STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255106	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brandon Nursing and Rehabilitation Center	355 Crossgate Blvd Brandon, MS 39042

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41680 Based on interviews, record review and facility policy review, the facility failed to ensure residents who smoked were allowed to exercise their right to smoke during the facility's designated smoking times for two (2) of 38 residents who smoke. Resident #6 and Resident #27 Findings Include: Review of the facility's policy titled, Resident [NAME] of Rights, dated 1/23, revealed, Each resident has a right to a dignified existence, self-determination, and communication .in a manner and in an environment that promotes maintenance or enhancement of (his or her) quality of life . A. Facility residents shall have the right to: . 15. Self determination, which the facility must promote and facilitate through support of resident choice . Resident #6 During an interview on 3/11/24 at 7:39 AM, Resident # 6 stated that they were not receiving their smoking breaks as scheduled or at all. She says that they are already in a nursing home and that the staff should at least honor the smoking time. Resident #6 reports that there appears to be a lot of staff horseplaying around when it comes time to smoke so they have enough people working; they simply do not want to do it. She stated that it upsets not just her but also the other residents. She went on to say that they should be allowed to smoke when they are scheduled to. A record review of Resident #6's Face Sheet revealed she was admitted on [DATE] by the facility. Resident #6's diagnoses included Nicotine Dependence. A review of the Quarterly Minimum Date Set (MDS) with an Assessment Reference Date (ARD) of 1/23/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #6 is cognitively intact. Resident #27 (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/11/24 at 9:02 AM, resident #27 reported that workers have not consistently taken them out for their scheduled smoke breaks. He says that it can take 45 minutes to an hour for them to get out, and worse, they may not be able to go out at all during some of the breaks. When he must wait for a long time, the staff tells him that no one is available, but they are trying to find someone to take them out. However, he stated that not finding someone to take them out does not appear to be an issue because he has frequently observed numerous nurses and Certified Nursing Assistants (CNA) simply hanging out at the nurse's desk when it is time for their smoke breaks, making it difficult to think workers are unavailable. Resident # 27 complained that this is extremely frustrating because he has no control over when he can smoke and feels disrespected and unimportant. A review of the Face Sheet of Resident #27 revealed that he was admitted to the facility on [DATE]. Resident #27's diagnoses included Nicotine Dependence. A review of the Quarterly MDS with an ARD of 1/16/2024 revealed a BIMS score of 13, which indicated Resident #27 is cognitively intact. In an interview with CNA#1 on 3/12/24 at 12:34 PM, she revealed that the residents are ready to go out at the scheduled times for their smoke breaks; however, the staff is not often available to take them out. The Director of Nursing, indicated in an interview on 3/14/24 at 2:36 PM, that it is the responsibility of the Unit Managers to assign CNAs to take residents out during scheduled smoke breaks. She stated residents are often not taken when scheduled for their smoke breaks. She revealed they are working on it because she is aware of the negative impact on the residents' feelings. During an interview on 3/15/24 at 10:30 AM, with the Administrator he explained he has only been at this facility for three (3) weeks. The Administrator said he's still trying to get acclimated to this facility. The Administrator said he expects the staff to provide the residents' preferences. 48669

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 37415 Based on interviews, record review, and facility policy review, the facility failed to ensure the attending physician was notified of repeated medication refusals for one (1) of five (5) residents reviewed for medications. Resident # 159 Findings include: A record review of the facility's policy titled, Notification of a Change in a Resident's Status, dated 11/17 revealed, POLICY: The attending physician/physician extender (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist) and the resident representative will be notified of a change in a resident's condition, per standards of practice and Federal and/or State regulations . Procedure: 1. Guideline for notification of physician/responsible party (not all inclusive): . h. Repeated refusals to take prescribed medication (for two days) . 2. Document in the Interdisciplinary Team (IDT) notes: a. Resident change in condition b. Physician/physician extender notification c. Notification of responsible party. Record review of Resident #159's Physician Orders for March 2024 revealed orders for Eliquis 5 mg (milligram) tablet take one tablet by mouth in the morning and one tablet before bedtime, Depakote DR (delayed release) 250 mg tablet one tablet by mouth twice daily, Metoprolol Tartrate 25 mg tab take one tablet by mouth in the morning and 1 (one) tablet before bedtime, Cymbalta 60 mg capsule give one cap by mouth once daily, Lansoprazole DR 30 mg capsule take one tablet by mouth every morning before breakfast, Allopurinol 100 mg tablet take one tablet by mouth in the morning, Folic Acid 1 mg tablet take one tablet by mouth in the morning, Diltiazem 120 mg tablet give one (1) tablet by mouth once daily, Cymbalta 20 capsule give one cap by mouth at bedtime, Buspirone HCL 10 mg tablet take one tablet by mouth TID (three times a day), and Quetiapine Fumarate 25 mg tab give 1/2 tablet (12.5 mg) by mouth twice daily. Record review of Resident #159's February 2024 Electronic Medication Administration Record (eMAR) revealed the resident refused medications eight (8) out of 29 days for the entire month of February 2024. Record review of Resident #159's March 2024 eMAR documentation revealed the resident only took medications for three (3) of 13 days reviewed for March 2024. On 03/12/24 at 12:00 PM, during an interview with the Director of Nursing (DON), she explained a resident has the right to refuse medications. The facility's policy is the nurse charts refusal on the eMAR that the resident refused and then the nurse should document the refusal in a nursing note, notify the responsible party, and the physician. The nurse should make several attempts to get the resident to take their medications, but they cannot make the resident take them After a resident refuses medications numerous times, the nurse should notify the physician to discontinue the medications or try other approaches. If a resident is their own Responsible Party (RP), the nurse should still notify the next RP. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/24 at 2:00 PM, during an interview with the Pharmacy Consultant, he explained he does monthly reviews but does not always look at the resident's eMAR. He explained he mostly looks at the physician orders and labs. The Pharmacy Consultant revealed he does medication passes with nurses and checks medication carts frequently. He explained he was not aware that Resident #159 had been refusing medications that much and stated that missing medications could lead to additional medical concerns and complications. At 2:15 PM on 03/13/24, during an interview with Resident #159's Physician, he explained he is aware of the resident's behaviors and noncompliance with care. The Physician reviewed the resident's eMARs and reported that's a lot of missed medications. He explained he was not aware the resident was missing medications, he confirmed resident's Depakote was increased due to a low level, but he was not aware of the resident missing that many doses. He confirmed the resident is also on Eliquis twice a day and missing this medication is a significant medication and is needed to prevent further complications. He added, his Nurse Practitioner may have been notified because she is here in the facility four (4) to five (5) days a week. On 03/13/24 at 02:30 PM, during an interview with Nurse Practitioner (NP) #2, she explained she was not aware Resident #159 had missed that many medications. She has heard occasionally that the resident had refused medications but was never told after each time or reviewed the eMAR. She stated the resident does have behaviors and is noncompliant of care. She confirmed the resident is on Eliquis twice a day and that is a significant medication and missing it could cause further medical complications. She does not like to discontinue medications because sometimes the resident may take meds one day and not the other. The NP stated that the facility uses so much agency staffing, and some don't care whether they give medications or not. The NP stated It does depend on how the nurse approaches the resident and offers the medications. On 03/15/24 at 11:41 AM, during a telephone interview with Resident #159's Resident Representative (RR)/daughter, she explained she has not been notified of her mom not taking her medications. She stated it is the responsibility of the facility to ensure her mom is taken care of, is taking her medications, and to notify her of any changes. On 03/15/24 at 11:50 AM, during a telephone interview with the Behavioral Health Nurse Practitioner, he explained he sees Resident #159 monthly but was not aware the resident had refused so many medications for the last month including both his psychiatric and medical medications. He was not aware of any interventions put in place to encourage the resident to take her medications. Record review of the behavior notes (Formal name of behavioral consultant agency) with dates of services on 01/31/24 and 02/17/24, revealed there was no documentation addressing Resident #159's refusal of medications. At 1:40 PM on 03/15/24, during an interview with the Director of Nurses (DON) and the Administrator, both explained they were not aware Resident #159 had missed so many medications by refusing and confirmed there is no system in place at this time on other ways to approach resident with medications. They expect the nurse to notify the RP and physician each time a resident refused medications. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #159's Departmental Notes for February and March 2024 revealed only three (3) notes that noted the NP was notified about Resident #159 not taking medications and only one (1) note stating the RP was notified. A note dated 02/16/24 at 4:43 PM revealed . nurse has communicated with NP and management in the past and is told she always do that . RP states she wasn't aware that the resident has been refusing medications . A note dated 02/20/24 at 5:26 AM revealed .Resident said I'm not gone take no medicine . np notified . A note dated 02/22/24 at 3:35 PM revealed . resident refuses medication daily. NP notified . Record review of Resident #159's Face Sheet revealed the facility admitted the resident on 02/08/23 with diagnoses that included Metabolic Encephalopathy, Unspecified Dementia, Functional Dyspepsia, Essential (primary) Hypertension, Major Depression, Anxiety Disorder, and Unspecified Atrial Fibrillation. Record review of Resident #159's Quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 01/25/24, revealed a Brief Interview for Mental Status (BIMS) score of 6, which indicated severe cognitive impairment. Section N revealed the resident received antipsychotic, antianxiety, antidepressant, and anticoagulant medications.