken breast reveled it was thick, gray, was not moist, and did not resemble the look of a chicken breast or patty. The chicken was in between a dry bun. The garden pasta salad included mushy white noodles in sauce with green broccoli granules. An observation of Resident #20's lunch meal with the Dietary Manger (DM) on 9/16/24 at 12:55 PM, revealed the meat was a chicken breast and was cooked today. She acknowledged the garden pasta salad was mushy and revealed it should not be like that. She stated the broccoli looked that way because of the type of broccoli they used. The DM explained she was aware the resident did not like the food and revealed she had many dislikes. An observation of the lunch meal on 9/17/24 at 12:50 PM, for Resident #20 revealed, the meal consisted of steamed white rice, a bowl of green peas, a roll, peanut butter cookie and unsweetened tea. The resident was unhappy with the meal and stated, I can't just eat a pile of rice with nothing on it, and I had the same green peas yesterday. An observation and interview on 9/17/24 at 12:57 PM, of Resident #20's lunch meal with the DM revealed the lunch meal looked that way because the resident had so many dislikes. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Registered Dietician (RD) on 9/18/24 at 10:49 AM, revealed she had been working at the facility for about 3 months. She revealed the menu was given to them from corporate. The RD explained that she or the Dietary Manager update the resident preferences quarterly and on admit. The RD was made aware of the lunch meal served to Resident #20 on 9/16/24 and 9/17/24 and confirmed someone should have intervened and asked the resident about getting her something else to eat. An interview with the Director of Nursing (DON) on 9/18/24 at 2:25 PM, revealed she was aware Resident #20 refused many foods that were sent down to her. She revealed the resident did not comply with a renal diet, and the kitchen did try and accommodate for her choices by sending a grilled cheese sandwich and soup with lunch and supper. Record review of the Admission Record revealed the facility admitted Resident #20 on 6/23/24 with medical diagnoses that included urinary tract infection and dependence on renal dialysis. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/9/24, revealed, under section C, a Brief Interview for Mental Status (BIMS) summary score of 15, which indicated Resident #20 was cognitively intact. Resident #27 An interview on 9/16/24 at 10:00 AM, with Resident #27 stated the food is terrible and the chicken was too hard to chew. Resident #27 revealed that she has received hash-browns that were still frozen inside and when she ask for an alternate meal then she got the same meal. She admitted she has complained to the aides, but that's the only people she knows to tell because that's who brings the meals in. An observation and interview with Resident #27 of the lunch meal on 9/17/24 at 12:44 pm revealed the resident received hamburger steak with gravy, fried potatoes and a roll. The hamburger patty was approximately and 1/8 inch thick and the brow gravy was watery and poured over the top of the hamburger patty. She stated its not good, but at least I can chew it. Record review of Resident #27's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Type 2 Diabetes Mellitus. Record review of Resident #27's Minimum Data Set with an Assessment Reference Date of 7/25/24 revealed under Section C a Brief Interview for Mental Status score of 15, which indicates the resident is cognitively intact. Resident #43 On 9/16/24 at 10:03 AM, an interview with Resident #43 confirmed that the chicken taste like it's been cooked for weeks and is too hard to chew. He stated he has gone to the cook's multiple times and complained, but nothing has improved. An observation of the lunch meal on 9/17/24 at 12:44 PM, revealed that Resident #27 received a hamburger steak with gravy, fried potatoes and a roll. The hamburger patty was approximately an 1/8 inch thick, and the brown gravy was watery and thin and poured over the top of the hamburger patty. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #43's Admission Record revealed he was admitted to the facility on [DATE] with medical diagnoses that included Alzheimer's Disease. Record review of Resident #43's MDS with an ARD of 7/23/24 revealed no score for his BIMS score in Section C. Resident #50 An observation of the lunch meal on 9/16/24 at 12:25 PM, revealed Resident #50 stated the food is terrible and that she has received hashbrowns that were still frozen inside. Resident #50 stated that the chicken for example is cooked to where it is too hard to even chew and the food is always cold. She revealed that she has asked for an alternate when she gets something she does not like or can't chew and she does not get the alternate, she gets a replacement of the same meal. Resident #50 she