STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255207	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plaza Community Living Center	4403 Hospital Road Pascagoula, MS 39581

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 37415 Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to ensure residents' rights for a clean, sanitary, and home-like environment as evidenced by resident rooms with holes in the walls and leaks in the ceilings in the dining room and hallways for one (1) of four (4) days of survey. Findings included: A review of the facility's policy titled Resident Rights, dated 11/23/2016, revealed, It is the policy of this facility to promote the rights of residents residing in this facility .Procedure .3. The facility will make every effort to provide residents a homelike environment . On 1/6/2025 at 10:30 AM, during an observation, water was dripping from the roof in the main dining room. A large puddle of water was observed on the floor with a wet floor sign placed over it. On 1/6/2025 at 10:40 AM, during an observation in Room South-8, a hole the size of a large ball was noted in the sheetrock, filled with pieces of cardboard. Resident #11 On 1/6/2025 at 10:45 AM, during an interview, Resident #11 confirmed the water was dripping from the roof and stated it had rained the day before. The resident noted that leaks typically occurred in the hallway near the nurses' station on both the north and south wings. The resident added that staff usually placed barrels in these areas to catch the water. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/16/24 revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. Resident #26 On 1/6/2025 at 10:50 AM, during an interview, Resident #26, who was sitting in the main dining room, confirmed that leaks occurred in various parts of the facility when it rained. The resident stated that repair work had been done in the past, but the leaks persisted, with new areas leaking unpredictably. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the MDS with an ARD of 11/6/24 revealed Resident #26 had a BIMS score of 15 indicating the resident was cognitively intact. Resident #35 On 1/6/2025 at 10:50 AM, during an interview, Resident #35 confirmed the ceiling was leaking in the dining room. The resident said the ceiling leaked in multiple areas when it rained, and staff typically placed wet floor signs and barrels to address the issue. Record review of the MDS with an ARD of 1/23/24 revealed Resident #35 had a BIMS score of 14 indicating the resident was cognitively intact. On 1/6/2025 at 11:00 AM, during an interview, Housekeeper #1 stated he was instructed to document environmental problems in the maintenance log at the nurses' station. He mopped up water on the dining room floor and noted that while the dining room rarely leaked, the north and south hallways leaked frequently during rain. Resident #67 On 1/6/2025 at 11:30 AM, during an interview, Resident #67 confirmed the roof leaked near the nurses' station on the north and south halls. The resident stated that repairmen had patched the roof multiple times, but the leaks shifted to other areas. The resident expressed frustration, saying the entire roof needed to be fixed. On 1/6/2025 at 11:31 AM, during an observation in Room North-1, a large open area was noted around the wall-mounted air conditioning unit, allowing visibility to the outside. Record review of the MDS with an ARD of 11/27/24 revealed Resident #67 had a BIMS score of 15 indicating the resident was cognitively intact. Resident #43 On 1/6/2025 at 12:05 PM, during an interview, Resident #43 expressed concern that animals, such as snakes, could enter the room through the gap. Record review of the MDS with an ARD of 12/13/24 revealed Resident #43 had a BIMS score of 12 indicating the resident had moderate cognitive impairment. On 1/9/2025 at 1:00 PM, during an interview, the Maintenance Director confirmed roof leaks in the north and south halls and acknowledged being unaware of the dining room leak. He noted that patches and silicone coatings had been applied to the roof, but the flat design caused water to shift to other areas. The Maintenance Director also confirmed awareness of paint chips and holes in the walls but had not received maintenance slips for the affected rooms. On 1/9/2025 at 3:45 PM, during an interview, the Administrator confirmed awareness of roof leaks in the north and south halls but stated she was unaware of the dining room leak. The Administrator explained that corporate consultants communicated with the roofing company, and repairs were limited to specific areas based on budget constraints.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 37415 Based on observation, interview, record review, and facility policy review, the facility failed to protect residents' right to be free from physical abuse when Resident #62 received scratches to his neck and face in an altercation with Resident #48 and Resident #41 received a hematoma to her head during an altercation with Resident #78 for four (4) of 20 sampled residents. Findings included: A review of the facility's Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, updated October 2022, revealed, Residents have the right to be free from abuse, neglect, misappropriation of property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Resident #48 and Resident #62 Altercation Record review of the facility's investigation dated 11/2/24 revealed Resident #62 and Resident #48 were involved in an altercation in the dining room. Resident #62, who was assisting with handing out clothing protectors, was punched by Resident #48 when he attempted to place a clothing protector on him. In response, Resident #62 hit Resident #48 back, and both residents fell to the floor. A dietary aide witnessed the incident, reported it to Registered Nurse (RN) #4 and both residents were separated. Resident #62 sustained scratches to his face and neck, while Resident #48 had no noted injuries. The physician, Director of Nursing (DON), and Administrator were notified. Interventions included instructing staff to prevent Resident #62 from distributing clothing protectors in the dining room and referring Resident #48 to the in-house psychiatric Nurse Practitioner. During an observation on 1/6/2025 at 10:50 AM, Resident #48 was noted sitting in his wheelchair in his room. Resident #48, who has expressive aphasia, communicated with head nods. During an interview on 01/06/2025 at 11:00 AM, Registered Nurse (RN) #3 explained that Resident #48 can talk but may not want to communicate because he cannot speak clearly. RN #3 reported she did not recall many details about the night Resident #48 and Resident #62 were involved in an altercation in the dining room. She noted both residents have a history of other altercations, which usually occurred due to Resident #62 wandering into rooms. RN #3 added that Resident #48 had hit Resident #62 previously when Resident #62 wandered into his room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 01/08/2025 at 09:30 AM, Resident #48 was observed sitting in his wheelchair in his room. When asked if he could answer yes or no questions, the resident nodded yes. When asked if he remembered the altercation in the dining room with Resident #62, the resident nodded yes. When asked if he and Resident #62 had previous issues, he nodded yes. When asked if he was upset about the clothing protector, he nodded no. When asked if he became upset when he saw it was Resident #62, he nodded yes. When asked if he landed on the floor during the incident, he nodded yes. When asked if he was hurt, he nodded no. When asked if he had punched Resident #62 before, he nodded yes. When asked if this occurred when Resident #62 came into his room, he nodded yes. When asked if he had any further altercations with Resident #62 since the dining room incident, he nodded no. When asked if everything was better now, he nodded yes and smiled. During an interview on 01/08/2025 at 12:15 PM, Dietary Aide #4 confirmed she provided a witness statement for the incident between Resident #48 and Resident #62. She stated the incident occurred around 5:20 PM as the dining room trays are typically distributed starting at 5:25 PM. She was at the kitchen window and saw Resident #62 walking around placing clothing protectors on other residents. Resident #48 was seated at the back table. When Resident #62 attempted to place a clothing protector on Resident #48, Resident #48 punched Resident #62, who punched him back, leading to a tussle. Dietary Aide #4 stated she told other kitchen staff the residents were fighting and then saw Resident #48 fall from his wheelchair to the floor. She immediately sought help from a nurse and Certified Nursing Assistant (CNA). She stated that residents were temporarily prohibited from being in the dining room without staff for about a week after the incident, but that policy was not maintained because residents would often gather unsupervised in the hallways instead. During a phone interview on 01/08/2025 at 05:40 PM, RN #5 stated she did not witness the incident between Resident #48 and Resident #62. She explained that Dietary Aide #4 informed her about the altercation. While walking down the hall, she encountered RN #4, who was with Resident #62. RN #4 informed her that Resident #62 had been fighting with another resident. RN #5 then escorted Resident #62 to his room and completed a body audit. She observed scratches on Resident #62's neck and face, noting that the scratches were superficial and required only first aid. RN #5 stated she completed the incident report for Resident #62, while RN #3 completed the incident report for Resident #48. She also confirmed she notified the Administrator and Director of Nursing (DON) about the incident. During a interview on 01/09/2025 at 03:50 PM, the Administrator stated that on the night of the incident, she was notified, and the Registered Nurses (RNs) completed the incident reports. She used the incident reports and statements from RN #4 and Dietary Aide #4 to complete her final report. She explained that she does not know if any other residents were present in the dining room at the time of the incident, except for Resident #26, whose interview was included in one of the incident reports. She acknowledged there were no staff in the dining room at the time of the altercation, as they were busy assisting other residents to the dining room. She confirmed interventions implemented included informing Resident #62 that he could no longer distribute clothing protectors and instructing staff not to allow him to pass out the clothing protectors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of progress notes dated 6/3/2024 at 5:45 PM revealed that Resident #48 and Resident #62 had a prior altercation. The progress notes stated, This writer was walking the hallway and noticed a wheelchair flipped up in the room. Upon entering the room, the resident