STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255191	A. BUILDING _____ B. WING _____	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATTALA COUNTY NURSING CENTER	326 HIGHWAY 12 WEST KOSCIUSKO, MS 39090

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey and a complaint investigation (CI) MS #23326 at the facility from 11/6/23 to 11/8/23. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements for participation and cited F584, F656, and F692. The facility was found to be in compliance with CI MS #23326 related to call lights within reach of residents. The facility is licensed for 120 beds and at the time of the survey the census was 103.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		12/7/23

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

Electronically Signed | 11/22/2023

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F 584	Continued From page 1 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and facility policy review the facility failed to maintain a safe environment as evidenced by a splintered chair rail molding for one (1) of 62 resident rooms observed. Resident #70. Findings include: Record review of the facility policy titled, "Maintenance and Repairs", with a revision date of 12/22, revealed "Purpose, To reduce risks and vulnerabilities..." An observation on 11/7/23 at 8: 20 AM, revealed an 18 inch section of wooden chair rail molding, located on the wall beside the residents bed that was splintered, jagged and sticking out toward the foot of Resident #70's bed.	F 584	*Resident #70 was assessed by the Director of Nursing on 11-09-23 and no adverse effects noted. An in-service was conducted with the Maintenance Supervisor by the Administrator on policy titled, "Maintenance and Repairs" on 11-09-23. On 11-06-23 the Maintenance Supervisor removed the jagged molding from the wall. *All one hundred five residents have the potential to be affected by the deficient practice. *Staff consisting of maintenance, housekeeping, laundry, licensed practical nurses, registered nurses, and certified nurse assistants were in-serviced by the Director of Nursing and/or Staff Development Nurse on the policy titled, "Maintenance and Repairs", beginning on	

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F 584	Continued From page 2 During an interview with Licensed Practical Nurse (LPN) #1 on 11/7/23 at 8:22 AM, she stated that if there was something broken in a residents room, they put the information on the log at the nurses station for Maintenance Staff #1. She stated he has to check and sign it daily. During an interview with Resident #70 on 11/7/23 at 8:30 AM, she stated that she did not know how long the wood had been splintered. During an observation and interview with LPN #1 on 11/7/23 at 8:32 AM, she confirmed the wooden chair rail molding was splintered and sticking out. She stated that she was not aware it was broken and stated that it could cause resident injury. A record review of the facility's "Maintenance and Repair Log" for 9/6/2023 through 11/7/2023 revealed no documentation that the chair rail molding in Resident #70's room was in disrepair. During an interview with Maintenance Staff #1 on 11/7/23 at 8:38 AM, he stated he was not aware that the wooden chair rail molding was in disrepair. During an interview on 11/7/23 at 12:46 PM, the Administrator stated that the facility makes periodic safety rounds in rooms, but missed the splintered chair rail molding in Resident #70's room. A record review of the facility's most recent "Safety Checklist", dated 10/27/23, for Resident #70's room revealed no documentation that the chair rail molding was in disrepair.	F 584	11-09-23. The Facility Quality Assurance committee was held on 11-09-23, with the committee consisting of Administrator, Director of Nursing, Medical Director, Infection Preventionist, Minimum Data Set Nurse, and Certified Nurse Aide, with policy titled, "Maintenance and Repairs" with no changes made to the policy. *Beginning 11-13-23, the Administrator and/or Administrative Assistant will monitor the Maintenance and Repairs checklist, located at Desk One and Desk Two Nurse's Station on bulletin boards, weekly for four weeks then monthly for three months. Beginning 11-13-23, the Administrator and/or Administrative Assistant will monitor five rooms per day, weekly for four weeks and monthly for three months. The Quality Assurance committee will address concerns identified from the checklist monthly for four months and make recommendations or changes as needed. The Quality Assurance committee will meet 12-04-23 and then monthly thereafter for four months to review monitoring of procedures to ensure compliance achieved until resolved.	

