STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yazoo City Rehabilitation and Healthcare Center	925 Calhoun Avenue Yazoo City, MS 39194

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, resident and staff interviews, record review and facility policy review, the facility failed to provide a resident with a dignified existence as evidenced by leaving a urinary catheter bag uncovered for one (1) of five (5) sampled residents with urinary catheters. Resident #20. Findings Include: Review of the facility policy titled, Protocol for Keeping Catheter Bags Covered for Dignity Purposes in a Nursing Home with no revision date revealed under Objective .To maintain the dignity, privacy, and comfort of residents with catheter bags by ensuring that catheter bags are properly covered . 2. Proper Covering of Catheter Bags .Catheter bags should be covered with an appropriate, discreet cloth or garment. Record review of the facility form, Resident Rights that is provided to residents when admitted to the facility, revealed that residents were to be treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care of his personal needs . An observation on 11/12/24 at 11:19 AM, revealed Resident #20 sitting up in her wheelchair in her room watching television. There was an uncovered urinary catheter bag hooked on the wheelchair frame and there was amber urine visible. An observation and interview on 11/13/24 at 10:28 AM, with Resident #20 revealed her lying in her bed eating breakfast. There was an uncovered urinary catheter bag hanging on the bed frame with 900 milliliters of urine in the bag and it was visible from the hallway. Resident #20 revealed that it bothered her a little for her urine to be visible and stated, It makes me feel kinda icky. She revealed that she would like her catheter bag to be covered. Record review of Resident #20's Order Summary Report revealed an order effective 10/31/24 for a privacy bag or covering over urine collection bag for dignity. An interview on 11/13/24 at 10:47 AM, with Licensed Practical Nurse (LPN) #4, revealed that they usually had blue privacy urinary bags on all residents with catheters. She confirmed that Resident #20 did not have a privacy catheter bag in use and that she would get it changed out. (continued on next page)

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	An interview with Registered Nurse (RN) #2 on 11/13/24 at 10:53 AM, revealed that they used blue privacy urinary catheter bags and that the catheter bag that Resident #20 had must have come from the hospital. She confirmed that Resident #20's catheter bag did not have a privacy covering and that visible urine was a dignity issue. She also agreed that someone should have caught this and changed it. Record review of Resident #20's Admission Record revealed an admitted [DATE] and that she had diagnoses that included Malignant Neoplasm of the Uterus and Type 2 Diabetes Mellitus. Record review of Resident #20's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/30/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated that she was cognitively intact.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 41878 Based on observation, staff and resident interview, and facility policy review, the facility failed to ensure a call light device was accessible for a dependent resident for one (1) of 32 sampled residents. Resident #7 Findings include: Record review of the facility policy titled, Resident Call System, with review date of 3/28/23, revealed, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation .1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. During an observation and interview on 11/13/24 at 8:30 AM, Resident #7 stated he used the call light to receive the assistance needed for his care, but his call light was not within reach. An observation revealed the resident was lying in his bed and the call light cord was twisted around the bed frame under the foot of the resident's bed and the call light button was not within the resident's reach. On 11/13/24 at 8:33 AM, an observation and interview with Certified Nursing Assistant (CNA) #4 in Resident #7's room, when asked about the call light, she stated the staff were to ensure the light was within each resident's reach, and this one was not where the resident could reach it. Observed her untangling the cord and laying it at the foot of the bed. Registered Nurse (RN) #2 entered the resident's room and confirmed with CNA #4 that the call light was not accessible for the resident, and it should have been secured within his reach. RN #2 stated this resident was cognitive and used the light to receive the care he needed, and it was necessary for the light to be within his reach. During an interview on 11/13/24 at 2:00 PM, the Director of Nursing (DON) confirmed that the staff members were to clip the light to the bedding within the resident's reach. She acknowledged this resident was cognitive and was able to use the call light to receive care. She confirmed the facility failed to ensure the call light was accessible for this resident. Record review of Resident #7's Admission Record revealed the facility admitted the resident on 8/17/2012 with the most recent admission being 7/11/19. His diagnoses included Type 2 Diabetes Mellitus, Hypertensive Heart Disease with heart failure, Chronic Obstructive Pulmonary Disease, and Repeated Falls. Record review of Resident #7's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/20/24, revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46013 Based on resident and staff interviews, record review, and facility policy review, the facility failed to resolve grievances related to missing clothes items for four (4) of six (6) residents in the resident council meeting. Resident #15, Resident #115, Resident #124, and Resident #126. Findings include: Record review of the facility policy titled, Filing Grievances/Complaints, with a revision date of 6/2024, revealed, Our facility will assist residents, their representatives (Sponsors), other interested family members, or advocates in filing grievances or complaints when such request are made .3. All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing (if requested), including a rationale for the response . A record review of the Resident Council minutes revealed there were complaints regarding missing clothes for the meeting dates of 5/2/24, 6/4/24, 8/2/24, 9/5/24, and 11/1/24. Interviews with residents during the Resident Council meeting on 11/13/24 at 10:03 AM, revealed Resident #15 (Resident Council President), Resident #115, Resident #124, and Resident #126 had concerns that they were still missing clothes. They unanimously voiced that the discussion of missing clothes had been addressed in almost every Resident Council meeting for months. Resident #15 revealed that he has had some compression socks missing for a long time and they tell him they will replace them, but they never do. Resident #126 stated that when he was admitted he had a jogging suit that is still missing. Resident #115 revealed that the shirt she has on now had gone missing a year ago and she had just received it back. She stated that her daughters gave her some new ankle socks for Mother's Day, but she refuses to wear them because she is afraid they won't return from laundry. An interview with the Activity Director on 11/13/24 at 11:04 AM, confirmed that missing clothes has been going on for a long time and they discuss it in almost every Resident Council meeting. She stated that she notifies the Licensed Social Worker (LSW) and laundry when the issue is discussed in the meetings. She revealed that she didn't know what was going on to cause this issue and confirmed that it still had not been resolved. An interview on 11/14/24 at 8:20 AM, with Housekeeper/Laundry #6 confirmed that they do get complaints of missing clothes. She stated that she thinks the biggest issue is that laundry gets backed up and they don't put their names on their clothes. In an interview on 11/14/24 at 8:45 AM, the LSW confirmed that the laundry issue with missing clothes had been an ongoing problem. In an interview on 11/14/24 at 9:23 AM, the Administrator confirmed that missing clothing had been an issue for a while. She admitted that she had been aware of the problem and had worked on some things, but it had not been resolved Resident #15 (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Admission Record revealed that the resident was admitted to the facility on [DATE]. Record review of Resident #15's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 9-13-2024 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. Resident #115 A review of the Admission Record revealed that Resident #15 was admitted to the facility on [DATE]. Record review of Resident #115's MDS with an ARD of 9-24-2024 revealed in Section C a BIMS score of 15, which indicated the resident was cognitively intact. Resident #124 A review of the Admission Record revealed that Resident #124 was admitted to the facility on [DATE]. Record review of Resident #124's MDS with an ARD of 8-15-2024 revealed in Section C a BIMS score of 15, which indicated the resident was cognitively intact. Resident #126 A review of the Admission Record revealed that Resident #126 was admitted to the facility on [DATE]. Record review of Resident #126's MDS with an ARD of 10-10-2024 revealed in Section C a BIMS score of 14, which indicated the resident was 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** 47874 Based on staff interview and record review, the facility failed to ensure a resident's code status was accurate in the physician orders for one (1) of 40 residents reviewed for advanced directives during initial pool. Resident #135 Findings Include: The facility provided a statement on letterhead signed by the Administrator that read, This facility does not have a policy for discrepancies between advance directive and physician order. Record review of Resident #135's Consent for Cardiopulmonary Resuscitation (CPR) dated, [DATE] revealed, Decline CPR: I understand that CPR constitutes an extraordinary measure and SHOULD NOT be performed was checked and signed by Resident #135's family member. Record review of Resident #135's Physician Order Detail revealed an order dated [DATE], CPR (Cardiopulmonary Resuscitation). An interview with Registered Nurse (RN) #1 on [DATE] at 10:58 AM, revealed in case of an emergency event, the staff would check Resident #135's Electronic Medical Record (EMR) under the orders to determine the resident's code status. She confirmed, after looking at the EMR, the resident was a full code and would be resuscitated should something happen. An interview with the Admission's Coordinator on [DATE] at 11:30 AM, revealed she went over the advanced directives with Resident #135's family member, which elected for the resident to be a DNR (do not resuscitate). She revealed the physician order, and the advanced directive consent should match for the resident and families wishes to be honored in an emergency event. An interview with Social Services #1 on [DATE] at 1:14 PM, revealed if Resident #135's physician order and the advanced directive consent do not match, the resident could be resuscitated when the resident and family did not want that. Record review of the Admission Record revealed the facility admitted Resident #135 on [DATE] with a medical diagnosis of Cerebral Infarction.