was noted sitting in his wheelchair, and another male resident was on the floor underneath Resident #48's wheelchair. Both residents were exchanging punches and holding each other's shirts. When asked how the altercation occurred, Resident #48 stated, He came in my room, and I asked him to get out and he wouldn't and got smart with me. When asked, Who struck who first? Resident #48 admitted to striking the other resident first. Both residents were separated by this writer and two other staff members and assessed for injuries. Upon assessment, Resident #48 was noted to have two small scratches on his left cheek. The areas were cleaned and left open to air. The family, physician, Director of Nursing (DON), and Administrator were notified of the incident. A record review of the Admission Record revealed the facility admitted Resident #48 on 05/07/20 with the diagnoses including Hemiplegia And Hemiparesis Following Cerebral Infarction. A record review of the Quarterly MDS with an ARD of 10/09/24 revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. A record review of Resident's Physical Aggression Initiated report dated 11/02/24 prepared by RN #3 revealed . I did not witness event. I was told by resident 48 and resident #62, that Resident #62 put on the clothing protector. Resident #62 put it on Resident #48 took it off then resident #48 hit Resident #62 in the gut, Resident #62 returned hit to Resident #48 in the torso . Nursing supervisor notified by RN #5. Residents were separated . no injuries observed at time of incident . No statements found . A record review of the Admission Record revealed the facility admitted Resident #62 on 01/26/22 with the diagnoses including Unspecified Dementia. A record review of the Quarterly MDS with an ARD of 12/11/24 revealed Resident #62 had a BIMS score of 7 which indicated he was severely cognitively impaired. A record review of Resident's Physical Aggression Initiated report dated 11/02/24 prepared by RN #3 revealed . I did not witness event. I was told by resident #48 and Resident #26, that Resident #62 put bib on Resident #48 took it off then Resident #48 hit Resident #62 in the gut, Resident #62 returned hit to Resident #48 torso . Nursing supervisor notified by RN #5, residents were separated . no injuries observed at time of incident . No statements found . Resident #41 and Resident #78 Altercation On 1/7/2025 at 5:15 PM, during an observation, several residents were standing in the hallway near the main dining room without staff supervision. Residents were overheard using profanity, and Resident #78 was observed hitting Resident #41 with her walker, knocking her to the floor. Staff intervened and separated the residents. A record review of the facility's incident reports dated 1/7/2025 revealed Resident #41 sustained a hematoma to the back of her head and was sent to the emergency room for evaluation. Resident #78 denied hitting Resident #41 with her walker and reported no injuries. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of the Admission Record revealed the facility admitted Resident #41 on 3/21/2023 with diagnoses including Chronic Obstructive Pulmonary Disease. A record review of the Quarterly Minimum Data Set (MDS) with an assessment Reference Date (ARD) of 11/20/2024 revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of three (3), indicating severe cognitive impairment. A record review of the Admission Record revealed the facility admitted Resident #78 on 3/22/2023 with diagnoses including Dementia. A record review of the Quarterly MDS with an ARD of 10/24/2024 revealed Resident #78 had a BIMS score of seven (7), indicating severe cognitive impairment.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 43283 Based on interviews, record review, and facility policy review the facility failed to implement their policy related to abuse, as evidenced by not reporting an allegation of abuse by Resident #54 in a timely manner and allowing an accused staff member to work during the investigation process and not completing a thorough investigation regarding an altercation between Resident#48 and Resident #62 for three (3) of 20 sampled residents. Findings include: A record review of the facility's policy Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigation with reviewed date 10/2022 revealed, . All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported . Reporting Allegations to the Administrator and Authorities . 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury . Investigating Allegations 1. All allegations are thoroughly investigated. The administrator initiates investigations . 6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. 7. The individual conducting the investigation as a minimum: c. observed the alleged victim, including his or her interaction with staff and other residents; . e. interviews any witnesses to the incident; . h. interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; . j. interviews other residents to whom the accused employee provides care or services, k. reviews all events leading up to the alleged incident, and l. documents the investigation completely and thoroughly. 8. The following guidelines are used when conducting interviews: . d. Witness statements are obtained in writing, signed, and dated. The witness may write his/her statement, or the investigator may obtain a statement . Follow -Up Report 1. Within five (5) business days of the incident, the administrator will provide a follow-up investigation report. 2. The follow-up investigation report will provide sufficient information to describe the results of the investigation, and indicate any corrective actions taken if the allegations were verified . Corrective Actions . 3. Any allegations of abuse are filed in the accused employee's personnel record along with any statement by the employee disputing the allegation, if the employee chooses to make one . Resident #48 and Resident #62 Altercation Record review of the facility's investigation dated 11/2/24 revealed Resident #62 and Resident #48 were involved in an altercation in the dining room. Resident #62, who was assisting with handing out clothing protectors, was punched by Resident #48 when he attempted to place a clothing protector on him. In response, Resident #62 hit Resident #48 back, and both residents fell to the floor. A dietary aide witnessed the incident, reported it to the nurse's station, and both residents were separated. Resident #62 sustained scratches to his face and neck, while Resident #48 had no noted injuries. The physician, Director of Nursing (DON), and Administrator were notified. Interventions included instructing staff to prevent Resident #62 from distributing clothing protectors in the dining room and referring Resident #48 to the in-house psychiatric Nurse Practitioner. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/07/25 at 02:00 PM, during an interview with the Administrator when she presented the final report of the Facility Reported Incident (FRI), she explained that is the final report that she submitted to the Attorney General Office (AGO) and to the State Agency (SA). She confirmed the report consisted of her final typed report and the two (2) statements obtained regarding the incident. She confirmed there were no other statements or interviews obtained from any other witnesses, to include who separated the residents and any other residents who may have witnessed the altercation. She confirmed body audits and incident reports were completed for both residents via the residents' nurses. She confirmed no other staff or residents were interviewed regarding the altercation except the ones mentioned in the report, that included Resident #26, Dietary Aide #4, and RN #4. She stated that she felt she completed the investigation. A record review of the Admission Record revealed Resident #48 was admitted by the facility on 05/07/20 with the diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/09/24 revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. A record review of the Admission Record revealed Resident #62 was admitted by the facility 1/26/22 with diagnoses including Unspecified Dementia. A record review of the Quarterly MDS with an ARD of 12/11/24 revealed Resident #62 had a BIMS score of 7 which indicated severely cognitively impaired. Resident #54 Allegation of Abuse On 01/06/25 at 02:20 PM, during an interview with Resident #54, she reported on Friday around 2 PM she had a Certified Nurse Aide (CNA) tell her that she wasn't going to put her back to bed and she would have to wait on the next shift to put her back to bed. She went to the nurse's station and complained about wanting to go to bed. The CNA did come back and put her to bed but while doing so the CNA whirled her around fast and made her cry. She stated she had not reported this to the Director of Nursing (DON) or the Administrator yet. She was so upset on Friday she could not tell anyone. The resident's roommate (unsampled resident #1) reported she heard the CNA on Friday tell Resident #54 she had to wait for the next shift. On 01/06/25 at 02:53 PM, during an interview in Resident #54's room with the DON and Administrator, she explained to both the incident that occurred on Friday in which the CNA told her that she was not going to put her back to bed and she would have to wait on next shift and about her quickly turning her around in her wheelchair. Both the DON and Administrator confirmed that they did not know anything about the issue and assured the resident to report any concerns to them right away. The DON and Administrator reported they will start their investigation regarding Resident #54's complaint. On 01/07/25 at 02:05 PM, during an interview with the Administrator, she stated she did not report the allegation to anyone because she did not feel it was abuse or neglect due to the CNA did put resident to bed before she left work on Friday and there were no problems. She reported she was not aware of the requirements to report any allegations of abuse if it was just allegations. She thought it had to be reported if the abuse was substantiated, and the abuse was not substantiated at this time, but the investigation continues. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/07/25 at 03:00 PM, during an interview with the DON, she confirmed she obtained the statements from both CNAs and the CNAs denied the allegations. She reported since Resident #54 was put to bed on Friday and changed, there was no need to suspend the CNA from working. A review of the facility's policy Abuse-Investigation was reviewed with the DON, she confirmed the policy indicates that allegations of abuse should be reported within two hours of an allegation involving abuse and that any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. The DON reported she is still doing more interviews and investigations regarding the allegations and the final report is not completed. On 01/08/25 at 10:30 AM, during an interview with CNA #4, she denied any abuse toward the resident, but confirmed she has been working this current week since 1/6/2025 at the facility on day shift. On 01/09/25 at 04:00 PM, during an interview with the Administrator and the DON, they both confirmed the investigation regarding Resident #54 is almost complete and the facility has five (5) days to send the final report. A review of the facility's policy with the Administrator and the DON, they both confirmed the facility policy explained any witnesses of the allegations should be interviewed and/or a statement given. The policy revealed the accused worker should be suspended while the investigation continues and should not have any resident care. Both confirmed the CNA continued to work and the allegation of abuse was not reported within two (2) hours. The Administrator reported she thought since the CNAs denied the allegations, there was no need to suspend or to report within two (2) hours because there was no abuse. A record review of the facility's assignment logs for days 01/03/25, 01/06/25, 01/07/25, and 01/08/25 confirmed CNA #4 worked and had resident assignments. A record review of the Admission Record revealed Resident #54 was admitted by the facility on 8/03/24 with current diagnoses including Cerebral Palsy. A record review of the Quarterly MDS with an ARD of 11/13/24 revealed Resident #54 had a BIMS score of 14, which indicted she was cognitively intact.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure each resident receives an accurate assessment. 48181 Based on observation, staff interview, and record review, the facility failed to accurately code Minimum Data Set (MDS) assessments when bedrails that were used as an enabler were coded as physical restraints on the MDS for three (3) of 20 sampled residents. (Residents #14, #73, and #43). Findings included: The facility did not provide a policy addressing MDS discrepancies. Resident #14 On 1/6/2025 at 10:40 AM, during an observation, Resident #14 was noted to have 1/2 bedrails at the top of the bed, but they were not raised at the time of observation. A record review of the Admission Record revealed the facility admitted Resident #14 on 9/14/2022 with diagnoses including Epilepsy and Hemiplegia. A record review of the Quarterly MDS with an Assessment Reference Date (ARD) of 11/6/2024 revealed in Section P of the MDS that Resident #14 had a bedrail used as a physical restraint. A record review of the Side Rail Evaluation, dated 10/17/24, revealed Resident #14 had expressed a desire to have bed rails raised while in bed for safety and comfort and to help turn in bed. Further review revealed that the resident used the bed rails for positioning or support and to help the resident rise from a supine position to a sitting/standing position. The evaluation indicated in the Summary of Findings that bilateral rails were used due to the residents' request and served as an enabler to promote independence. Resident #73 On 1/7/2025 at 10:22 AM, during an observation, Resident #73's bed was noted to have 1/4 bed positioning enablers at the head of the bed on both sides. A record review of the Admission Record revealed the facility admitted Resident #73 on 6/25/2024 with diagnoses including Acquired Absence of Right and Left Leg Above Knee. A record review of the MDS with an ARD of 12/25/2024 revealed Resident #73 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS indicated in Section P the resident had a bedrail used as a physical restraint. A record review of the Side Rail Evaluation, dated 10/17/24, revealed Resident #73 had expressed a desire for use of bed rails. The evaluation indicated in the Summary of Findings that bilateral rails were used due to the residents' request and served as an enabler to promote independence. Resident #43 (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Many	On 1/7/2025 at 10:25 AM, during an observation, Resident #43's bed was noted to have 1/4 bed positioning enablers at the head of the bed on both sides. A record review of the Admission Record revealed the facility admitted Resident #43 on 8/30/2024 with diagnoses including Metabolic Encephalopathy. A record review of the Quarterly MDS with an ARD of 12/6/2024 revealed Resident #43 had a BIMS score of 12, which indicated moderate cognitive impairment. The MDS noted in Section P that bedrail usage was less than daily. A record review of the Side Rail Evaluation, dated 10/17/24, for Resident #43 indicated in the Summary of Findings that bilateral rails were used due to the residents' request and served as an enabler to promote independence. On 1/9/2025 at 1:42 PM, during an interview, Licensed Practical Nurse (LPN) #2 acknowledged the residents were miscoded for having a physical restraint because the residents used the rails as enablers. LPN #2 stated she was responsible for ensuring the accuracy of the MDS prior to submission. She explained the purpose of the MDS is to document services provided for insurance purposes and stated she would learn from this mistake and improve. On 1/9/2025 at 1:47 PM, during an interview, the Director of Nursing (DON) acknowledged the residents' MDS assessments were miscoded for having physical restraints related to bedrails. The DON stated it was the responsibility of the MDS nurse to ensure the MDS is coded correctly prior to submission. She explained that the purpose of correct MDS coding is for accurate billing and data representation. The DON stated she expected the MDS nurse to gather data and verify accuracy. On 1/9/2025 at 1:52 PM, during an interview, the Administrator acknowledged there was an MDS discrepancy related to bed rails being coded as a physical restraint. The Administrator stated the purpose of the MDS was to ensure the facility accurately reflects what is being done for the resident. She stated her expectation is that the MDS nurse carefully verifies information before submission and seeks clarification when necessary.