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F 584	Continued From page 3 During an interview on 11/7/23 at 1:43 PM, with the Administrator revealed that the splintered wood on the chair rail molding could cause an injury to the resident. Record review of Resident #70's Facesheet revealed that she was admitted to the facility on 10/16/2023, with diagnoses of Cerebral Infarction and Diabetes Mellitus. Record review of Resident #70's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/25/23 revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident is cognitively intact.	F 584		
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).	F 656		12/7/23

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F 656	Continued From page 4 (iii) Any specialized services or specialized 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 fluid restriction care plan for one (1) of 27 care plans reviewed. Resident #72 Findings include: A review of the facility policy titled, "Care Plan Process, "revised 08/17, revealed "The comprehensive care plan is an interdisciplinary communication tool...The care plan must include measurable objectives and timeframe's and must describe the services that are to to be furnished	F 656	*On 11-09-23, the Director of Nursing assessed resident #72 with no negative findings noted. On 11-07-23, Minimum Data Set Nurse updated resident #72 care plan on to include noncompliance with fluid restrictions as ordered. *Five residents of one hundred five residents with an order for fluid restrictions have the potential to be affected by the deficient practice. *Beginning 11-09-23, Director of Nursing and Staff Development Nurse immediately initiated in-services with Registered	

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F 656	Continued From page 5 to maintain the residents highest practicable physical, mental, and psychosocial well-being..." A record review of the care plan for Resident #72 titled, ... " ...Receives Hemodialysis ...Problem Onset: 08/02/2023 ...Approaches ...Fluid restriction as ordered ...1500 ml (milliliter) Fluid Restriction: Dietary to provide 1080 ml with meals. Nursing allowed to provide 180 ml day shift, 120 ml in the evenings, and 120 ml on night shift..." An observation with Resident #72 on 11/6/23 at 11:00 AM, revealed six (6) eight (8) ounce bottles of water and seven (7) eight-ounce Shasta colas on the resident's bedside table. An interview with the Director of Nursing (DON) on 11/07/23 at 9:29 AM, she revealed the purpose of the care plan is to direct the residents care and after review of Resident #72's care plans staff were not following the care plan for fluid restriction. An interview with the Minimum Data Set (MDS) Registered Nurse (RN) on 11/07/23 at 10:51 AM, she revealed the purpose of the care plans are to direct resident specific care and not following the care plan could lead to a resident not receiving the specific care they need. Record review of the Facesheet revealed that the facility admitted Resident #72 to the facility on 8/02/23 with diagnoses that included End Stage Renal Disease and Heart Failure. Record review of the open quarterly MDS Section C with an Assessment Reference Date (ARD) of 11/03/23, revealed that Resident #72 had a Brief	F 656	Nurses and Licensed Practical Nurses on policy titled "Care Plan Process" with a revision date of 08/17, that included care plan with interventions related to fluid restrictions as ordered. In-Services will be ongoing until all Registered Nurses and Licensed Practical Nurses have been in-serviced. The facility Quality Assurance committee was held 11-09-23, with the committee consisting of Administrator, Director of Nursing, Medical Director, Infection Preventionist, Minimum Date Set Nurse and Certified Nurse Aide, with policy titled "Care Plan Process" with revision date 8/17 with no changes made to the policies. *Beginning 11-13-23, the Director of Nursing and/or Staff Development Nurse will monitor by review on form titled "Care plan for fluid restrictions" on three residents care plans for implementation of care plan with interventions related to fluid restrictions weekly for four weeks then monthly for three months. The Quality Assurance committee will address concerns identified from the reviews monthly for four months and make recommendations or changes as needed. The Quality Assurance will meet 11-09-23 then 12-04-23, and then monthly thereafter for four months to review monitoring of policies and procedures to ensure compliance achieved until resolved.	