has complained to the aides about the food, because that was all she knew to do. Record review of Resident #50's Admission Record revealed the resident was admitted to the facility on [DATE] with medical diagnoses that included Chronic Obstructive Pulmonary Disease. Record review of Resident #50's MDS with an ARD of 6/13/24 revealed under Section C a BIMS score of 14, which indicated the resident is cognitively intact. An interview on 09/18/24 at 8:25 AM, with the Administrator confirmed that food has been a concern for a while. We met once a month for a while, but when the Dietary Manager went out on maternity leave in March 2024 the committee dwindled away. She stated that residents were allowed to come to the meetings when they had them. On 9/18/24 at 9:30 AM, an interview with the DM and the District Dietary Manager they confirmed they have had complaints about food for a while. The DM stated that some of the complaints they have received have been about the residents not liking the chicken. She stated that she was off on maternity leave from March 2024 through May 2024 and confirmed that the food committee meetings that were being held once a month stopped after she left on maternity leave. She admitted that she still gets repetitive complaints about food. On 9/18/24 at 11:00 AM, an interview with the Administrator confirmed that food complaints have been ongoing and should have been resolved by now. 44804

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 46013 Based on observation, resident and staff interviews, and record review, the facility failed to be administered in a manner that allowed it to use its resources effectively to ensure the well-being of its residents for four (4) of the four (4) days of the survey. Findings Include This tag is cross referenced to F 565, F 677, F 689, F 761, and F 880 A review of the typed statement on facility letterhead revealed that the facility did not have an Administration Policy and was signed by the Administrator. F 565 On 9/17/24 at 3:05 PM, during the resident council meeting held Resident #25 revealed that the food is terrible. She has complained about it in the resident council before, but nothing has improved. Resident #3 confirmed that they have complained about the food in resident council meetings every month and nothing is done. Resident #25 and Resident #50 stated that they never know when the resident council meeting is going to be each month because it is not put on the monthly activity calendar During an interview on 9/17/24 at 3:40 PM, with the Administrator confirmed that all residents should be made aware of the time and date of the resident council meetings are being held, because this is their home and that is their right to participate. She stated that complaints during the resident council meetings do not necessarily get put on a grievance form. She revealed that if for example it was a complaint about the food then the dietary department would meet with the resident or residents that complained. Record review of the resident council meeting minutes confirmed that food was discussed in the resident council meeting minutes for 9/24, 8/24, 7/24, 6/24, 5/24, 3/24 and 2/24 food and menu concerns were mentioned. During an interview with the Administrator on 09/18/24 at 8:25 AM, confirmed that food had been a concern for a while. During an interview on 9/18/24 at 11:00 AM, the Administrator confirmed that food complaints have been ongoing and should have been resolved by now. F 677 Resident #7 During an observation on 9/17/24 at 8:15 AM, revealed Resident #7 was lying in bed with eyes open, alert but confused. It was noted when entering the room that there was a very strong odor of urine in the room. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview with Certified Nurse Aide (CNA) #7 on 9/17/24 at 8:18 AM, confirmed the strong odor of urine in the room. She revealed the resident was incontinent and explained that she had not made a round on the resident since her shift started at 7 AM. CNA #7 revealed the last round would have been done on the 11-7 shift. CNA #7 pulled back the top cover and checked to see if the resident was wet. An observation revealed the resident had on 2 blue briefs. The top brief was heavily saturated in urine. CNA #7 confirmed the resident was not supposed to have on 2 briefs and agreed it gives the impression that staff were not rounding and providing incontinent care, as they should be. She revealed she normally made rounds with the 11-7 shift, but she did not do it this morning and confirmed she should have. During an interview with the Director of Nursing (DON) on 9/17/24 at 11:00 AM, revealed not providing incontinent care timely and wearing 2 briefs could cause an increased risk for skin breakdown. She explained that using 2 briefs on a resident made it look like they were not wanting to make rounds on the residents. During