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 41680 Based on observations, interviews and record review the facility failed to maintain a clean, homelike environment as evidenced by the facility failing to ensure clean linen was available for two (2) of 35 sampled residents. Resident #120 and #194 Findings Include: Resident #120 During an observation and interview on 03/11/24 at 09:15 AM, Resident #120 was observed lying in bed. The room had a strong odor. Resident said he had a bowel movement and needed somebody to clean him up. The resident turned the call light on. On 03/11/24 9:45 at AM, an observation of Resident #120 revealed that the call light was turned off and the resident had not received the care he needed. The resident's brief was saturated with urine and a large amount of brown stool. During an interview on 03/11/24 at 9:50 AM, Certified Nursing Assistant (CNA) #6 revealed the facility does not have any clean sheets at this time. CNA #6 stated that she had explained to the resident that she was not going to get him up until she could get clean sheets. During an interview on 03/11/24 at 10:00 AM with the Registered Nurse (RN) #2, she stated she was told that the facility did not have any clean sheets. She said they told her they would bring some out as soon as they could. During an interview on 03/11/24 at 10:12 AM with Resident #120, he revealed he had received incontinent care but did not want to get up. Resident #120 said he was forced to sit up in the chair because the facility did not have any clean sheets available. The resident said this has happens several times a week. A record review of Resident #120's Face Sheet revealed the facility admitted the resident on 08/22/22 with diagnoses that included Seizures, Type 2 Diabetes Mellitus, and Angina Pectoris. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 01/02/24 revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated resident had severe cognitive impairment. Resident #194 On 03/11/24 at 11:06 AM, in an interview an observation of Resident #194, the resident was observed lying in bed. The bed did not have a fitted sheet on the mattress. He stated they told him they were out of sheets, he stated it happens all the time. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #194 Face Sheet revealed Resident #194 was admitted to the facility on [DATE] with diagnoses that included Paraplegia, unspecified and Stoneflies of Vertebra, Sacral and Sacrococcygeal region. Review of Resident #194's Quarterly MDS with an ARD of 02/9/24, revealed a BIMS score of 12, which indicated the resident was cognitively intact. Section GG revealed the resident used a wheelchair as mobility and required partial or moderate assistance for transfer from bed to chair. During an interview on 03/15/24 at 8:45 AM, with the Director of Nursing (DON) stated the staff has been trained on where to get the linen when its none on the hall. The DON confirmed most of the staff working in this facility are agency staff and there are different nurses and CNA's working daily. During an interview on 03/15/24 at 09:00 AM, with the Laundry Supervisor explained the facility has plenty of linen. The staff can come to laundry when there's none on the floor. The supervisor confirmed there are no laundry staff working the 11-7 shift. The staff come in at 6:00 AM. The sheets that's left in the dryer overnight should be folded and the sheets should be placed on the floor for the morning shift. During an interview 3/15/24 at 10:35 AM, with RN #4 confirmed she did an in-service with the staff about the location of the linen because the staff was using the lack of linen as an excuse not to change the resident's beds, which caused residents to stay soiled longer. However, RN #4 also confirmed most of the staff that attended the in-service no longer work for the facility. A record review of the facility's, Linen Locations In-service dated 2/14/24 through 2/22/24 revealed the staff was educated on linen is located on each unit in the linen closet. If there is no linen present, go to laundry room. If none is present linen is in the basement then call the laundry supervisor. During an interview on 3/15/24 at 11:10 AM, with the Administrator said he was told that the laundry staff that come in at 6:00 AM should load the carts with linen and place them on the floor so the CNA's will be able to provide care. The Administrator said he did not know the staff did not have linen in the morning to provide care.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 37415 Based on observations, interviews, record reviews, and facility policy review, the facility failed to resolve a resident's grievance related to Activities of Daily Living (ADL) care and shower for one (1) of 35 sampled residents reviewed for ADLs. Resident #167 Findings include: A record review of the facility's policy titled, Grievance/Missing Property dated 8/17 revealed, Purpose: To provide an opportunity for residents, resident representatives, and/or family to present concerns or grievances to the proper authorities at the facility and to receive responses to the issue(s) raised . Procedure: . 