

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 06/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255142	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Ocean Springs Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1199 Ocean Springs Road Ocean Springs, MS 39564	
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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 43283 Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right for a dignified dining experience when the staff did not provide incontinence care for a resident which resulted in odors in the resident's room, causing the meal to be unappetizing, for one (1) of 22 sampled residents. Resident #38 Findings include: A review of the facility's policy Resident's Rights and Responsibilities, effective 01/07 revealed .Each nursing facility resident has a right to a dignified existence .A facility must protect and promote the rights of each resident . On 4/15/24 at 12:17 PM, during an observation in the hallway, Resident #38's call light was lit up above the door. Certified Nurse Aide (CNA) #2 walked into the resident's room, explained to the resident that it would be a minute because she was passing out meal trays, and she exited the room. There were no meal trays being served on the hall at that time. On 4/15/24 at 1:10 PM, during an interview and observation, Resident #38 was lying in bed. There was a strong odor in the room. Resident #38 explained her brief was soiled before lunch and she had asked the staff to change her. She stated the staff told her that she had to wait because the lunch trays were being passed out. She said she had to eat her lunch while wearing a soiled brief and she was uncomfortable with the odor. On 4/15/24 at 1:35 PM, in an interview and observation of Resident #38, CNA #10 and CNA #1 came into the resident's room to check on her. The resident reported to both to the CNAs that she had been sitting in a soiled brief for over an hour and had to eat lunch while she was dirty. Both reported they were not aware that the resident needed assistance before lunch trays were served. Resident #38 expressed to both CNAs that she wanted to be changed. During the incontinence care, there was a dark brown ring on the incontinence pad and the resident's brief was heavily soiled. On 4/15/24 at 2:35 PM, during an interview with CNA #2, she explained that she did not tell anyone that Resident #38 had requested and needed to have her brief changed because she had forgotten. (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 - Few	On 04/16/24 at 4:00 PM, during an interview with the Director of Nursing (DON), she explained that any staff member, including a CNA or a nurse, could assist with changing a resident and expressed that it was not acceptable for a resident to have to wear a soiled brief while eating lunch or any other time for a long period of time. She explained she expected the staff to assist the residents when they request it and to provide care every two (2) hours and as needed. On 04/18/24 at 3:30 PM, during an interview with the Administrator, he explained he expected all staff to do their job and to treat residents with dignity and respect. He would expect staff to never allow a resident to stay in a soiled brief during lunch. A record review of the Admission Record revealed the facility admitted Resident #38 on 1/12/21 with current diagnoses including Spinal Stenosis. A record review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/13/24, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 43283 Based on interviews, record reviews, and facility policy review, the facility failed to develop care plan interventions for a resident with a Urinary Tract Infection (UTI) (Resident #55) and for a resident with Substance Use Disorder (SUD) (Resident #57), and failed to implement a care plan intervention related to a low air loss mattress (Resident #261) for three (3) of 22 resident care plans reviewed. Findings include: A record review of the facility's policy Plans of Care with revision date 09/25/17 revealed . An individual person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative (s) to the extent practicable and updated in accordance with state and federal requirements . Resident #55 On 4/15/24 at 10:55 AM, during an interview, Resident #55 explained he had a UTI and was taking medication for the UTI. Record review of the Admission Record revealed the facility admitted Resident #55 on 9/1/22 and had current diagnoses including Hemiplegia and Hemiparesis following Unspecified Cerebrovascular Disease. Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/29/24 revealed Resident #55 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Section GG revealed he required total dependence for toileting hygiene and Section H revealed he was always incontinent of bowel and bladder Record review of the Order Summary Report with active orders as of 04/16/24, revealed Resident #55 had a Physician's Order, dated 4/12/24, for Bactrim DS (an oral antibiotic) for UTI until 4/26/24. Further review revealed a Physician's Order, dated 4/4/24, for Macrobid (an oral antibiotic) for acute cystitis (bladder infection) with hematuria (blood in the urine). Record review of Resident #55's Comprehensive Care Plan revealed there was no care plan with interventions developed related to the diagnosis of UTI. At 03:00 PM on 4/17/24, during an interview and review of the comprehensive care plan, the Director of Nursing (DON) confirmed Resident #55 did not have a care plan in place for UTI and that care plans should be updated when new physician orders are received. The care plan should remain in place until the issue is resolved. She stated she expected care plans to be developed to ensure residents are receiving proper care. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/24 at 3:45 PM, during an interview with Licensed Practical Nurse (LPN) #1, she stated she was responsible for resident care plans. She confirmed there was no care plan developed for Resident #55 related to his UTI and she confirmed he was currently taking antibiotic medication related to UTI. She explained the purpose of the care plan was for staff to know how to take care of the residents and she expected the staff to follow all resident care plans. Resident #57 On 4/16/24 at 9:00 AM, an interview with Resident #57's family member revealed Resident #57 had a history of alcohol abuse since he had an accident which caused him to become paralyzed from the waist down. The family member commented that the resident has been drinking more lately and felt as if he needed some help with substance abuse. The family member stated the facility had not recommended any programs or behavioral health services related to SUD. During an interview on 4/16/24 at 10:00 AM, with License Practical Nurse (LPN) #2 states, she explained that she was the care plan nurse. She confirmed Resident #57 had an alcohol abuse problem and the facility had not developed a care plan or had thought about putting interventions into place to assist the resident with SUD. A record review of the Admission Record revealed the facility admitted Resident #57 on 8/2/23 with current diagnoses including Quadriplegia and Unspecified Injury at C1 Level of Cervical Spinal Cord. A record review of the Annual MDS with an ARD of 3/20/24 revealed Resident #57 had a BIMS score of 15, which indicated he was cognitively Intact. A review of the medical record for Resident #57 revealed there was no comprehensive care plan developed with interventions related to Substance Use Disorder (SUD). Resident #261 Record review of the comprehensive care plan for Resident #261 with an initiation date of 12/08/23, revealed a Focus (Proper Name) has self-care deficits r/t (related to) needs assistance .Intervention/Tasks . THERAPEUTIC MATTRASS (mattress) . On 4/16/24 at 1:00 PM, in an interview with a family member of Resident #261, she explained she attended a care plan meeting with the facility and the Medical Doctor (MD) apologized to her during the meeting because the Resident #261 was moved from the skilled unit to the long term care (LTC) unit in January of 2024 and the facility did not move his air mattress to the new bed. On 4/17/24 at 10:00 AM, in an interview with the Director of Nursing (DON), she confirmed that when Resident #261 moved from the skilled unit to the LTC unit, the low air loss mattress that was ordered for him was not moved to his new bed. Record review of the Admission Record revealed the facility admitted Resident #261 on 9/26/23 with current diagnosis including Injury of Cervical Spinal Cord. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/2/2024 revealed Resident #261 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated he was cognitively intact.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37415 Based on interviews and record review the facility failed to ensure a resident's safety by not assessing for the risk of substance use and not developing interventions for a resident with known substance use disorder (SUD) for one (1) of 22 sampled residents. (Resident # 57) Findings include: During an interview on 4/15/24 at 1:00 PM, Resident #57 stated that he frequently signed himself out of the facility to visit a friend that lived down the street. He confirmed he used his electric wheelchair to travel beside the road to his friend's home. He commented that the facility was trying to discharge him from the facility because he enjoyed visiting his friends outside of the facility. The resident confirmed he would drink a couple of beers while visiting his friends sometimes but denied bringing alcohol or tobacco back into the facility. During an interview on 4/16/24 at 9:00 AM, Resident #57's family member revealed Resident #57 had a history of alcohol abuse since he had an accident which caused him to become paralyzed from the waist down. The family member commented that the resident has been drinking more lately and felt as if he needed some help with substance abuse. The family member stated the facility had not recommended any programs or behavioral health services related to SUD. On 4/16/24 at 10:00 AM, during an interview with License Practical Nurse (LPN) #2 states, she explained that she was the care plan nurse. She confirmed Resident #57 had an alcohol abuse problem and the facility had not developed a care plan or had thought about putting interventions into place to assist the resident with SUD. During an interview on 4/16/24 at 11:00 AM with the Director of Nursing (DON), she stated Resident #57 enjoyed leaving the facility two or three times a week on his electric scooter. The DON confirmed that he signed himself out and traveled along the side of the highway and visited his friends. During these visits, he would drink alcohol and returned to the facility impaired. The DON explained that because the resident was cognitively intact, he could make his own decisions. The DON stated Resident #57 brought alcohol and tobacco products back into the facility when he returned and would give tobacco products to the other residents. The DON confirmed the facility has not assessed or developed interventions related to the resident's alcohol abuse. The DON also stated the resident has been seen by behavioral health services previously, but those visits were not related to substance use disorder. In an interview on 4/17/24 at 2:00 PM with the Medical Director (MD), he confirmed Resident #57 should be referred to a program because he needed help dealing with alcohol abuse. The MD stated the facility did not have interventions in place to assist the resident with his behavior. A record review of the Admission Record revealed the facility admitted Resident #57 on 8/2/23 with current diagnoses including Quadriplegia and Unspecified Injury at C1 Level of Cervical Spinal Cord. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/20/24 revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively Intact.		