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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** 30908 Based on observation, staff interview, and facility policy review, the facility failed to provide a safe, clean, comfortable, and homelike environment for two (2) of three (3) survey days. Findings include: Record review of the facility policy titled, Homelike Environment revised February 2021, revealed under the policy statement, Residents are provided with a safe, clean, comfortable and homelike environment room [ROOM NUMBER]-P An observation on 11/12/24 at 3:23 PM of room [ROOM NUMBER]-P revealed the smell of urine when standing at the bedside. An observation on 11/13/24 at 1:29 PM in room [ROOM NUMBER]-P revealed areas of a dark brown liquid scattered around the lid of the commode and multiple large areas of dark brown liquid scattered across the bathroom floor and on the resident's recliner. An observation on 11/13/24 at 2:02 PM in room [ROOM NUMBER]-P revealed had a dried dark brown substance smeared on the bathroom floor that appeared to have been attempted to be cleaned. This observation revealed the scattered dried dark brown substance remaining on the commode and recliner. An interview with Housekeeper #6 on 11/13/24 at 2:04 PM, revealed that they clean the rooms twice a day and sometimes three times. She stated that she had already been in this room twice today cleaning. She confirmed that she observed the dark brown substance that she thought was diarrhea in the room earlier. She stated, But we aren't supposed to clean that up and that the Certified Nursing Assistants (CNA) do it with housekeeping sanitizing afterwards. The housekeeper confirmed that she had already mopped the room earlier today, but she didn't mop the bathroom. An interview on 11/13/24 at 2:06 PM, with CNA #3 confirmed that the diarrhea was scattered across the bathroom floor in room [ROOM NUMBER]-P. She stated that she had attempted to clean it up from the floor, commode and recliner but that she didn't have any cleaner. She revealed that the housekeepers tell us that we have got to clean up bowel movement. An interview on 11/13/24 at 2:15 PM, with Housekeeping #1 stated that it is our policy to let the CNAs clean it up and we just go behind them and sanitize. An interview on 11/13/24 at 2:18 PM, with Housekeeping #4 and Housekeeping #1, Housekeeping #4 stated that We don't clean up bodily fluids because we don't know what the resident might have, aids, hepatitis. We haven't been trained on how to do that, we let the aids do it. Housekeeping #1 confirmed that it is not a homelike environment to allow bowel movement to stay on the floor so long that it dries. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 11/14/24 at 9:10 AM, with the Director of Nurses (DON) confirmed that her CNA's don't have chemicals to clean up bowel movement in a resident's bathroom. She stated that if they are in the room changing a resident then they are expected to clean up incontinent briefs and take out the trash, but we don't have them cleaning the resident's bathrooms up when a resident messes it up. 46013 room [ROOM NUMBER] During an initial tour on 11/12/24 at 10:10 AM, an observation in room [ROOM NUMBER] revealed a large dried brown substance smeared approximately 6 inches by 6 inches on the base of the front of the toilet bowl. During an interview and observation on 11/12/24 at 11:30 AM, CNA #2 confirmed that the front of the toilet bowl had a large area of dried feces, and it looked like it had been there for a while. CNA #2 revealed that housekeeping had just finished cleaning room [ROOM NUMBER], but