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F 656	Continued From page 6 Interview of Mental Status (BIMS) score of 13 which indicated that she was cognitively intact. A record review of the admission MDS Section O dated 8/09/23, revealed Resident #72 received dialysis while a resident at the facility.	F 656		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review, and facility policy the facility failed to follow a physician prescribed fluid restriction for one (1) of five (5) residents on fluid restriction. Resident #72.	F 692	*On 11-09-23, the Director of Nursing assessed resident #72 with no negative findings noted. On 11-07-23, the Director of Nursing and Medical Records Nurse removed beverages from resident #72 room and Staff Development Nurse	12/7/23

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F 692	Continued From page 7 Findings include: A review of the facility policy titled, "Fluid Restriction," revised 02/22, revealed Policy: "Fluids will be restricted as directed by physician's orders." An observation and interview with Resident #72 on 11/6/23 at 11:00 AM, revealed six (6) eight (8) ounce bottles of water and seven (7) eight-ounce Shasta cola's on the bedside table. Resident #72 stated she keeps the drinks left on her meal trays so she can drink them later. Resident #72 confirmed she was on Dialysis but was unsure if she was on a fluid restriction and stated, "I drink as much as I want because I don't pee very much and even drinking more, I still don't pee very much, I just don't know why." A review of the Physician's Telephone Order dated 8/02/23 for Resident #72 revealed, an order for "1500 ml (milliliter) Fluid Restriction: Dietary to provide 1080 ml with meals. Nursing allowed to provide 180 ml day shift, 120 ml in the evenings, and 120 ml on night shift." An observation and interview with Licensed Practical Nurse (LPN) #2 on 11/07/23 at 7:45 AM, she confirmed Resident #72 had several bottles of water and Shasta drinks on her bedside table and revealed that Resident #72 was on fluid restriction because she is on Dialysis and should not have all those drinks in her room. LPN #2 revealed it was possible for Resident #72 to consume over her recommended fluid restriction with all the drinks on her bedside table and staff would not know the total amount of fluids consumed and a potential concern would be fluid overload.	F 692	notified resident #72 Resident Representative of orders for fluid restriction and removal of beverages 11-07-23, and Director of Nursing notified Physician about resident #72 noncompliance with fluid restriction on 11-09-23. *Five of one hundred five residents have orders for fluid restrictions and have the potential to be affected by the deficient practice. *Beginning 11-09-23, Director of Nursing and Staff Development Nurse immediately initiated in-services with Registered Nurses and Licensed Practical Nurses in policies titled "Fluid Restriction" with a revision date of 02/22 and "Hydration Policy" with a revision date of 05/13, that included adhering to fluid restrictions as ordered. In-services will be ongoing until all Registered Nurses and Licensed Practical Nurses have been in-serviced. The facility Quality Assurance Committee meeting was held 11-09-23 with the committee consisting of Administrator, Director of Nursing, Medical Director, Infection Preventionist, MDS Nurse and CNA with policies titled "Fluid Restriction" with revision date of 02/22, and "Hydration Policy" with a revision date 05/13, with no changes made to the policies. *Beginning 11-13-23, Director of Nursing and/or Staff Development Nurse will monitor by observation on form titled "Fluid Restriction" to ensure no fluids left in resident rooms with orders for fluid restriction on three residents weekly for four weeks then monthly for three months. The Quality Assurance Committee will	

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F 692	Continued From page 8 An interview with Certified Nurse Assistant (CNA) #1 on 11/7/23 at 7:55 AM, she confirmed Resident #72 was on a fluid restriction and revealed she knew the drinks were in Resident #72's room because the resident likes to keep the drinks left on her meal trays. CNA #1 also revealed she did not remove the drinks from the room because the nurse did not tell her to. An interview with the Director of Nursing (DON) on 11/07/23 at 9:29 AM, she confirmed Resident #72 was on a fluid restriction and should not have fluids left in her room and a possible concern would be the resident could drink extra fluids leading to fluid overload related to her End-stage Renal Disease. Record review of the Facesheet revealed that the facility admitted Resident #72 to the facility on 8/02/23 with diagnoses that included End Stage Renal Disease and Heat Failure. Record review of the open quarterly Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) on 11/03/23, revealed that Resident #72 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated that she was cognitively intact. A record review of the admission MDS Section O dated 8/09/23, revealed Resident #72 received dialysis while a resident at the facility.	F 692	address concerns identified from the reviews monthly for four months and make recommendations or changes as needed. The Quality Assurance Committee will meet 11-09-23 and 12-04-23, and then monthly thereafter for four months to review monitoring of policies and procedures to ensure compliance achieved until resolved.	