an interview with the Administrator on 9/17/24 at 11:10 AM, revealed the aides were responsible for making rounds on the resident every 2 hours, and if the resident was a heavy wetter, they were to increase their rounds to hourly or every 30 minutes. F 689 Resident #22 During an observation of Resident #22 on 9/16/24 at 10:00 AM, revealed he was lying in bed. with a cigarette box lying at the foot of the bed in a white and blue pack. Resident #22 revealed he was a smoker and stated, They don't let us keep cigarettes in our rooms. There's not anything in the pack. The box contained 1 cigarette and one-half (1/2) of a used cigarette butt. During an interview with the Director of Nursing (DON) on 9/17/24 at 11:00 AM revealed, the Administrator keeps the cigarettes locked up in her office and distributes 2 cigarettes in a zip lock baggies to each resident that was going to smoke at each break. She revealed, we tell the families that the residents can't have them and if they buy them, they must leave them with the Administrator. She revealed Resident #22 did go out with a friend and could be getting them that way. The DON explained that the aides and nurses know that when they see cigarettes' or a lighter on a resident, they cannot have it. She stated, We cannot search the resident's room or the resident for the items. During an interview with the Administrator (ADM) on 9/17/24 at 11:10 AM revealed, the facility did not allow the residents to keep smoking paraphernalia and Resident #22 knew that. She revealed the resident had one friend that he went out of the facility with, but he knew the resident could not have them. She stated, I use the honor system. I can't go into his room and search or shake him down. She confirmed the resident could set something on fire in the building by keeping smoking materials. Resident #34 During an observation of Resident #34's bedside dresser on 9/16/24 at 10:15 AM revealed a bottle of Rolaids Antacid Ultra Strength #72 count, Magnesium 200 mg (milligrams) #60 count, and a bottle of Multivitamin tablets #200 count. An interview with the resident revealed, he brought them from home and stated, I just take them when I think about it. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview with the ADM on 9/17/24 at 12:10 PM, revealed that they (the staff) were not aware that Resident #34 had the medication in his room and was taking it. She revealed that the resident did not have an order to self-administer meds and confirmed that he could potentially get overmedicated if he was receiving the same medications from the nurses. F 761 During an observation on 9/16/24 at 9:04 AM, revealed an unattended medication cart sitting outside the dining room near the beginning of the B Hall. The top of the cart contained a medicine cup full of a red liquid, a bottle of magnesium, Colace and calcium sitting on the top of the medication cart. During an observation and interview on 9/16/24 at 9:06 AM, with the Assistant Director of Nurses (ADON) confirmed there was a medicine cup full of a red liquid, and three bottles of over-the-counter medication that included magnesium, Colace and a bottle of calcium. She stated that medication should never be left out on the medication cart while there is no nurse at the cart. She stated this is to prevent other residents from ingesting the medication that could lead to an accident or harm. She revealed that this medication cart belonged to Licensed Practical Nurse (LPN) #2 and she was not sure where she was. During an observation and interview on 09/17/24 at 12:40 PM, revealed Registered Nurse (RN) #1 standing at the B wing medication cart. RN #1 had medication cards in her hand. She opened the red narcotic binder and placed the medication cards inside the binder. RN #1 then closed the top of the binder, left the cart, and went down the hall. The medication card edges were visible and accessible to anyone passing the medication cart. RN #1 returned to the unattended medication cart at 12:43 PM. She confirmed four (4) medication cards, including Baclofen, Buspar, Augmentin, and Cyproheptadine, were left on the medication cart unattended and unsecured. She revealed she should not have left the medication on the cart unattended and confirmed it could have been a hazard for other residents who could have gotten into the medications. During an interview with the Director of Nurses (DON) on 9/18/24 at 9:10 AM confirmed that medication should never be left on top of a medication cart unattended. She stated that any resident could have come by and drank or took that medication. F 880 An observation outside Resident #20's room on 9/16/24 at 9:18 AM, revealed, the door was open. Upon entering the room, the privacy curtain was pulled in the middle of the room, and a blue and white soiled disposable bed pad could be seen lying on the floor with a dark brown substance on it. Certified Nurse Aide (CNA) #8 was assisting the resident and revealed she was helping the resident with her colostomy bag. She confirmed the bed pad was soiled and revealed it should not be placed on the floor and should be bagged and disposed of. She revealed this action could spread germs throughout the facility. An interview with the Administrator (ADM) on 9/17/24 at 12:10 PM, revealed, soiled trash should never be placed on the floor and should be placed in a bag and transported out of the room. She confirmed placing soiled trash on the resident's floor was an infection control concern. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation of the facility on 09/16/24 from 10:00 AM until 11:30 AM revealed there was one (1) EBP sign on room A4 on the A-Hall. The tour of the B-Hall revealed there were (2) signs on (2) different rooms, and no signs were observed on the C- Hall or D- Hall. During an interview on 09/16/24 3:13 PM, with Certified Nurse Assistant (CNA) #3 revealed she is not familiar with EBP. She stated she has never been told anything about it and has no idea what it means. During an interview on 09/16/24 3:24 PM, with Licensed Practical Nurse (LPN) #3 confirmed she has never heard of EBP and could only guess what it was. During an interview on 09/16/24 at 3:35 PM, with Registered Nurse (RN)/Infection Preventionist revealed she thinks enhance barrier precautions means that she would like for staff to wear gloves if there is a suspicion on an infection and if it is air born then she would want them to wear a mask. During an interview on 09/16/24 at 3:56 PM, with CNA #4 on A Hall revealed she was aware of what EBP, because she works in another facility, but has not been told anything about it at this facility. During an interview on 09/16/24 at 3:58 PM, with CNA #5 on the B Hall revealed she may have attended an in-service about EBP, but she is not certain. She stated she thinks it means that they use extra precautions for residents with a EBP sign on their door. She confirmed that if there were two residents in a room with a EBP sign then she would not know which resident was on EBP. She revealed since she would not know which resident needed EBP then she would use precautions with both. She confirmed she does not know the purpose of EBP. During an interview on 9/17/24 at 11:40 AM, with the Administrator revealed she is not sure why after in servicing two months ago that EBP that it was not known by staff and implemented or why the signs were not on the doors like they should have been. She confirmed that someone should have audited staff after the in-service and implementation of EBP to make sure it was going correctly. She revealed the purpose of EBP is to prevent the staff from giving the resident an infection and from the staff bringing an infection out and giving it to someone else. An observation of medication pass on 9/18/24 at 8:15 AM, with Licensed Practical Nurse (LPN) #6, revealed she prepared Resident #2's PEG (Percutaneous Endoscopic Gastrostomy) medication and stopped at the resident's door to read the sign posted that read, Enhanced Barrier Precautions. LPN #6 entered the room and administered Resident #2's medications via PEG tube without donning (putting on) a gown. An interview with LPN #6 on 9/18/24 at 8:35 AM, confirmed she did not put on a gown to practice EBP while administering Resident #2's medications. She revealed that she did stop and read the sign on the door, but the sign did not specify that she needed to practice precautions while giving peg (Percutaneous Endoscopic Gastrostomy) meds. LPN #6 revealed she had been in-serviced on the measures, but she must have missed the part about the need to dress out with PEG meds. She confirmed that a peg tube was considered an indwelling medical device and stated, It makes sense.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46013 Based on observations, staff and resident interviews, record review, and facility policy review, the facility Quality Assurance and Assessment (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee put into place following the recertification survey of 6/22/23. This was for deficiencies recited during a recertification survey on 9/16/24. The recited deficiencies included F 550, F565, F584, F656, F677, F689, F761, and F880. The continued failure of the facility during two state surveys indicates a pattern of the facility to sustain an effective QAA program. This was for eight (8) of 18 deficient practice citations. Findings Included: This citation is cross-referenced to: F 550, F 565, F 584, F 656, F 677, F 689, F 761, and F 880 Review of the facility policy titled Quality Assurance and Performance Improvement dated February 2017 revealed, Purpose: QAPI is a data driven, proactive approach to improving the quality of life, care and services in our centers. The activities of QAPI involve team members at all