housekeeping does not clean any stool up; rather, the CNAs are responsible for cleaning it. room [ROOM NUMBER] An observation on 11/12/24 at 10:20 AM and again at 2:25 PM in room [ROOM NUMBER] revealed a dark brown substance on the floor under the head of the bed. The privacy curtain was hanging off approximately (approx.) eight (8) hooks and drooped resulting in it touching the floor on the left side. An observation of room [ROOM NUMBER]'s exterior door frame revealed a thick black substance around the frame and side of the wall. An observation on 11/13/24 at 8:49 AM revealed the condition of room [ROOM NUMBER] remained the same as the prior day's observation. During an interview and observation on 11/13/24 at 1:30 PM, Housekeeper #5 confirmed that room [ROOM NUMBER] had a large dark brown substance behind the head of the bed, He stated that it was dirty and possibly from the floor waxing. He confirmed the privacy curtain was off some of the hooks and touching the floor on the left side and that there was a black substance around the bottom door frame of the exterior door and wall. He revealed the floors need good buffing and the room needs to be cleaned. 45598 room [ROOM NUMBER]-W An observation on 11/12/24 at 10:43 AM in room [ROOM NUMBER]-W revealed an air conditioner unit to the right side of the bed with multiple areas of a black substance on the upper front surface of the air flow vents and on the temperature control panel. An observation on 11/13/24 at 10:32 AM and at 11:30 AM in room [ROOM NUMBER]-W, revealed an air conditioner unit with black substance on the surface of the air flow vents across the upper front of the unit and control panel. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview with Registered Nurse (RN) Supervisor on 11/13/24 at 11:35 AM, confirmed the black substance on the front covering of the air conditioner unit and he revealed that it looked like black dirt. He revealed that it should have been cleaned by housekeeping to maintain a clean environment. He revealed that the black substance in the air vent could be breathed in and could cause a respiratory infection. An interview with Housekeeper #1 on 11/13/24 at 11:38 AM, revealed that they deep cleaned two resident rooms a day and that each resident room was deep cleaned once a month. She confirmed the black substance on the air conditioner unit and stated, It looks like black lent. She revealed that deep cleaning included bed rails, furniture, and the outer surface of the air conditioner including the air flow vents. She revealed that she didn't know when this room was last deep-cleaned and confirmed that this should have been noticed and cleaned. An interview on 11/13/24 at 2:27 PM, with Housekeeping #4 confirmed that resident rooms were deep cleaned once a month, and this included the surface of the air conditioner units. 47874 An observation at the end of the 200 hall by the exit door, on 11/12/24 at 12:04 PM revealed a large brown discolored area on the ceiling tiles that measured approximately 2-foot x 1 foot. An observation and interview with Housekeeping Supervisor #1 on 11/13/24 at 11:20 AM, confirmed the area on the ceiling and described the area as, looks like something is leaking up there. An observation and interview with Maintenance #2 on 11/13/24 at 11:26 AM revealed, the discolored area on the ceiling tile was from the air conditioning unit, which was stored above the ceiling, being stopped up and leaking. He revealed he was not aware that it had leaked onto the ceiling tiles. He confirmed the residents and visitors would expect the building to be in good repair and a homelike environment.