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F 0690 Level of Harm - 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 review, and facility policy review, the facility failed to provide incontinence care in a timely manner for six (6) of 22 sampled residents and resulted in Resident #57 having skin excoriations and Resident #55 free from wearing two (2) incontinence briefs with a current diagnosis of Urinary Tract Infection (UTI). (Residents #57, #55, #1, #8, #14, and #38) Findings include: Resident #57 On 4/15/24 at 10:00 AM, during an observation, staff were transferring Resident #57 from the bed to an electric wheelchair using a mechanical lift. On 4/15/24 at 4:00 PM, during an observation and interview, Resident #57 was in his electric wheelchair and stated that he had been up in his chair since 10:00 AM and the staff had not changed his brief since then. He explained that he usually wears two (2) incontinence briefs during the day to hold his urine because it takes several staff members to transfer him with the lift and to change him. On 4/15/24 at 4:15 PM, during an observation of incontinence care for Resident #57, Certified Nurse Assistants (CNAs) #3, #4 and #5 assisted the resident to bed. The CNAs removed two (2) briefs that were saturated with urine and soiled with bowel movement (BM). The resident's perineal area and lower buttocks were red and excoriated. During an interview on 4/15/24 at 4:30 PM, with CNA #3, CNA #4 and CNA #5, they explained Resident #57 requested two (2) briefs on dayshift staff did not want to change him and get him back up. The CNAs said they normally assist the resident to bed around 9:00 PM, provide incontinence care, and use a barrier cream on his perineal area and buttocks. An observation on 4/16/24 at 1:00 AM of incontinence care with CNA #7, CNA #12, and CNA #13, revealed Resident #57's brief was saturated with urine. He had redness and excoriations to the perineal area and his lower buttocks had excoriated areas that were bleeding. During an interview on 4/16/24 at 1:30 AM with CNA #7, CNA #12 and CNA #13 confirmed Resident #57 had excoriated areas and that the nurses had advised them to use a barrier cream. On 4/17/24 at 9:00 AM, during an interview with the Medical Director, he confirmed he had been made aware of the excoriations to Resident #57's perineal and buttock areas. The staff were in the process of transferring him to his wheelchair when he went to the resident's room to observe the areas and he was only able to see the redness and excoriations to the perineal area. He asked the wound care nurse to follow up with the excoriated areas. During an interview on 4/18/24 at 10:33 AM with the Director of Nursing (DON), she stated she was unaware Resident #57 had excoriated areas. (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	A record review of the Admission Record revealed the facility admitted Resident #57 on 8/2/23 and he had current diagnoses including Quadriplegia. A record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/20/24 revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Review of section GG revealed Resident #57 required substantial/maximal assistance with toileting hygiene. Resident #55 On 04/16/24 at 1:10 AM, during an observation and interview, Resident #55 was wearing two incontinence briefs. Licensed Practical Nurse (LPN) #2 confirmed he was wearing two briefs. Resident #55 reported sometimes the CNAs will put four (4) or five (5) briefs on him so they will not have to change him during the night. LPN #2 explained residents should not wear two briefs unless there is a specific care plan intervention to do so. She explained that wearing two briefs could cause skin breakdown and moisture associated skin damage. The CNAs should round every two hours to check on the residents, but she did not check behind them to be sure they were completing their rounds. At 1:45 AM on 04/16/24, during an interview with CNA #8, she explained she had not checked on Resident #55 this shift and the 3-11 must have applied two briefs to the resident. She reported she usually started her rounds at 12 AM but had not checked Resident #55 yet. On 04/17/24 at 11:30 AM, during an interview with Registered Nurse #2/Infection Preventionist Nurse, she explained that being left in a soiled brief for long periods of time increased the risk for UTIs and skin breakdown. Record review of the Admission Record revealed the facility admitted Resident #55 on 9/1/22 and had current diagnoses including Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease. Record review of the Quarterly MDS with an ARD of 03/29/24 revealed Resident #55 had a BIMS score of 15, which indicated he was cognitively intact. Section GG revealed he required total dependence for toileting hygiene and Section H revealed he was always incontinent of bowel and bladder. Record review of the Order Summary Report with active orders as of 04/16/24, revealed Resident #55 had a Physician's Order, dated 4/12/24, for Bactrim DS (an oral antibiotic) for UTI until 4/26/24. Further review revealed a Physician's Order, dated 4/4/24, for Macrobid (an oral antibiotic) for acute cystitis (bladder infection) with hematuria (blood in the urine). Resident #1 On 04/15/24 at 12:17 