STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A374	A. BUILDING _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOXUBEE COUNTY NURSING HOME	78 HOSPITAL RD MACON, MS 39341

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 10/16/23 through 10/19/23. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements of participation related to F636, F656, and F688. The census at the time of the survey was 59 and the facility is licensed for 60.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status.	F 636		11/28/23

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

Electronically Signed | 11/06/2023

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F 636	Continued From page 1 (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to accurately complete a Minimum Data Set (MDS) assessment as evidenced by the presence of a pressure ulcer not being indicated on the	F 636	1. Immediate action taken for the resident found to have been affected include: Resident # 50 Comprehensive Assessment was updated by the Minimum Data Set Coordinator on 10/20/2023.	

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F 636	Continued From page 2 assessment for one (1) of 16 MDS assessments reviewed. Resident #50 Findings Include: Review of the facility policy titled, "MDS 3.0 Completion" with an implementation date of 6/14/21 and no revision date revealed under the "Policy...Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan." An interview on 10/18/23 at 8:45 AM, with Registered Nurse (RN)/Treatment Nurse #1 revealed that Resident #50's pressure ulcer was facility acquired and was currently still receiving treatment to the heel that started in July of this year. Review of Resident #50's physicians orders revealed an order dated 7/27/23 to "Paint left (L) heel Deep Tissue Injury (DTI) with betadine for one week." Review of Resident #50's MDS assessment with an Assessment Reference Date (ARD) of 8/21/23 revealed in Section M that the resident did not have a pressure ulcer. A telephone interview on 10/18/23 at 2:00 PM, with the MDS nurse revealed she saw the order dated 7/27/23 for pressure ulcer treatment for Resident #50 but failed to mark the resident having a pressure ulcer on her MDS assessment. An interview on 10/19/23 at 10:30 AM, with the Administrator confirmed that Resident #50 had a facility acquired deep tissue injury with an order	F 636	2. All residents who have pressure ulcers have the potential to be affected by this practice 3. The following actions were taken to reduce the risks of future occurrence include: A. Minimum Data Set Coordinator will meet with treatment nurse by 10/31/2023 to generate a list of all residents who have pressure ulcers, date pressure ulcers were observed to make sure that all pressure ulcers are coded correctly on the MDS. B. Administrator will in-service Minimum Data Set Coordinator on coding pressure ulcers appropriately on the Minimum Data Set by 11/2/2023. 4. Administrator and/or Director of Nurses will audit all residents with pressure ulcers weekly times three months starting on 11/6/2023 to make sure that pressure ulcers are coded on the most recent Minimum Data Set. Audit to be completed by 11/27/2023 and quality Assurance Performance Improvement Committee will be meeting on 11/28/23 to discuss results. A. Results of audits will be reported by Administrator to Quality Assurance Performance Improvement Committee monthly times three months starting on 11/28/2023.	

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F 636	Continued From page 3 for treatment dated 7/27/23 and should have been included on the residents 8/21/23 MDS quarterly assessment and it was not. She revealed the purpose of the MDS assessment is to gather all the information regarding the care and to make sure we are giving the residents the care they need and deserve. Record review revealed that Resident #50 was admitted to the facility on 2/23/23 with medical diagnoses that did not include pressure ulcer. This review revealed the resident's admitting diagnoses include Type 2 Diabetes Mellitus without complications.	F 636		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		11/28/23

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F 656	Continued From page 4 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review the facility failed to implement a care plan regarding the placement of hand rolls per physician's order for one (1) of 16 care plans reviewed. Resident #29 Findings include: Review of the facility policy titled, "Comprehensive Care Plans" with an implementation date of 6/14/21 revealed, "Policy...It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with	F 656	1. Immediate action taken for the resident found to have been affected include: A. resident number 29 hand rolls were applied as ordered on 10/17/2023 by treatment nurse. B. Care plan of resident number 29 were reviewed and updated on 10/17/2023 by treatment nurse/administrator 2. All residents with handrolls have the potential to be affected	

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F 656	Continued From page 5 resident rights, that includes measurable objectives and timeframes to meet a residents medical, nursing, and mental and psychosocial needs..." Record review of Resident #29's care plan with an onset date of 9/3/23 revealed, "I am at risk for pressure ulcers related to poor body control/positioning, poor cognition, contractures to right and left hand ... Approaches... Resident to wear hand roll in bilateral hands on at 9 AM and off at 3 PM to help prevent further contracture ..." On 10/16/23 at 11:33 AM, observation revealed Resident #29's hands were contracted bilaterally. No hand rolls were in place to bilateral hands. In an interview on 10/17/23 at 4:13 PM, Registered Nurse (RN) #1 revealed Resident #29's hand rolls were applied two and a half (2-1/2) hours late today. An interview on 10/18/23 at 3:10 PM with Certified Nurse Assistant (CNA) #1 revealed she does have access to the resident's care plans and the purpose of the care plan was to make sure we know the care the resident needs., An interview on 10/18/23 at 3:15 PM with RN #1 revealed that with Resident #29's hand rolls not being applied to the resident per the physician's order would mean that the resident's care plan was not implemented. An interview on 10/18/23 at 3:22 PM with the Director of Nurses (DON) confirmed that Resident #29's care plan was not implemented when the hand rolls were not applied on Monday and part of Tuesday of this week. He stated that	F 656	3. The following actions were taken to reduce the risk of future occurrence include: A. All nurses and certified nursing assistant will be in-serviced and educated on following resident number 29 and other residents care plans, proper application and proper time on applying hand rolls. In-service will start on 11/1/2023 and will be completed by 11/8/2023. 4. Administrator and/or Director of Nurses will audit resident's care plan who has hand rolls or splints weekly for 3 months starting 11/6/23. Quality Assurance Performance Improvement Committee will meet monthly starting 11/28/2023 for three months then re-evaluate to ensure consistent substantial compliance has been achieved as determined by the committee. A checklist/log was generated to monitor through observation to ensure that staff is following the comprehensive care plan.	