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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** 41878 Based on observation, resident and staff interview, record review, and facility policy review the facility failed to implement a care plan related to implementing Enhanced Barrier Precautions (EBP) (Resident #20) and performing activities of daily living (ADL) (Resident's #38 and #80) for three (3) of 30 resident care plans reviewed. Findings include: Review of facility policy titled Care Plans, Comprehensive Person-Centered, reviewed January 2023, revealed, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident . Resident #20 Record review of Resident #20's Care Plan revealed that she had a deep tissue injury to the left heel and revealed, This resident is on Enhanced Barrier Precautions and Use EBP when providing wound care . On 11/13/24 at 11:20 AM. observation and interview revealed Resident #20 had an EBP sign on their room door. Observed Licensed Practical Nurse (LPN) #4 complete wound care to Resident #20's left heel without donning a gown prior to the wound care being performed. LPN #4 revealed that she knew she was suppose to use EBP with wound care but she got nervous and forgot. She revealed that the purpose of EBP was to prevent the spread of infection, and it was to protect the residents as well as the staff. On 11/13/24 at 11:43 AM An interview with Registered Nurse (RN) #2, confirmed that Resident #20 was on EBP because she had a urinary catheter and a wound. She revealed that EBP was supposed to be followed to protect the residents from the possible spread of infection. Record review of Resident #20's Admission Record revealed an admitted [DATE] and that she had diagnoses that included Malignant Neoplasm of Uterus, Pressure - Induced Deep Tissue Damage of Left Heel, and Type 2 Diabetes Mellitus. Record review of Resident #20's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/30/24 under Section C revealed a Brief Interview for Mental Status (BIMS) Score of 14 which indicated that she was cognitively intact. Resident #38 Record review of Resident #38's care plan, date initiated 9/24/19 revealed, The resident has an ADL self-care performance deficit. Interventions included Personal hygiene: shave facial hair as requested by resident or RP (Responsible Party) as needed and Bathing/showering: check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Shave as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 11/12/24 at 12:15 PM, it was noted that Resident #38 had long, jagged nails with a brown substance noted under her nails and some facial hair. Resident #38 stated the staff would trim and clean her nails and shave her at times, but it had not been done lately. During an interview and observation with Resident #38 and the Director of Nursing (DON) on 11/13/24 at 2:20 PM, confirmed the resident needed nail care and shaved. She confirmed the facility failed to ensure the ADLs for a dependent resident was done as desired by the resident, therefore, the care plan for ADL care for this resident was not followed. During an interview on 11/13/24 at 3:40 PM, the Minimum Data Set (MDS) Director stated the care plan provided a guide for the residents' care and Resident #38 had a care plan developed for her ADL care. She confirmed the care plan related to nail care and shaving for this resident was not implemented. Record review of Resident #38's Admission Record revealed the facility admitted the Resident #38 on 9/24/19 with medical diagnoses that included Epilepsy and Intellectual Disabilities. Record review of Resident #38's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/12/24, revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. 47157 Resident #80 Record review of Resident #80' s care plan titled, The resident has an ADL self-care performance deficit r/t (related to) left side hemiparesis, Impaired balance, revealed, interventions: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse . An interview and observation with Resident #80 on 11/13/24 at 11:00 AM, revealed the residents' fingernails to be approximately three-fourths (3/4) inch long, jagged in appearance, with a thick dark brown substance under all the nail beds. He stated he could not remember the last time his nails were cut. In an interview with Licensed Practical Nurse #2 on 11/13/24 at 10:25 AM, she confirmed Resident #80's fingernails were very long, jagged and had some type of brown substance under the nails. An interview with the MDS Coordinator on 11/13/24 at 10:53 AM, revealed after review of Resident #80's ADL care plan that staff did not implement his care plan intervention related to nail care. She then revealed the purpose of the comprehensive care plan is to direct the resident specific care needed for each resident. Review of the Admission Record revealed Resident #80 was admitted by the facility on 7/12/19 with medical diagnoses that included Quadriplegia and Need for Assistance with personal hygiene. Record review of Resident #80's Section C of the MDS with an ARD of 8/15/24 revealed a BIMS score of 15, indicating the resident was cognitively intact.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255146	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Yazoo City Rehabilitation and Healthcare Center	925 Calhoun Avenue Yazoo City, MS 39194