levels of the organization to identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor the effectiveness of our interventions. QAPI is consistent with our Service Standard: We continually strive to improve personal and company performance . During the recertification and complaint survey on 6/19/23 the facility was cited for F 550, F 558, F 565, F 584, F 623, F 625, F 656, F 677, F 689, F 690, F 725, F 761, and F 880. During the recertification and complaint survey on 9/16/24 the facility was cited for F 550, F 561, F 565, F 578, F 583, F 584, F 606, F 656, F 657, F 658, F 677, F 689, F 700, F 761, F 804, F 835, F 867, and F 880. During an interview on 9/18/24 at 11:30 AM, the Administrator (ADM) revealed our EMBRACE rounds, which are checklist sheets assigned to all department heads except maintenance. Our role with that program is to go out and catch the issues found and ensure they are immediately corrected. She revealed that she and the Director of Nurses (DON) have the whole building to round on and catch deficient practices. She revealed when the staff made their rounds, and they should have found the issues that the State Agents (SA) found again during this annual survey. She revealed I don't think we haven't gotten to the root cause of the issues. She confirmed she feels like the staff finds deficient practices when they do the Embrace rounds, then stated, but the follow-up is where we are missing it. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 9/19/24 at 10:55 AM, the ADM revealed, regarding the re-cited deficient practices observed again with this survey, regarding Activities of Daily Living (ADL) care is something we have to work on continually and revealed what we are doing is still not working. She revealed we are all responsible for following-up and making sure that ADL care it is being done. Everybody that sees it has a responsibility even if they are not clinical and they see issues they are to report it to the clinical team. She revealed that the facility gets so focused on filling the shifts and staffing and just the day to day running of the center that we are missing those details, we are doing big picture stuff. She revealed, We are here every day, and we get kind of numb to it. I don't think it would be fair to say that it is only the floor staff that gets numb to it, all of us including myself and the DON have been in and out of rooms and should be catching these issues. The Administrator confirmed, there is a disconnect somewhere and revealed, while we are monitoring for a period of time we see improvement, but when we stop monitoring and following-up we start seeing complacency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 44804 Based on observation, staff interviews, record review and facility policy review, the facility failed to fully implement Enhanced Barrier Precautions (EBP) precautions and failed to follow infection control measures while providing resident care for two (2) of four (4) survey days that had the potential to affect 11 residents on EBP and Resident #2 and Resident #20. Findings Include Review of the facility policy titled, Policies and Practices - Infection Control with an effective date of 11/1/17 revealed .Policy Statement: This center's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections . Record review of a typed statement on facility letterhead, dated September 18, 2024 and signed by the Administrator, revealed (Proper name of facility) uses the CDC (Centers of Disease Control) guidelines for the implementation of Enhanced Barrier Precautions. An observation of the facility on 09/16/24 from 10:00 AM until 11:30 AM revealed there was one (1) EBP sign on room A4 on the A-Hall. The tour of the B-Hall revealed there were (2) signs on (2) different rooms, and no signs were observed on the C- Hall or D- Hall. An interview on 09/16/24 3:13 PM, with Certified Nurse Assistant (CNA) #3 revealed she is not familiar with EBP and stated she has never been told anything about it and has no idea what it means. An interview on 09/16/24 3:24 PM, with Licensed Practical Nurse (LPN) #3 confirmed she has never heard of EBP and could only guess what it was. An interview on 09/16/24 at 3:35 PM, with Registered Nurse (RN)/Infection Preventionist revealed she thinks enhance barrier precautions means that she would like for staff to wear gloves if there is a suspicion on an infection and if it is air born then she would want them to wear a mask. An interview on 09/16/24 at 3:56 PM, with CNA #4 on A Hall revealed she was aware of what EBP is because she works in another facility, but has not been told anything about it at this facility. An interview on 09/16/24 at 03:58 PM, with CNA #5 on the B Hall revealed she may have attended an in-service about EBP, but she is not certain. She stated she thinks it means that they have to use extra precautions for residents with a EBP sign on their door. She confirmed that if there were two residents in a room with a EBP sign on the door, then she would not know which resident was in EBP. She revealed since she would not know which resident needed EBP then she would use precautions with both and confirmed she does not know the purpose of EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview and observation on 09/17/24 at 11:05 AM, with CNA #2 revealed she was performing incontinent care on a resident on the C- Hall that had a EBP sign on their door. On interview she stated that they in serviced her yesterday about EBP and why it needs to be done. She stated that she did not know about EBP prior to yesterday, but now they have signs on the resident's doors that need it and to wear a gown and gloves when performing care. An interview on 09/17/24 at 11:10 AM with RN/Infection Preventionist confirmed that an in-service was done with the employees one on one yesterday. She admitted that additional residents were added for EBP after she learned more about it and signs were put on their doors. An interview on 9/17/24 at 11:20 AM, with the Director of Nurses (DON) stated that they did an in-service on EBP two months ago. She stated that they had a different infection control nurse then and knows that she put signs on the resident's doors and educated the staff. She confirmed that more than three resident rooms should have had signs for EBP. She stated that the actual follow-up to the in-service auditing performance would have been done by the infection control nurse that was here when we implemented it. She agreed she should have been aware that it was not being implemented and felt like the infection control nurse would have told her. An interview on 9/17/24 at 11:40 AM with the Administrator confirmed she is not sure why after in servicing two months ago that EBP was not known by staff and implemented or why the signs were not on the doors like they should have been She confirmed that someone should have audited staff after the in-service and implementation of EBP to make sure it was going correctly. She revealed the purpose of EBP is to prevent the staff from giving the resident an infection and from the staff bringing an infection out and giving it to someone else. Record review of a typed list of residents on EBP dated 9/17/24 and signed by the Administrator revealed on 9/16/24 upon the State Agency (SA) entrance to the facility there were four (4) residents listed on EBP. On 9/17/24 the list was revised and included 11 residents listed on EBP. Resident #20 An observation and interview outside Resident #20's room on 9/16/24 at 9:18 AM, revealed the door was open. Upon entering the room, the privacy curtain was pulled in the middle of the room, and a blue and white soiled disposable bed pad could be seen lying on the floor with a dark brown substance on it. Certified Nurse Aide (CNA) #8 was assisting the resident and revealed she was helping the resident with her colostomy bag. She confirmed the bed pad was soiled and revealed it should not be placed on the floor and should be bagged and disposed of. She revealed this action could spread germs throughout the facility. An interview with the Administrator (ADM) on 9/17/24 at 12:10 PM, revealed soiled trash should never be placed on the floor and should be placed in a bag and transported out of the room. She confirmed placing soiled trash on the resident's floor was an infection control concern. Resident #2 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of medication pass on 9/18/24 at 8:15 AM, with LPN #6, she prepared Resident #2's PEG (Percutaneous Endoscopic Gastrostomy) medication and stopped at the resident's door to read the sign posted that read, Enhanced Barrier Precautions. LPN #6 entered the room and administered the residents' medications via PEG tube without donning (putting on) a gown. An interview with LPN #6 on 9/18/24 at 8:35 AM, confirmed she did not put on a gown to practice enhanced barrier precautions while administering Resident #2's medications. She revealed that she did stop and read the sign on the door, but the sign did not specify that she needed to practice precautions while giving PEG meds. LPN #6 revealed she had been in-serviced on the measures, but she must have missed the part about the need to dress out with peg meds. She confirmed that a peg tube was considered an indwelling medical device and stated, It makes sense. An interview with the Director of Nursing (DON) on 9/18/24 at 9:10 AM, confirmed staff should be using EBP with the medications given by feeding tube and revealed the staff have all been in-serviced on that. Record review of the Admission Record revealed the facility admitted Resident #2 on 5/19/23 with medical diagnoses that included Unspecified dementia and Encounter for fitting and adjustment of other gastrointestinal appliance and device. 47874