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F 656	Continued From page 6 the hand rolls not being applied could lead to further contractures. In an interview on 10/19/23 at 9:40 AM, with the Administrator confirmed that Resident #29's care plan was not implemented because the resident's hand rolls were not applied on 10/16/23 from 9 AM-3 PM and not until 11:30 AM on 10/17/23. Record review of Resident #29's "Face Sheet" revealed the resident was admitted to the facility on 9/19/19 with medical diagnoses that included Contracture, Right Hand and Contracture, Left Hand. Record review of Resident #29's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/28/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident is severely cognitively impaired.	F 656		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688		11/28/23

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F 688	Continued From page 7 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to place hand rolls on a resident with contractures for one (1) of 25 residents reviewed with contractures. Resident #29 Findings include: Review of the typed documentation on facility letterhead dated 10/19/23 and signed by the Administrator revealed, "We have no policy on splints or hand rolls." An observation on 10/16/23 at 11:33 AM revealed Resident #29 had contracted hands bilaterally with no splints. An observation on 10/17/23 at 11:15 AM revealed Resident #29 lying in bed; hands contracted bilaterally with no splints or hand roll. Record review of Resident #29's Physician Orders revealed an order dated 10/14/21 for resident to wear hand roll in bilateral hands, on at 9 AM and off at 3 PM, to help prevent further contracture. An interview on 10/17/23 at 3:05 PM, with Licensed Practical Nurse (LPN) #1 revealed Resident #29's hand rolls are supposed to be applied by the treatment nurse and are documented on the Treatment Administration Record.	F 688	1. Immediate action taken for the resident found to have been affected include: A. An in-service was conducted on 10/17/2023 by administrator with treatment nurse including the proper application and proper timing of application of handrolls/splints to prevent any decrease om range of motion/mobility. B. On 10/18/23 resident number 29 handrolls was initiated appropriately at appropriate time according to care plan 2. All residents of the facility who require splints to prevent decline in ROM, according to person-centered care plans, have the potential to be affected by this practice. 3. The following actions were taken to reduce the risk of future occurrence include: A. A log of residents requiring use of splints/handrolls were generated and will be monitored by Administrator and/or Director of Nurses monthly starting on 11/6/2023 and will refer to the therapy department if any problems noted. B. Starting on 11/2/23 and completed by 11/9/23 all nursing staff will be in-serviced by Quality Assurance Nurse and/or Director of Nurses including the proper	

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F 688	Continued From page 8 An observation and interview on 10/17/23 at 3:10 PM, with Registered Nurse (RN)/Treatment Nurse #1 and LPN #1 revealed Resident #29 lying in bed with hands contracted bilaterally with a hand roll applied to the right hand. This observation revealed the hand roll on the left hand was secured with Velcro around the resident's wrist, but the roll was hanging free and not inserted into the resident's contracted hand. An interview with RN #1 revealed it is her responsibility to apply the resident's hand rolls daily at 9 AM and remove them at 3 PM. She stated that she knows she did not apply the resident's hand rolls today until about 11:30 AM and that the purpose of the hand rolls is to prevent the resident's hands from further contracture. An interview on 10/17/23 at 4:13 PM, with RN #1 revealed she was late applying Resident #29's hand rolls because the Certified Nursing Assistants (CNAs) were giving the resident a bath between 8 AM-9 AM. She admitted the hand rolls were applied 2 1/2 hours late and stated that applying the hand rolls late would result in the resident not having them on the amount of time daily that was physician ordered and could lead to worsening contractures. An interview on 10/18/23 at 12:15 PM, with LPN #2 revealed she was Resident #29's treatment nurse on 10/16/23 and did not apply the hand rolls because she could not find them. She stated that she had asked other staff about the missing hand rolls and went to laundry but did not find them. She stated that laundry was going to look for them, but they were not found before her shift ended at 3 PM. She stated that normally she would have just used a rolled-up hand towel	F 688	timing of the application of handrolls/splints to prevent any decrease in range of motion/mobility. 4. Administrator and/or Director of Nurses will observe residents requiring splints or handrolls for 3 times a week for 3 months to assure the proper and consistent use of recommended splints/handrolls starting on 11/6/2023 and Quality Assurance Performance Improvement Committee will be meeting on 11/28/23 to discuss results. Results will be taken to the Quality Assurance Performance Improvement Committee starting on 11/28/2023 for three months then re-evaluate to ensure consistent substantial compliance has been answered as determined by the committee.	

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F 688	Continued From page 9	F 688		

in place of the missing hand rolls but was not sure that was ok. She confirmed that she did not ask her supervisor if it would be ok to use a rolled-up hand towel but should have. She revealed the purpose of the resident's hand rolls is to prevent further contracture of the resident's hands or skin breakdown.

An interview on 10/18/23 at 3:22 PM, with the Director of Nurses (DON) confirmed that Resident #29's hand rolls not being applied properly could lead to further contractures or skin breakdown.

An interview on 10/19/23 at 9:40 AM, with the Administrator confirmed that Resident #29's hand rolls not being applied could have led to skin issues for the resident.

Record review of Resident #29's "Face Sheet" revealed the resident was admitted to the facility on 9/19/19 with medical diagnoses that included Contracture, Right Hand and Contracture, Left Hand.

Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/28/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident is severely cognitively impaired.