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43283 Based on observation, interviews, record review, and the facility policy review the facility failed to provide adequate supervision to prevent resident-on-resident altercations between Resident #62 and Resident #48 and between Resident #41 and Resident #78 for four (4) of 22 sampled residents. Findings included: Resident #48 and Resident #62 Record review of the facility's investigation dated 11/2/24 revealed Resident #62 and Resident #48 were involved in an altercation in the dining room. Resident #62, who was assisting with handing out clothing protectors, was punched by Resident #48 when he attempted to place a clothing protector on him. In response, Resident #62 hit Resident #48 back, and both residents fell to the floor. A dietary aide witnessed the incident, reported it to Registered Nurse (RN) #4 and both residents were separated. Resident #62 sustained scratches to his face and neck, while Resident #48 had no noted injuries. The physician, Director of Nursing (DON), and Administrator were notified. Interventions included instructing staff to prevent Resident #62 from distributing clothing protectors in the dining room and referring Resident #48 to the in-house psychiatric Nurse Practitioner. On 01/06/2025 at 11:51 AM, during an observation in the dining room, Resident #26 was placing clothing protectors on other residents without staff present. On 01/07/2025 at 02:20 PM, during an interview, Resident #26 confirmed he witnessed the altercation between Residents #62 and #48. He stated that no staff were present in the dining room at the time and that it was common for the dining room to be unsupervised. On 01/08/2025 at 12:15 PM, during an interview, Dietary Aide #4 stated she observed the altercation between Residents #62 and #48 on 11/2/24 from the kitchen window and sought help from a nurse and Certified Nursing Assistant (CNA). She confirmed there were no staff in the dining room at the time. Dietary Aide #4 added that after the incident, residents were temporarily prohibited from being in the dining room without staff, but this restriction was not maintained. A record review of the Admission Record revealed Resident #62 was admitted by the facility on 01/26/2022 with diagnoses including Unspecified Dementia and Psychotic Disorder. A record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/11/2024 revealed Resident #62 had a Brief Interview for Mental Status (BIMS) score of seven (7), indicating severe cognitive impairment. A record review of the Admission Record revealed Resident #48 was admitted by the facility on 05/07/2020 with diagnoses including Hemiplegia and Aphasia. A record review of the MDS with an ARD of 10/09/2024 revealed a BIMS score of 15, indicating the resident was cognitively intact. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #41 and Resident #78 On 01/07/2025 at 03:00 PM, during an observation there was an altercation between Resident #78 and Resident #41 near the exit door for smoking, which is near the dining room. No staff were present at the time of the incident. Record review of the facility's, Incident Report, dated 01/07/25 revealed Resident #41 was walking in the hallway next to the kitchen when another resident called this resident a (expletive) this resident then called the other resident a (expletive) and then proceeded to slap the other resident in the face. Both residents began pushing each other when the Resident #78 pushed Resident #41 with her wheelchair, knocking Resident #41 to the floor where she hit the back of her head. The staff immediately intervened and assessed the resident for injury. Resident #41 noted to have quarter sized hematoma to the back of her head. Charge nurse took Resident #41's vital signs, and the Medical Director and family was notified the resident was sent to the local emergency room for an evaluation. A record review of Resident #41's Admission Record revealed the resident was admitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease and Major Depressive Disorder. A record review of Resident #41's MDS dated [DATE] revealed a BIMS score of (3), indicating severe cognitive impairment. A record review of Resident #78's Admission Record revealed the resident was admitted on [DATE] with a diagnosis of Unspecified Dementia. A record review of Resident #78's MDS dated [DATE] revealed a BIMS score of seven (7), indicating severe cognitive impairment.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50921 Based on observation, staff interview, record review, and facility policy review, the facility failed to discard expired food items from the refrigerator, remove opened, exposed, and unlabeled food items from freezer, and ensure dietary staff wore a hair restraint while plating food for two (2) of three (3) observations. Findings included: A review of the facility's policy, Personal Hygiene, revised [DATE], revealed, Objective: Participants will learn what guidelines for personal hygiene are needed to promote a safe and sanitary Food and Nutrition Services department .3. Head Covering Worn .Hair must be appropriately restrained or completely covered. Beards, mustaches, or any body hair that may be exposed .must be covered . A review of the facility's policy, Labeling and Dating for Safe Storage of Food, revised [DATE], revealed, .All products should be dated upon receipt . All products should be dated when opened . Use Use-By dates on all food once opened and stored under refrigeration . Expiration dates supersede storage guide . On [DATE] at 10:43 AM, during an observation and interview with the Dietary Manager (DM), there was one (1) container of mayonnaise with a manufacturer's use-by date of [DATE] and (1) bag of shredded lettuce with a use-by date of [DATE] in Refrigerator #1. In Freezer #2, there was (1) opened, exposed, and uncovered pie shell undated, (1) opened exposed, and unlabeled bag of corn on the cob, (1) opened, exposed, and unlabeled bag of biscuits, and (1) opened, exposed, and unlabeled bag of cinnamon rolls. The DM confirmed the mayonnaise and shredded lettuce were expired and there were opened and exposed food items in the freezer. She expressed that she had reminded the kitchen staff to date and label opened food items in the freezer. On [DATE] at 10:46 AM, during an interview, the Registered Dietitian (RD) revealed that kitchen staff receive monthly in-services, with the last one held in [DATE]. Topics covered during monthly in-services included pest control, resident rights, sanitation, gloves, cleaning, and labeling and dating food in refrigerators. The RD stated the expectation for kitchen staff is to work as a team, prepare food per guidelines, maintain sanitation, and follow instructions. On [DATE] at 11:34 AM, during an observation, Dietary #2 (Kitchen Aide) was plating food and preparing trays and was not wearing a hair restraint on his beard. On [DATE] at 1:03 PM, during an interview, the DM stated that in-services for kitchen staff are held every other month and as needed. The DM noted the last in-service, held in [DATE], covered topics such as equipment upkeep and gloves. An in-service in [DATE] included topics on hair nets and beard guards. The DM emphasized that staff are expected to follow guidelines, rules, and apply the information from in-services. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:27 PM, during a follow-up interview, the DM confirmed Dietary #2 had prepared resident's plates at the steam table for lunch and was not wearing a hair restraint for his beard as required. She commented that she has had to remind dietary staff to wear hair restraints. On [DATE] at 4:20 PM, during a phone interview, Dietary #2 confirmed he had received in-service training on hair restraints but could not recall the dates. He stated he typically washes dishes but plated food on [DATE] because another worker called in. The dishwasher acknowledged the importance of wearing hairnets and beard guards to prevent hair from getting into residents' food. On [DATE] at 4:30 PM, during an interview, the Administrator acknowledged she was aware of the findings in the dietary department. The Administrator stated her expectations included following guidelines to prepare foods in a manner that prevents illness and ensures food is appealing to residents. A record review of dietary in-service records dated [DATE] and [DATE] revealed the dietary staff received training regarding covering labeling, dating, and wearing hair restraints.

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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, interview, and facility policy review, the facility failed to prevent the possible spread of infection when a Certified Nurse Aide (CNA) placed soiled linens on the floor of a resident's room and against her clothes for one (1) of four (4) days. Findings included: A review of the facility's policy titled Laundry and Bedding-Soiled, dated October 22, 2008, revealed, .Soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen . On 1/7/2025 at 3:45 PM, during an interview and observation, there was a strong urine odor at the South Front Hall. While walking past Room S7, soiled linen was observed placed on the floor beside the bed. CNA #1 was in the room and explained the soiled linen should not have been placed there and stated that she knew better. CNA #1 picked up the soiled linens from the floor, placing them directly against her clothing on her body, before putting them on the bare mattress of the resident's bed. She further explained that she should have placed the soiled linens in a bag because they should not be on the floor. CNA #1 retrieved a plastic bag, placed the soiled linen in the bag, and took it to the soiled linen room. On 1/8/2025 at 9:45 AM, during an interview, Registered Nurse (RN) #1/Infection Preventionist, stated she expected staff to use a bag to place soiled linen in and to avoid placing linen on the floor or against their body. On 1/9/2025 at 10:05 AM, during an interview, the Director of Nursing (DON) explained her expectations for staff to follow infection control guidelines and policies to prevent infections. She stated staff are educated to bring clean linen into rooms using trash bags and use the same bags to collect and transport dirty linen immediately to the soiled linen room. She emphasized that no dirty linen or trash bags should be placed directly on the floor or against staff's bodies to prevent the spread of infection.