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F 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. 41878 Based on observation, resident and staff interview, record review, and facility policy review, the facility failed to provide the necessary services to maintain grooming and personal hygiene for residents who are unable to self-perform activities of daily living (ADL's) for (2) two of 161 residents observed for ADL's. (Resident # 38 and #80) Findings include: Review of the facility policy titled, Activities of Daily Living (ADL), Supporting, revised March 2018 revealed, Policy Statement: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain grooming and personal hygiene . Resident #38 On 11/12/24 at 12:15 PM, an observation and interview revealed that Resident #38 had long, jagged nails with a brown substance under each of her nails and facial hair. Resident #38 stated the staff sometimes trim and clean her nails and shave her at times, but it's been a while. An observation and interview with Resident #38 on 11/13/24 at 2:10 PM, revealed the resident continued to have long, jagged, dirty nails and facial hair. She stated she wanted her nails to be trimmed and to be shaved and she had told some of the staff, but it had not been done. On 11/13/24 at 2:20 PM, during an interview and observation with Resident #38 and the Director of Nursing (DON) , the DON asked the resident about her nails and facial hair and the resident stated she told the staff she wanted to be shaved and have her nails trimmed, but it had not been done. The DON stated it was the responsibility of the staff to ensure nails were trimmed and clean and that the residents were shaven as they preferred since each resident needed to be cared for and happy with their appearance. She also stated the jagged nails could cause harm to the skin. She confirmed the facility failed to ensure the activities of daily living (ADL) care for a dependent resident was done as desired by the resident. Record review of Resident #38's Admission Record revealed the facility admitted the resident on 9/24/19 and diagnoses that included Epilepsy and Intellectual Disabilities. Record review of Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/12/24, revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had a moderate cognitive impairment. 47157 Resident #80 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/12/24 at 11:00 AM, an interview and observation of Resident #80 revealed the residents' fingernails to be approximately three-fourths (3/4) inch long past the tips of the fingers, jagged in appearance, with a thick dark brown substance under all the nail beds. He stated he could not remember the last time his nails were cut. He then stated he would like to have them cut and cleaned. He stated he has asked staff several times to trim his nails, but it has not been done. An observation of Resident #80's fingernails on 11/13/24 at 10:15 AM, revealed no change in the resident's fingernails. On 11/13/24 at 10:25 AM, an interview with Licensed Practical Nurse #2 she confirmed Resident #80's fingernails were very long, jagged and had some type of brown substance under the nails. She revealed that one of the concerns from the nails not being cleaned and trimmed was that he could scratch himself. On 11/13/24 at 11:00 AM, an interview with the Infection Control Nurse , she confirmed that with Resident #80's nails being long and dirty then the resident could scratch himself and possibly get a skin infection. In an interview with the Director of Nursing 11/13/24 at 2:36 PM, she revealed Resident #80 stated he wanted his nails trimmed and cleaned today. Record review of the Task Care Guide for November 2024 for Resident #80 revealed no documentation of refusals of care. Review of the Admission Record revealed Resident #80 was admitted by the facility on 7/12/19 with diagnoses of Quadriplegia and Need for Assistance with personal hygiene. Record review of Resident #80's Section C of the MDS with an ARD of 8/15/24 revealed in Section C a BIMS score of 15, indicating the resident was cognitively intact.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46013 Based on staff interviews, record review, and facility policy review, the facility failed to monitor a resident receiving anticoagulant medication for signs of bruising and bleeding for one (1) of five (5) residents reviewed for unnecessary medication. Resident #47 Findings include: Record review of the facility policy titled Anticoagulation-Clinical Protocol with a revision date of November 2018 revealed under, Monitor and Follow-Up: 5 . The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems . Record review of Resident #47's Order Summary Report revealed an order dated 9/23/2024, Apixaban oral tablet 2.5 mg (milligrams) Give 1 tablet by mouth two times a day related Peripheral Vascular Disease. Record review of the Order Summary Report and the Medication Administration Record (MAR) for Resident #47 revealed there was not a monitoring tool