STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66SR	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY REHABILITATION AND NURSING CT	1436 EAST CENTRAL AVENUE WIGGINS, MS 39577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) conducted Complaint Investigations (CI), MS #22402 and MS #22664, at the facility, from 8/31/23 through 9/8/23. Both MS #22402 and MS #22664 were investigated related to neglect. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirement. The SA cited M500 and M640.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to	M 500		10/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66SR	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY REHABILITATION AND NURSING CT	1436 EAST CENTRAL AVENUE WIGGINS, MS 39577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 1 participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66SR	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY REHABILITATION AND NURSING CT	1436 EAST CENTRAL AVENUE WIGGINS, MS 39577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 2	M 500		

responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66SR	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY REHABILITATION AND NURSING CT	1436 EAST CENTRAL AVENUE WIGGINS, MS 39577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 3 documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on interviews, record review, and facility policy review, the facility failed to notify the physician of blood glucose readings of 60 or below for one (1) of two (2) residents reviewed for glucose readings. Resident #4.	M 500	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66SR	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY REHABILITATION AND NURSING CT	1436 EAST CENTRAL AVENUE WIGGINS, MS 39577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 4 Findings Include: Record review of the facility's policy, "Hypoglycemia Management" policy, dated 3/27/23, revealed, " ...It is the policy of this facility to ensure effective management of a resident who experiences a hypoglycemic episode ...Compliance Guidelines ...5. If the blood glucose reading is 60 mg/dL(milligrams/deciliter) or below, the nurse will utilize the hypoglycemia protocol as per the practitioner's orders, with follow up blood glucose as indicated, and notify the practitioner of the results as ordered ..." Record review of the "Face Sheet" revealed the facility admitted Resident #4 on 8/5/23 with a diagnoses that included Type 2 Diabetes Mellitus. Record review of the "Physician Orders" for the month of August 2023 revealed there were no physician orders for routine accu-checks after 8/16/23. Record review of the "Therapeutic Protocols" revealed there were standing Physician Orders for Hypoglycemia as follows: Obtain accu-check, if Blood Glucose (BG) less than 60 and resident is able to swallow, give four (4) ounces of milk/juice or one (1) pack of Insta Glucose. If resident is unable to swallow, give Glucagon one (1) Milligram (MG) Intramuscular (IM). Recheck accu-check in 15 minutes (mins). Notify Medical Doctor (MD)/Nurse Practitioner (NP) if BG is still less than 60. Record review of the "Departmental Notes" revealed there was a "Nurse Notes", completed by Licensed Practical Nurse (LPN) #3, dated 8/26/23 at 3:15 AM, for " ...glucose reading was	M 500	response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action taken for the resident found to be affected include: • The Director of Nursing (DON) notified the nurse practitioner of resident #4 blood glucose readings of 55 and 56 from August 31, 2023 on September 8, 2023. • An in-service was conducted by the DON on September 8, 2023, with Nursing Staff on hypoglycemic protocol, using therapeutic protocol, writing a physician order, and notifying the provider or practitioner and notifying resident or resident representative of blood glucose of 60 and below as well as any signs or symptoms and on Notification of Changes. 2. Identification of other residents having the potential to be affected was accomplished by: • The facility determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: • All Nurses were in-serviced regarding the facility policy on Resident Rights, 24-hour Report, Documentation, Physician Orders, Therapeutic Protocol, Customer Service, Care Plans, Notification of Changes, Survey Readiness, Abuse and Neglect, Hypoglycemia on September 14, 2023, and September 18, 2023. • Quality Assurance Performance Improvement (QAPI) Plan implemented for Notification of Changes, Therapeutic Protocol, Hypoglycemia, on September 11, 2023. • Face Sheets of all residents have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66SR	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY REHABILITATION AND NURSING CT	1436 EAST CENTRAL AVENUE WIGGINS, MS 39577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 5 49 ... After about 30 minutes I rechecked his glucose and his reading at that time had increased to 72." Record review of the "Departmental Notes" revealed, on 8/31/23 at 6:11 AM, " ...Glucose this am was 55 ... Rechecked @ 0600 and only increased to 56. 