3. Social Service is responsible for notifying resident representative, family/next of kin and Ombudsman, as appropriate, of resolution. Supervisory personnel shall be responsible for notifying the resident of resolution and so indicate on grievance form. Should resolution(s) not be satisfactory and/or grievances reoccur, Social Service will notify the Grievance Official and Executive Director; and schedule a meeting with the involved parties . On 03/11/24 at 10:27 AM, during an interview Resident #167 reported she got put in here because her daughter hates the word Dementia. The resident revealed she has Dementia but has good and bad days. She stated she is supposed to get her showers on Monday, Wednesday, and Friday (MWF), but does not always get it then and she needs to have her hair washed because it's dirty and itchy. Resident #167 was observed scratching at her hair, while wearing a toboggan. On 03/12/24 at 9:28 AM, observed Resident #167 lying in bed, wearing a toboggan on her head. She explained she did not get her hair washed last night and it still itches. She is upset because it's therapy day and no one has gotten her up. At 2:00 PM on 03/12/24, during an interview with Certified Nurse Aide (CNA) #3, she explained Resident #167 gets showers on the evening shift, but sometimes the resident gets a bed bath on day shift. On 03/12/24 at 3:20 PM, during an interview with Social Services (SS) #1, she explained Resident #167's daughter usually comes and sees Resident #167 every other day. The daughter complained to her about resident's care last month in February and she filed a grievance for the daughter. The facility held an interdisciplinary team meeting including the Director of Nursing (DON), the Assistant Administrator and the new Administrator and they completed a staff in-service regarding care. She revealed she was not aware Resident #167 was still not getting showers three times a week. SS #1 confirmed the grievance is not resolved. On 03/14/24 at 03:40 PM, observed CNA #1 coming out of Resident #167's room, she explained today is the first time she has worked with the resident because she works agency and knows nothing about the resident. CNA #1 revealed she had just assisted the resident back to bed. She stated the resident did not receive a shower but, she did wipe the resident off. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/14/24 at 4:30 PM, during an interview with the Assistant Director of Nursing (ADON), she explained she had spoken to Resident #167's daughter about three (3) months ago. The ADON stated the daughter mostly talked about staff not doing their job, which included not giving the resident showers three (3) times a week. She did follow-up with the daughter, and she reported things were getting much better. The ADON revealed she was not aware Resident #167 was still not getting showers and stated she had not checked the records. She confirmed the facility has a lot of agency staffing in the building but was not aware of inconsistency in care, but if Resident #167 is still not getting showers, then the grievance is not resolved. At 5:00 PM on 03/14/24, during an interview with Registered Nurse (RN) #2, the 400 Hall Supervisor for 7-3, she explained if a resident refuses a shower, the CNA is to notify the nurse and the nurse will attempt to get resident to go to the shower, but if the resident continues to refuse, they will offer a bed bath. She explained she had not heard Resident #167 had been refusing showers or that the resident complained about not getting showers. She confirmed that according to the shower schedule, Resident #167 is scheduled to receive showers on Tuesday, Thursday, and Saturday on the evening shift. On 03/15/24 at 10:49 AM, during an interview with the Director of Nursing (DON) and Assistant Administrator, they both explained they don't remember what or when the team met with Resident #167's daughter or what the concern was about. At 11:00 AM on 03/15/24, during an interview with the Assistant Administrator, she explained Resident#167's daughter was spoken to over the phone last month regarding the quality of care the CNA's were providing but was not aware the concerns the RR voiced was still a problem. The Assistant Administrator confirmed if there is still a problem, then the grievance filed by the daughter is not resolved. On 03/15/24 at 2:37 PM, during an interview with SS #1, she explained when Resident #167's daughter complained she filed a grievance and that's all she charted. A record review of Resident #167's Face Sheet revealed the facility readmitted the resident ,on 02/05/24. Resident #167 has diagnoses that include Cerebrovascular Disease, Unspecified, Type 2 Diabetes Mellitus, Unspecified Convulsions, and Essential (primary) Hypertension. A record review of Resident #167's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/12/24, revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment. Section E revealed the resident did not reject care in the seven (7) day look back period. Section GG indicated the resident is dependent on staff for showers. Section H revealed the resident is always incontinent of bowel and bladder. A record review of Resident #167's Bathing Report for 03/01/24 through 03/12/24 revealed only three (3) bed baths during that time and no showers. A record review of Resident #167's Grievance Intake/Decision Form dated 02/12/24 revealed the daughter who is the Resident Representative expressed a grievance. The summary of the grievance revealed a concern about ADL care of her mother. The summary of pertinent findings or conclusions revealed the resident received ADL care and shower preferences updated.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 37415 Based on observation, interviews, record reviews, and facility policy review, the facility failed to ensure residents were not left soiled for extended periods of time and received incontinent care timely for one (1) of four (4) dependent residents reviewed for activities of daily living/incontinent care. Resident #167 Findings include: Record review of the facility policy Incontinent Care with a reviewed date of 1/15 revealed POLICY: To provide routine, preventive skin, perineal care to residents after an incontinent episode . On 03/11/24 at 10:27 AM, Resident #167 reported she has to wait for long periods of time to be changed especially on night shift and sometimes only gets changed once a night. On 03/12/24 at 9:28 AM, observed Resident #167 lying in bed, she reported the night shift took long periods of times to come change her last night and she stayed wet for hours again. Resident # 167 stated This happens all the time and my daughter has already spoken to the staff about it. On 03/12/24 at 2:00 PM, during an interview with Certified Nurse Aide (CNA)#3, she explained Resident #167 is total assistance for Activities of Daily Living (ADL)s and incontinent of bowel and bladder. CNA #3 stated the resident's daughter visits frequently and often complains about different things. CNA #3 revealed there are times when the resident has complained to her about the night shift not changing her and confirmed that in the past, there have been times when she has noticed the resident was soaked with urine on the first morning rounds. On 03/12/24 at 3:20 PM, during an interview with Social Service #1, she confirmed that Resident #167's daughter did complain to her about the resident's care and especially about the resident not getting changed frequently on the shift and has stayed soiled and wet for long periods of time. Social Service #1 revealed the facility held an interdisciplinary team meeting including Director of Nursing (DON), the Assistant Administrator, and the new Administrator and everyone was aware of the complaint. During an observation on 03/13/24 at 5:40 AM, during an incontinent check with the Director of Nurses (DON) revealed a strong urine and bowel movement (BM) odor noted upon entering the room. Observation revealed a pillowcase between the legs of Resident #167 that was soaked with dark colored urine and a large amount of BM. The resident reported the pillowcase was put there because of the urine dripping so much out of the brief and it takes so long for staff to change her. The resident stated she had to do something because they do not change me when I am wet. It was noted that the pillowcase was folded and placed perfectly between the resident's legs in the groin area. On 03/13/24 at 6:00 AM, during an interview with the DON, she confirmed there was the pillowcase placed between the resident's legs and that the resident was heavily soiled. She stated she does not expect any resident to have to put anything between their legs to absorb urine. The DON stated she expects staff to complete care every two hours or more frequently as needed. (continued on next page)

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/13/24 at 6:50 AM, during an interview with CNA #8, he explained the last time he changed any resident was around 3:30 AM. He stated he does not know where the pillowcase came from and did not know how it got under Resident #167. At 9:50 AM on 03/13/24, during an interview with Licensed Practical Nurse (LPN)#8, the night nurse on 400 hall, she explained she makes rounds initially when she comes on to assure all residents are in their room. She stated she makes rounds opposite of the CNAs, but she revealed her rounds are only to make sure the residents are in bed and does not check the residents for being soiled or wet. She stated she does not have time for that but expects the CNAs to change and reposition all residents who are dependent on staff for care. On 03/14/24 at 4:30 PM, during an interview with the Assistant Director of Nurses (ADON), she explained she had spoken to resident's daughter about three (3) months ago and the daughter mostly talked about her mother staying wet and soiled for long periods of time. On 03/15/24 at 10:49 AM, during an interview with the DON and Assistant Administrator, they both explained they don't remember what or when the team met with Resident #167's daughter or what the concern was about. At 11:00 AM on 03/15/24, during an interview with Assistant Administrator, she explained had spoken to Resident #167's daughter over the phone last month regarding quality of care but was not aware the concerns voiced were still a problem. She stated she expects staff to not allow residents to be left soiled or wet for long periods of time. A record review of Resident #167's Face Sheet revealed the facility readmitted the resident, on 02/05/24 with diagnoses that included Cerebrovascular Disease, Unspecified, Type 2 Diabetes Mellitus, Unspecified Convulsions, and Essential (primary) Hypertension. A record review of Resident #167's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/12/24, revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated severe cognitive impairment. Section E revealed the resident did not reject care in the seven (7) day look back period. Section GG indicated the resident is dependent on staff for showers. Section H revealed the resident is always incontinent of bowel and bladder.