for staff to monitor for signs of bruising and bleeding with the anticoagulant (blood thinner) medication Apixaban. An interview with Licensed Practical Nurse (LPN) #5 on 11/14/24 at 8:10 AM, confirmed that Resident #47 is on an anticoagulant medication. She confirmed the facility did not have a monitoring task implemented on the resident's MAR for bruising or signs of bleeding. She revealed that it is very important to monitor a resident that is on a blood thinner. In an interview on 11/14/24 at 9:05 AM, the Director of Nurses (DON) confirmed that Resident #47 is on an anticoagulation medication, and he should be monitored for bruising or signs of bleeding. She confirmed the resident was not being adequately monitored for the potential outcomes associated with the use of anticoagulation medications, and he should be. Record review of the Admission Record revealed Resident #47 was admitted to the facility on [DATE] with medical diagnoses that included Peripheral Vascular Disease.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, staff interviews, and facility policy review the facility failed to ensure the proper storage of drugs as evidenced by a medication cart being left unlocked during medication administration for one (1) of four (4) medication carts observed. Findings Include: Record review of the facility policy titled Storage of Medications with reviewed date of July 2024 revealed under policy statement, The facility stores all drugs and biologicals in a safe, secure, and orderly manner .9. Unlocked medication carts are not left unattended An observation on 11/13/24 at 8:20 AM, revealed Licensed Practical Nurse (LPN) #3, administer medications to a resident in room [ROOM NUMBER]. LPN #3 left the medication cart outside of room [ROOM NUMBER] with the medication drawers facing the outside of the door. At 8:35 AM, upon exiting room [ROOM NUMBER], an observation revealed that the medication cart was unlocked while unattended. There was a resident sitting beside the cart in a wheelchair and two residents who self propelled themselves by the cart during this timeframe. LPN #3 confirmed that the medication cart was unlocked and revealed that residents could have come up to the medication cart and took what they wanted out of the drawers. She confirmed that the medication cart was supposed to be locked at all times unless the nurse was present and preparing medications for administration. An interview on 11/13/24 at 2:36 PM, with Registered Nurse (RN) #2, revealed that the medication carts were supposed to be locked at all times to prevent anyone from getting into the carts while unattended. She revealed that the only time the medication cart should be unlocked was if the nurse was standing at the cart getting medications out. RN #2 confirmed that LPN #3 should have locked the medication cart prior to entering room [ROOM NUMBER].

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45598 Based on observation, staff interviews, record review, and facility policy review the facility failed to ensure that Enhanced Barrier Precautions (EBP) was implemented for a resident that required EBP for (1) of five (5) direct care areas observed. Findings Include: Record review of the facility policy, Enhanced Barrier Precautions (EBP) dated 04/01/24 revealed that EBP are indicated for residents with any of the following: Wounds and/or indwelling medical devices even if the resident is not known to be infected . The policy also revealed that gloves and gowns are to be donned when performing wound care. An observation on 11/13/24 at 11:20 AM, revealed Licensed Practical Nurse (LPN) #4, completed wound care to Resident #20's left heel without donning a gown prior to the wound care being performed. LPN #4 revealed that she knew to use EBP with wound care, but she got nervous and forgot. She revealed that the purpose of EBP was to prevent the spread of infection, and it was to protect the residents as well as the staff. There was EBP signage on the resident's door. An interview on 11/13/24 at 11:43 AM, with Registered Nurse (RN) #2, revealed that Resident #20 was on EBP because she had a urinary catheter and a wound. She revealed that EBP was supposed to be followed to protect the residents from the possible spread of germs or infection. RN #2 confirmed that LPN #4 should have worn gloves and a gown when she provided wound care for Resident #20. Record review of Resident #20's Order Summary Report dated 11/08/24 revealed an order to cleanse the deep tissue injury to her left heel with povidone-iodine and leave open to air. Record review of Resident #20's Care Plan revealed that she had a deep tissue injury to the left heel and revealed, This resident is on Enhanced Barrier Precautions and Use EBP when providing wound Record review of Resident #20's Admission Record revealed an admitted [DATE] and that she had diagnoses that included Malignant Neoplasm of Uterus, Pressure - Induced Deep Tissue Damage of Left Heel, and Type 2 Diabetes Mellitus. Record review of Resident #20's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/30/24 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated that she was cognitively intact.