PM, during an observation and interview, Resident #1's call light was lit up and sounding. CNA #2 went into the resident's room, explained that it would be a minute because the staff were passing meals trays, and turned the light off. There were two (2) nurses sitting at the nurse's station and there were no meal trays observed on the hall. CNA #2 explained it was the policy of the facility not to change residents while meal trays were being passed out on the floor. (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	At 12:30 PM on 04/15/24, during an observation and interview, Resident #1 was eating lunch and he stated that he needed to be changed. At 1:15 PM on 04/15/24, during an observation and interview, Resident #1 was sitting in his wheelchair in his room and reported that he had not been changed. On 04/15/24 at 01:25 PM, during an observation and interview, Resident #1 left his room and went down the hallway. CNA #10 explained no one had told her that Resident #1 requested to be changed. A record review of the Admission Record revealed the facility admitted Resident #1 on 12/01/2014 and he had current medical diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction. A record review of the Annual MDS with an ARD of 01/16/24 revealed Resident #1 had a BIMS score of 15, which indicated he was cognitively intact. Section GG revealed he required maximal assistance for toileting hygiene and Section H revealed he was frequently incontinent of bowel and bladder. Resident #8 On 04/16/24 at 1:15 AM, during an observation and interview, Resident #8 was wearing two (2) incontinence briefs that were wet with urine. LPN #2 explained there should be no residents wearing two briefs at any time unless the resident has been care planned to have them. LPN #2 stated that residents wearing two incontinence briefs could cause skin breakdown or infection. On 04/16/24 at 1:45 AM, during an interview with CNA #8, she explained she had not checked on Resident #1 since the beginning of her shift at 11 PM and the double briefs must have come from the 3-11 shift. She stated she usually started her rounds at 12 AM, but she must have forgotten to check on Resident #1. Record review of the Admission Record revealed the facility admitted Resident #8 on 1/15/20 and had current diagnoses including Acute on Chronic Systolic (Congestive) Heart Failure. Record review of the Quarterly MDS with an ARD of 3/6/24 revealed Resident #8 had a BIMS score of 00, which indicated his cognition was severely impaired. Section GG revealed he required maximal assistance with toileting hygiene and Section H revealed he was always incontinent of bowel and bladder. Resident #14 On 04/16/24 at 1:05 AM, during an observation and interview, Resident #14's brief was torn off and there was BM noted on the resident. The incontinence pad underneath the resident had a brown ring. CNA #8 reported it was not unusual for the resident to tear off the brief and explained that she completed rounds on the residents at 12 AM, 2AM, 4 AM, and 6 AM. CNA #8 stated that she did not think she had checked Resident #14's brief earlier because the resident was asleep. She confirmed there was a brown ring noted to the incontinence pad and that Resident #14 had not been changed for a long period of time. (continued on next page)		

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 04/16/24 at 1:23 AM, during an interview with LPN #2, she explained that when there was a brown ring on a resident's incontinent pad, then the resident had not been changed for a long period of time. She said the CNAs should complete rounds on the residents every two (2) hours, but she did not check behind the CNAs. A record review of the Admission Record revealed the facility admitted Resident #14 on 9/3/13 with current medical diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction. A record review of the Quarterly MDS with an ARD of 3/18/24 revealed Resident #14 had a BIMS score of 00, which indicated her cognition was severely impaired. Section GG revealed she required maximal assistance for toileting hygiene and Section H revealed she was always incontinent of bowel and bladder. Resident #38 During an observation on 4/15/24 at 12:17 PM, Resident #38's call light was on and Certified Nurse Aide (CNA) #2 walked into the resident's room, explained to the resident that it would be a minute because she was passing out meal trays, and exited the room. There were no meal trays being served on the hall. During an observation and interview on 4/15/24 at 1:10 PM, Resident #38 was lying in bed and there was a strong odor in the room. Resident #38 explained her brief was soiled before lunch and she had asked the staff to change her. She stated the staff told her that she had to wait because the lunch trays were being passed out. During an observation and interview on 4/15/24 at 1:35 PM, Resident #38 reported to CNA #10 and CNA #1 that she had been sitting in a soiled brief for over an hour. Both reported they were not aware she needed assistance before lunch trays were served. During incontinence care, there was a dark brown ring on the incontinence pad and the resident's brief was heavily soiled. During an interview on 4/15/24 at 2:35 PM, CNA #2 explained she did not tell anyone that Resident #38 had requested to have her brief changed because she had forgotten. On 04/16/24 at 1:20 AM, during an interview and observation, Resident #38 reported that she had not been changed all night. LPN #2 confirmed Resident #38's brief was wet and soiled. A record review of the Admission Record revealed the facility admitted Resident #38 on 1/12/21 with current diagnoses including Spinal Stenosis. A record review of the Quarterly MDS with an ARD of 3/13/24, revealed Resident #38 had a BIMS score of 14, which indicated she was cognitively intact. During an interview with the Director of Nursing (DON), on 04/16/24 at 4:00 PM, she explained she was unaware that staff were applying two incontinence briefs on the residents. She reported that no residents should wear two briefs and she expected the staff to follow the standards of care for all residents. She explained there were enough staff on the units to assist with resident care if the CNAs were busy. She expected staff to keep residents from having to wait for long periods of time to receive assistance with incontinence care. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255142	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Ocean Springs Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1199 Ocean Springs Road Ocean Springs, MS 39564	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0690 Level of Harm - Actual harm Residents Affected - Few	43283		

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 47873 Based on staff interview, record review, and facility policy review, the facility failed to accurately submit direct care staffing information based on payroll data to the Centers for Medicare and Medicaid (CMS) as required for Quarter 1 of Fiscal Year (FY) 2023 (October - December 2023) for one (1) of five (5) quarters reviewed. Findings include: Record review of facility's policy Staffing Requirements, effective 11/30/2014, revealed, .Purpose .To provide a sufficient number of employees . A review of the Payroll Based Journal (PBJ) Staffing Data report from the Certification and Survey Provider Enhanced Reports (CASPER) database for FY Quarter 1 (October 1-December 31) revealed the Metric of Excessively Low Weekend Staffing was triggered related to .Submitted Weekend Staffing is excessively low. Record review of the facility PBJ Data entry report for October, November, and December of 2023 revealed PBJ Salaried Employee Hour Adjustments occurred for the Minimum Data Set (MDS) Staff RN and the adjustments did not occur on weekends or for any other facility salaried employees. On 4/16/24 at 2:48 PM, the Human Resource Coordinator explained the corporate office was responsible for submitting PBJ staffing data for all the facilities in the corporation and she was unaware the PBJ staffing information was inaccurate until she had reviewed the audit spreadsheet provided by the corporate office. She stated the PBJ submitted as per the audit spreadsheet did not reflect the salaried employees who had worked hourly on the weekends. She confirmed the data submitted in the first quarter of FY 2024 was not accurate because the facility utilized salary staff on weekends for coverage and this inaccuracy in reporting led to excessively low weekend staffing being triggered. She confirmed that she would not have known this information since she received no feedback of the reported information. During an interview on 4/16/24 at 2:48 PM, with Licensed Practical Nurse (LPN) #4, she stated that she was unaware the facility failed to electronically submit PBJ staffing data to CMS accurately in the first quarter of FY 2024. She confirmed that she was responsible for making the staffing schedules and during October, November, and December of 2023, salaried staff had helped to cover the schedule. The Administrator stated in an interview on 04/18/24 at 1:51 PM, that he was not aware that the facility failed to electronically submit PBJ staffing data to CMS accurately in the first quarter of FY 2024. The Administrator stated that the corporate office was responsible for submitting the PBJ staffing data for all the facilities in the corporation. He confirmed that he was knowledgeable of the importance of accurately reporting PBJ information to CMS and that it was ultimately the responsibility of the facility to ensure accuracy.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 48181 Based on staff interview, record review, and facility policy review, the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to ensure the program was sustained during transitions in leadership and failed to maintain implemented procedures and monitor the interventions the committee put into place in April 2022. This was for two (2) recited deficiencies originally cited in April 2022 on an annual recertification survey. The deficiencies were in the area of residents' rights and wounds. The facility's continued failure during two surveys shows a pattern of the facility's inability to sustain an effective QAPI Committee for two (2) of eight (8) deficient practice citations. Findings Include: A record review of the facility's policy, Quality Assurance Performance Improvement Program (QAPI), with a revision date of 10/24/2022, revealed, Policy: The Center and organization has a comprehensive, data-driven Quality Assurance Performance Improvement Program that focuses on indicators of the outcomes of care and quality of life .Program Design and Scope .Systematic Analysis and Action: The center will ensure systems and actions are in place to improve performance. 