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	255106	A. Building B. Wing	03/15/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 37415 Based on observations, staff interviews, record review and facility policy review, the facility failed to maintain less than a 5% medication error administration rate, as evidenced by not administering medications per physician's orders for four (4) of 33 medications administered, resulting in a 12.12% medication error rate. Findings include: A record review of the facility's policy titled Medication Errors, dated 01/15, revealed POLICY: Medication/Treatment errors shall be documented on the Medication Error Report. An error shall be defined as any variation in administration of medication from the physician's orders and/or facility policy . A record review of the facility's policy titled Enteral Tube Medication Administration Procedures, dated 06/23, revealed . Procedure: 1. Check MAR/eMAR (Medication Administration Record/electronic Medication Administration Record) . 8. Administer each medication separately, flushing tube with approximately 15 ml (milliliters) of water after each dose unless fluid restricted . On 03/12/24 at 11:15 AM, during an interview with Licensed Practical Nurse (LPN) #4, she explained resident gets all her medications through her PEG (Percutaneous Endoscopic Gastrostomy) tube and gets tube feedings starting at 3:00 PM. At 9:20 AM on 03/13/24, during an observation and interview, LPN #4 crushed Resident #118's medications and administered medications per the resident's PEG tube. The medications administered included Aspirin 81 mg (milligram), Sertraline 125 mg, Multivitamin with minerals, and Amlodipine 2.5 mg. After administering the medications, LPN #4 read the medication orders and explained the orders for these four (4) medications indicated they were to be given by mouth. LPN #4 confirmed that was incorrect, as the resident is to receive all medications per PEG tube. She confirmed she gave the medications per the resident's PEG tube. On 03/13/24 at 10:00 AM, during an interview with the Director of Nursing (DON), she reviewed the medication orders for Resident #118 and confirmed the medications were ordered to be given by mouth. As the resident has a PEG tube, she stated she would expect the nurse to clarify the orders with the physician prior to administration. The DON confirmed that any variation in administration of medications from the physician's orders would be considered a medication error. A record review of Resident #118's Physician Orders for March 2024 revealed orders with start date 11/15/23, for Amlodipine Besylate 2.5 mg tab administer one tablet by mouth every morning, Aspirin 81 mg chewable tablet give 1 tablet by mouth daily, Multivitamin with Minerals tab give 1 tablet by mouth daily, and Sertraline HCL (Hydrochloride) 125 mg tablet give 1 tablet by mouth daily.

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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. 41680 Based on observation, interviews and record review the facility failed to serve the residents food in a manner that was appealing and palatable for two (2) of 35 sampled residents. Residents #5 and #362 Findings include: Resident #5 On 03/11/24 at 08:43 AM in an interview and observation of Resident #5, the resident stated the food tastes like slop. The resident only consumed the cold cereal and milk. A record review of the Face Sheet, for Resident # 5, revealed the facility admitted the resident on 5/24/13, The resident's diagnoses included Type 2 Diabetes Mellitus and Iron Deficiency Anemia. A record review of the March 2024 Physician Orders, for Resident #5, revealed an order for a regular diet. A record review of the Annual Minimum Data Set (MDS), for Resident #5, with an Assessment Reference Date (ARD) of 1/30/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #362 During an interview on 03/11/24 at 11:13 AM, Resident #362 complained the food just tasted bad and was not very appealing. A record review of the Face Sheet, for Resident #362, revealed the facility admitted the resident on 02/21/24, with diagnoses that included Encounter for other Orthopedic Aftercare and Essential Hypertension. A record review of the March 2024 Physician Orders, for Resident #362, revealed an order for a regular diet. Record review of Admission MDS, for Resident #362, with ARD 02/28/24, revealed a BIMS score of 15, which indicated the resident was cognitively intact. On 3/12/24 at 1:00 PM, a lunch tray was tested with the Dietician. The lunch contained a hamburger patty with gravy, carrots, black-eyed peas, cornbread, and chocolate cake. The alternate meal was baked ham, scalloped potatoes, and Mexican corn. The Mexican corn, scalloped potatoes and carrots was determined to be bland. All vegetables were bland and had no taste. On 03/12/24 1:18 PM, in an interview, the Dietician stated the carrots could be a little sweeter. She stated some residents will complain of food being too salty or spicy. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/24 at 2:53 PM, Resident #362 and personal sitter explained resident ate 50% of lunch meal today. On 03/12/24 at 3:00 PM, during an interview with Certified Nursing Assistant (CNA) #3, she explained Resident #362 has complained to her about the food. CNA #3 stated the resident likes fresh fruits and vegetables and keeps these in her personal refrigerator because the resident does not like the facility's food.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47873 Based on observation, staff interviews and facility policy review, the facility failed to ensure foods were stored safely in the walk-in refrigerator, as evidenced by food stored without being labeled or dated with use-by dates and boxes of food stored on the floor in the walk-in freezer for one (1) of two (2) kitchen observations. Findings include: Record review of the facility's policy titled, Labeling and Dating Foods (Date Marking), from Health Technologies, Inc. Guidelines & Procedure Manual, 2016 Edition, revealed, Guideline: All foods will be properly labeled according to the following guidelines. Procedure: . 2. Date marking for refrigerated storage food items . Once opened, all ready to eat potentially hazardous food will be re-dated with a use by date according to current safe food storage guidelines or by the manufacturer's expiration date . 4. Prepared food or opened food items should be discarded when: The food item does not have a specific manufacturer expiration date and has been refrigerated for 7 days. The food item is leftover for more than 3 days. The food item is older than the expiration date. Record review of facility's policy titled, Food Storage (Dry, Refrigerated, or Frozen), from Health Technologies, Inc. Guidelines & Procedure Manual, 2016 Edition, revealed, Guideline: Food shall be stored on shelves in clean, dry area, free from contaminants. Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety . On 03/11/24 at 7:45 AM, during the initial tour of the kitchen with the Registered Dietician (RD) #2, an observation of the walk-in refrigerator revealed clear containers with unknown substances that were neither labeled nor dated with a use-by date. Observation of the walk-in freezer revealed containers/boxes of food stored on the floor. On 03/14/24 at 9:45 AM, during an interview, RD #1, revealed that their Dietary Manager had been out sick, however today, she had decided not to return. She revealed the facility had recently undergone a Mississippi State Department of Health (MSDH) food establishment inspection for permit to operate and had received a C rating. RD #1 noted that it is the Dietary Manager's reasonability to label and date potentially hazardous foods (PHFs). She also revealed that the organization of the freezer falls on the Dietary Manager, as well as the Dietary staff. RD #1 confirmed and that foods should not be on the floor, including food in the freezer, as it should be (six) 6 inches above the floor to prevent contamination of the food. On 03/14/24 at 9:56 AM, during an interview, RD #2 confirmed that on the initial walk through of the kitchen and observation of the walk-in refrigerator and freezer, there were clear containers with unlabeled, unknown substances that were not labeled or dated with use-by dates. The Dietician also confirmed that there were containers/boxes of food stored on the floor in freezer, which did not protect the food from contamination. She revealed that food should be stored at least 6 inches above the floor on surfaces that are clean and protected from contamination, such as splashing. RD #2 acknowledged that it is the cook's reasonability to label and date PHFs, and the Dietary Manager should ensure that foods are stored at least six (6) inches above the floor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/14/24 at 03:55 PM, during an interview with the Administrator, he revealed that his expectations for dietary staff was to follow food storage and labeling policies that they had in place. The Administrator also confirmed that the facility had undergone a MSDH food establishment inspection for permit to operate and received a rating of C. He stated the dietary staff was working to bring the C up to a B rating.