0600 this am A tube of Instaglucose was given and will inform oncoming nurse to recheck in about 30 minutes ..." Signed by: LPN #3 On 9/7/23 at 1:00 PM, an interview with the NP confirmed that when a resident has a BG of less than 60, she expected the staff to follow the therapeutic protocol, but to notify her when they use the protocol. She conveyed she was not notified of Resident #4's BG results of less than 60 at any time. On 9/8/23 at 12:28 PM, an interview with the Director of Nurses (DON), she revealed that on 8/26/23 and 8/31/23, Resident #4 had a BG result of less than 60 and although the staff followed the therapeutic protocols, or standing orders, a Physician's Order should have been written and the physician should have been notified. The DON stated that she expected staff to write a Physician's Order with the date and time and follow through with the order onto the medical record, including the Medication Administration Record (MAR) when they are utilizing therapeutic protocols. She confirmed the staff did not write orders for the therapeutic protocol or notify the physician. On 9/8/23 at 12:30 PM, an interview with License Practical Nurse (LPN) #3 revealed she used the Therapeutic Orders for Resident #4 when his blood sugar was less than 60 on 8/26/23 and	M 500	been updated with current resident representative information, completed September 21, 2023 by the Administrator and Assistant Administrator. 4. How the corrective actions will be monitored to ensure the practice will not recur: • The DON, Assistant Director of Nursing (ADON), and Resident Care Manager (RCM) will complete weekly audits for 12 consecutive weeks starting September 11, 2023 of all residents with the diagnosis of Diabetes to ensure that physician/practitioner orders are followed for monitoring blood glucose and notifying the physician/practitioner of blood glucose levels of 60 or below. This will be measured by checking the nurse's notes and the Medication Administration record (MAR) to ensure the physician was notified. • The DON, ADON and RCM will complete weekly audits for 12 consecutive weeks beginning on September 11, 2023, of residents who have required use of therapeutic protocols to ensure the order was written in the resident's medical record and the provider and resident/ resident representative was notified of changes in condition. • Validation checklist will be reviewed by the Administrator weekly beginning September 11, 2023 and go on for 12 weeks. • The Pharmacy Consultant will conduct audits of blood glucose levels during the next three monthly visits beginning in October 2023. • Audit records will be reviewed by the Quality Assurance Committee on October	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66SR	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY REHABILITATION AND NURSING CT	1436 EAST CENTRAL AVENUE WIGGINS, MS 39577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 500	Continued From page 6 8/31/23. She explained that she did not get a repeat BG within 15 minutes as per the orders and did not notify the physician on 8/31/23 when his repeat BG reading was less than 60. She confirmed that she did not write a Physician's Order for the Therapeutic Protocol for Hypoglycemia. On 9/8/23 at 1:44 PM, an interview with the facility's Pharmacist revealed that if a resident had a BG result of less than 60, the nurse should notify the physician.	M 500	6, 2023 and the following three months or until such time consistent substantial compliance has been achieved as determined by the committee.	
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level III Based on interviews, record reviews, and facility policy review, the facility failed to use the appropriate equipment during ambulation and provide adequate supervision to prevent an injury for one (1) of three (3) sampled residents, as evidenced by a resident who had a fall, sustained a left hip dislocation, and required hospitalization after he was ambulated without a walker or wheelchair and left unsupervised on the toilet. (Resident #1) Findings include:	M 640	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan correction is submitted as the facility's credible allegation of compliance. 1. Immediate action(s) taken for the resident found to have been affected include: • The Director of Nursing (DON) and	10/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66SR	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY REHABILITATION AND NURSING CT	1436 EAST CENTRAL AVENUE WIGGINS, MS 39577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 640	Continued From page 7 A review of the facility policy, "Incidents and Accidents", dated 5/13/23, revealed " ...It is the policy of this facility for staff to report, investigate and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident ..." A record review of the facility-reported investigation, dated 8/16/23, revealed, " ...Summary: On 8/13/23 (Proper name of Resident #1) was assisted to the toilet by a CNA (Certified Nurse Aide). CNA left room and returned when his call light came on again. CNA went to his restroom where (Proper name of Resident #1) was seated on the toilet. (Proper name of Resident #1) stated that he fell off the toilet..." A record review of the "Resident Incident Report" revealed the "Incident Type" as "Fall/Unobserved" and the "Date/Time" was listed as 8/13/23 08:00 AM. Further review revealed that the "Narrative of incident and description of injuries" indicated "Resident stated after CNA put him on the toilet, he fell and had put himself back on the toilet before CNA returned to room". "Resident Condition at Time of Incident" revealed "Mobility" as "WC (Wheelchair) - non-motorized". "Medical risk factors" indicated "Fall History" and "Fracture/Amputee" and "Activity at time" indicated "To/frm (from) bathrm (bathroom)-alone ..." A record review of the "Diagnostic Imaging" report, dated 8/13/23, from a local acute care hospital revealed, "History: Hip pain status post fall, with a history of recent surgery" and "Impression: Superior dislocation of a left hip arthroplasty, without discrete or displaced fracture ..."	