11. The Center will establish and utilize a systematic approach to identify underlying causes of problems .12. The center will develop corrective actions based on the information gathered and review effectiveness of the actions . F550: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right for a dignified dining experience when the staff did not provide incontinence care for a resident which resulted in odors in the resident's room, causing the meal to be unappetizing, for one (1) of 22 sampled residents. Resident #38 F686: Based on interviews, record review, and facility policy review, the facility failed to ensure a Pressure Ulcer (PU) intervention related to an air mattress was continued after a room change for one (1) of three (3) residents reviewed for PUs. Resident #261 A record review of the Statement of Deficiencies and Plan of Correction (Form 2567) from the previous annual survey in April 2022, revealed F550 was cited due to not covering a resident during incontinence/catheter care and F686 was cited regarding failure to provide wound care within professional standards. On 04/18/24 at 3:40 PM, an interview with the facility's Administrator, he stated he was not working for the company at the time of the recertification survey that occurred in April 2022. The Administrator confirmed he had reviewed the Form 2567 and was aware of the facility's previous citations.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43283 Based on observation, staff interview and facility policy review, the facility failed to prevent the possible spread of infection as evidenced by a nurse touching medications with her bare hand and Certified Nursing Assistants (CNAs) discarding soiled linens and briefs on the floor for three (3) of nine (9) medication and incontinence care observations. Findings include: Medication Administration Review of the facility's policy Medication- Oral Administration Of, revised 8/15/2019, revealed, Procedure . Refrain from touching powders, capsules, or pills with hands . On 04/16/24 at 8:59 AM, during a medication administration observation, Registered Nurse (RN) #3 placed a resident's pill into her ungloved hand and placed it in a medication cup. On 04/16/24 at 10:59 AM, during an interview with RN #3, she confirmed she had placed a resident's pill in her ungloved hand and then put it in a medication cup because it was easier that way. She said she knew that it was not right, and it was not the way she was trained to administer medications. She stated it was a break in infection control. On 04/17/24 at 9:45 AM during an interview with RN #2/Infection Preventionist, she revealed the facility policy on medication administration specifically speaks to not touching medications with your hands. Incontinence Care Review of the facility's policy Perineal Care, revised 9/5/17 revealed . Procedure . dispose of linen . On 4/16/24 at 1:05 AM, in an observation of incontinence care for Resident #14, CNA #8 removed a soiled brief, incontinence pad, and linens and placed them directly on the floor, without placing them in a bag. After CNA #8 completed the care, she went to retrieve a bag, and then placed all the soiled items from the floor into a bag and placed them in the dirty linen room. At 1:25 AM on 4/16/24, in an observation of incontinence care for Resident #38, CNA #8 was assisted by CNA #9. CNA #8 removed a soiled brief and discarded it directly onto the floor and not in a bag. After she completed the care, CNA #8 retrieved a bag and placed the dirty brief in a bag and placed it in the trash. At 1:35 AM on 4/16/24, during an interview with Licensed Practical Nurse (LPN) #2, she explained that dirty or soiled linens and briefs should not be placed directly onto the floor and should be contained in a garbage bag to maintain proper infection control. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/16/24 at 1:40 AM, during an interview with CNA #8, she confirmed she discarded dirty linens and briefs on the floor when providing care for Resident #14 and Resident #38. She explained she should have placed all the dirty linen in a bag while, but she got nervous and tried to hurry up and clean the residents. On 04/16/24 at 4:00 PM, during an interview with the Director of Nursing (DON), she explained she was informed of the dirty linen being placed on the floor during care and the CNA received disciplinary action. She reported that CNA #8 had been trained and had competency skills check off related to incontinence care and infection control. The DON stated that she expected the staff to follow standard practices related to infection control. On 04/17/24 at 11:30 AM, during an interview with Registered Nurse #2/Infection Preventionist Nurse, she explained that discarding soiled briefs and linens directly onto the floor was an infection control issue and even though the CNA and picked up the soiled items from the floor, the concerns were still present on the floor. 47873		