M 640	Assistant Director of Nursing (ADON) met with Certified Nursing Assistant (CNA) #1, Registered Nurse (RN) #2 and Licensed Practical Nurse (LPN) #1 on September 8, 2023, and in-serviced on review of baseline care plan of residents to determine how much assistance is required, supervision and if any medical equipment is required. DON met with CNA#1, RN#2, and LPN#1 on September 8, 2023, and in-serviced on safety, and incidents and accidents, supervision, and devices. 2. Identification of other residents having the potential to be affected was accomplished. • The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk for future occurrences include: • All LPN's, RN's and CNA's were in-serviced by the DON, ADON and Administrator on the facility policy for Accidents and Supervision and Falls on September 14 and September 18, 2023. • On September 11, 2023, all resident falls/accidents were reviewed by the nursing management team to ensure appropriate implementation of safety interventions including updating the plan of care. This will continue for 12 weeks. • On September 11, 2023, all therapy recommendations are reviewed Monday through Friday by nursing management team, equipment is ordered and available to the resident, and care plans updated. This will be on going. • The DON, ADON, and Resident Care Manager (RCM) reviewed the Minimum	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66SR	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY REHABILITATION AND NURSING CT	1436 EAST CENTRAL AVENUE WIGGINS, MS 39577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 640	Continued From page 8 A record review of "Departmental Notes", for Resident #1, dated 8/11/23 at 12:32 PM, revealed a "Nurse Notes" that indicated, " ...Weakness noted to BLE (Bilateral Lower Extremities) mobility via wheelchair ..." A record review of "Departmental Notes", for Resident #1, dated 8/12/23 at 11:24 AM, revealed a "Nurse Notes" that indicated, " ...Transfer x 1. Needs assist with ADL's (Activities of Daily Living) ..." Record review of "Departmental Notes, Category Nurses Notes" dated 8/13/23 at 9:41 AM, revealed "...Resident was sent out to (Proper Name of Local Emergency Room) (ER) via (Proper Name of Ambulance Service)...ER nurse called back at 09:40 stating resident's hip was out of place..." A record review of the "PT (Physical Therapy) & Plan of Treatment", dated 8/11/23, revealed, " ...Patient Referral and History Current Referral Reason for referral/current illness: Patient is a 90 yo (year old) male who suffered a fall in his garden on 7/23/23 resulting in a L (Left) displaced femoral fx(fracture) ...Medical Factors Precautions: Falls risk ...Fall Risk Assessment History of Falls Has Patient fallen in past year? = Yes How many times? = 6 ...Steadiness Does Patient feel unsteady when standing? = Yes Does Patient feel unsteady when walking? = Yes ...Does Patient worry about falling? = Yes ...Functional Mobility Assessment ...Resident uses a wheelchair? = Yes ...Reason for Therapy Clinical Impressions/Reason for Skilled Services: Skilled services required to address deficits in strength, endurance and balance affecting safety with functional mobility ..."	M 640	Data Set (MDS)Assessments on September 11, 2023 for all residents who have been identified as having a potential risk for falls and fall and safety risk assessments were checked for completeness and interventions currently in place are appropriate. DON, ADON will continue to review these weekly for 12 weeks. 4. How the corrective action will be monitored to ensure the practice will not recur: • The DON/ADON/RCM will complete weekly audits beginning September 11,2023 for 12 consecutive weeks of monitoring staff to make sure they are using the proper equipment while transferring residents. This will be monitored by the DON, ADON or RCM two times a week for 5 residents in the building for 12 weeks. • Audit records will be reviewed by the Quality Assurance Committee on October 6, 2023 and the following three months until such time consistent substantial compliance has been achieved as determined by the committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66SR	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY REHABILITATION AND NURSING CT	1436 EAST CENTRAL AVENUE WIGGINS, MS 39577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 640	Continued From page 9 Record review of the "Nurse Data Collection and Screening" document for Resident #1, dated 8/11/23, revealed, "Risk: Fall Risk Form ...History of Falls 3 or more falls in past 3 months ..." On 8/31/23 at 11:40 AM, in an interview with CNA #1, she confirmed that on 8/13/23, before breakfast trays were delivered, she assisted Resident #1 without his walker to the restroom. She said that he ambulated himself but held on to her arm for stability and he had a slow, unsteady gait while walking to the toilet. She stated that she gave him the call bell and advised him to call when he needed assistance back to bed. She then closed the bathroom door for privacy and left the resident's room. CNA #1 explained that after approximately five (5) minutes, his call light came on and she returned to the resident's room. She opened the bathroom door and Resident #1 was sitting on the toilet. He stated that he had fallen off the toilet and had gotten himself back onto the toilet without assistance. He complained of left leg pain at that time. CNA #1 said that the staff is supposed to review the baseline care plan on the kiosk to determine how much assistance is required to safely ambulate and toilet residents. She confirmed that she did not review the kiosk because a night shift CNA had reported to her that the resident could ambulate without a walker or wheelchair. On 8/31/23 at 12:57 PM, an interview with the Physical Therapist (PT) revealed that Resident #1 needed the assistance of one staff member for toileting, transferring and ambulating. The PT also recommended the use of a wheelchair or walker for safety and confirmed that he expected the facility staff to follow his recommendations.	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66SR	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY REHABILITATION AND NURSING CT	1436 EAST CENTRAL AVENUE WIGGINS, MS 39577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 640	Continued From page 10 On 8/31/23 at 1:06 PM, an interview with the Physical Therapy Assistant (PTA) confirmed that she reviewed the Occupational Therapy and Physical Therapy recommendations and completed the base care plan to indicate the level of assistance required with ambulation, transfers, and mobility. The PTA recommended that Resident #1 have assistance from one person with either a walker or wheelchair for ambulation. On 9/1/23 at 11:28 AM, during an interview with the Director of Nurses (DON), she stated that Resident #1 was assisted without his walker to the bathroom by CNA #1 and he had been left alone in the bathroom. The resident reported that he had fallen and gotten himself back up to the toilet without any assistance. She revealed that according to CNA #1, the resident requested privacy and she felt she could leave him alone in the bathroom. The DON confirmed that CNA #1 should have used a walker or wheelchair as per the care plan to assist Resident #1 with walking to the restroom. On 9/1/23 at 11:48 AM, an interview with the Administrator revealed that on 8/13/23, Resident #1 was assisted to the toilet by CNA #1 and the resident stated that he had fallen and gotten back onto the toilet within approximately three (3) minutes. On 9/8/23 at 2:00 PM, in an interview with CNA #1, she confirmed that even though Resident #1 was a new admission, had a slow and unsteady gait, a history of falls, and a diagnosis of Hemiplegia, she thought that because he had asked for privacy and he was alert and oriented, she could leave him unsupervised while on the toilet, and walk away from the resident's room. CNA #1 also confirmed because Resident #1	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66SR	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY REHABILITATION AND NURSING CT	1436 EAST CENTRAL AVENUE WIGGINS, MS 39577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
M 640	Continued From page 11	M 640		

reported that he had fallen and had left leg pain, she used a wheelchair and transferred the resident from the toilet to the wheelchair and assisted him to his bed.

On 9/8/23 at 2:30 PM, an interview with the DON revealed that she expected new residents who required assistance with toileting to be supervised and not left alone. She confirmed that CNA #1 should not have left the resident in his bathroom alone and unsupervised.

On 9/8/23 at 4:00 PM, during an interview with Registered Nurse (RN) #2 revealed, that on 8/13/23, LPN #1 informed her that Resident #1 had reported that he had fallen off the toilet, but that he put himself back on the toilet without any assistance. RN #2 said that Resident #1 was back in his bed at that time and complained of left hip pain. She described Resident #1 as "weak and confused." RN #2 notified the Nurse Practitioner (NP) of the allegation of a fall and the resident's pain and the NP gave an order to send Resident #1 to the local Emergency Department (ED) for evaluation and treatment.

A record review of the "Face Sheet" revealed the facility admitted Resident #1 on 8/11/23 with diagnoses including Left Femur Fracture, Presence of Left Artificial Hip Joint, Hemiplegia following Cerebral Infarction affecting Left Side, and History of Falling.

A record review of the Discharge Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 8/13/23 revealed Resident #1 was admitted by the facility on 8/11/23 from an inpatient rehabilitation facility. He was discharged to an acute hospital on 8/13/23, which was two (2) days after his admission to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	66SR	A. BUILDING: _____ B. WING _____	C 09/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY REHABILITATION AND NURSING CT	1436 EAST CENTRAL AVENUE WIGGINS, MS 39577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE