STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255217	A. BUILDING _____ B. WING _____	11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER HEIGHTS HEALTHCARE CENTER	402 ARNOLD AVENUE GREENVILLE, MS 38701

(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) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 11/19/23 to 11/21/23. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements for participation with deficiencies cited at F640 and F641. The facility is licensed for 60 beds and at the time of the survey the census was 44.	F 000		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		12/20/23

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

Electronically Signed | 12/04/2023

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F 640	Continued From page 1 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to submit a Discharge Minimum Data Set (MDS) assessment timely in accordance with the current federal and state submission timeframes for one (1) of 16 resident MDS assessments reviewed. Resident #40 Findings include: A review of the facility policy titled, "MDS Completion and Submission Timeframes" revised September 2010 revealed, "Policy Statement: Our facility will conduct and submit resident	F 640	1.The facility did submit a Discharge Minimum Data Set (MDS) assessment for resident # 40 on November 21,2023. 2. There is a potential for all residents that are being discharged to be affected by this deficient practice. 3. On December 1, 2023 the MDS nurse completed an 100% audit of all residents discharged from the facility in the last 6 months to see if any other resident had been affected by this deficient practice. The audit revealed that no other resident	

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F 640	Continued From page 2 assessments in accordance with the current federal and state submission timeframes. Policy Interpretation and Implementation: ... 2. The following timeframes will be observed by the facility: Assessment type: ...Discharge Assessment ...Transmission Date: MDS Completion Date +(plus) 14 calendar days..." Record review of the Discharge MDS assessment for Resident #40 revealed the resident was discharged 9/22/23. Section Z revealed Section K Swallowing /Nutritional Status was completed on 11/16/23. A review of the MDS transmission reports from 9/22/23-11/24/23 revealed Resident #40 had no assessments transmitted during this time frame. An interview with MDS/Care plan Nurse on 11/21/23 at 8:00 AM, revealed that she and the other MDS Licensed Practical Nurse (LPN) were new to the job at the time the discharge assessment for Resident #40 was completed and were not responsible for transmitting the MDS. The MDS/Care plan nurse also revealed she recently found that the dietary section for Resident #40's discharge assessment was not completed by the Assessment Reference Date (ARD), and she notified the Dietary Manager to complete her section and confirmed the discharge MDS should have been submitted as soon as the dietary section was completed but it was not. The MDS/Care plan nurse also revealed the purpose of the MDS is to paint a picture of the level of care the resident requires and determines the payment reimbursement and confirmed the discharge assessment for Resident #40 should have been transmitted 14 days after the assessment was completed.	F 640	had been affected. The MDS nurse received in-service education by the administrator on November 29, 2023 on requirements for completing discharged Minimum Data Set (MDS). Beginning on December 1, 2023 the MDS nurse will monitor all residents that are discharged from the facility, weekly, to ensure that they have a discharged Minimum Data Set (MDS) submitted timely via CMS requirements for 3 months finding will be reported to the Quality Assurance committee for further review and changes as indicated. 4. Beginning on December 1, 2023 the Director of Nursing will monitor all residents that are discharged from the facility, Monthly, to ensure that they have a discharged Minimum Data Set (MDS) submitted timely via CMS requirements finding will be reported to the Quality Assurance committee on December 18, 2023 and then for 3 months there after or until issues are resolved.	

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F 640	Continued From page 3 A interview and record review with the MDS/LPN on 11/21/23 at 8:05 AM, confirmed she was new to the job when Resident #40's discharge assessment would have been submitted and revealed the Corporate Nurse was transmitting the assessments at that time. The MDS/LPN revealed that by not submitting the discharge MDS timely it would appear as if Resident #40 was still a resident in the building receiving services. She verified after review of the transmission validation reports she was unable to find where the discharge MDS for Resident #40 was transmitted. A phone interview with the Corporate Nurse on 11/21/23 at 8:55 AM, revealed after review of the discharge MDS for Resident #40 she determined the MDS was never closed, and the dietary section was not completed until 11/16/23. She revealed at the time the assessment for Resident #40 was completed the facility was in transition with new MDS nurses and the facility missed that the discharge assessment was not closed or transmitted. An interview with the Dietary Manager on 11/21/23 at 9:35 AM, revealed she was notified by MDS/Care plan nurse that the dietary section was not completed for Resident # 40, so she completed that section on 11/16/23. Record review of the Face Sheet revealed that the facility admitted Resident #40 on 4/12/23 with diagnosis of Hemiplegia following cerebral infarction affecting right dominate side and the resident was discharged on 9/22/23.	F 640		
F 641 SS=D	Accuracy of Assessments	F 641		12/20/23

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F 641	Continued From page 4 CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) assessments for a Preadmission Screening and Resident Review (PASRR) for two (2) of 16 sampled residents. Resident #4 and Resident #15. Findings Include: A record review of the facility policy "Certifying Accuracy of the Resident Assessment", revised December 2009 revealed "Policy Statement: All personnel who complete any portion of the Resident Assessment (MDS) must sign and certify the accuracy of that portion of the assessment..." Resident #4 A record review of Resident #4's annual MDS with a Assessment Reference Date (ARD) of 5/26/2023, indicated a "No" to A1500, "Is the resident currently considered by the state level II PASRR process to have serious mental illness ..." A record review of Resident #4's "Summary Findings Report," dated 10/20/2022, revealed ... Mental Health: ...The resident meets criteria for having a diagnosis of mental illness as defined by Preadmission Screening Resident Review (PASRR)..."	F 641	Tag 0641 1. Resident # 4 and Resident # 15 had a corrected annual (MDS) submitted on December 1, 2023 indicating a "yes" to A1500. 2. There is potential that all residents that require a Preadmission Screening Resident Review (PASSR)that indicates a mental illness may be effected by this deficient practice. 3. A 100% audit of residents residing at the facility MDS "Summary Findings Reports" question A1500 for accuracy completed on December 1, 2023 by MDS/Care Plan Nurse (MDS/CP). The MDS/Care Plan Nurse (MDS/CP) working at River Heights Healthcare Center received additional education on answering A1500 accurately for residents who meet criteria for having a diagnosis of mental illness as defined by Preadmission Screening Resident Review (PASRR) on November 30, 2023 by the facility Administrator. Beginning on December 1, 2023 the MDS Nurse will monitor the Summary Finding Reports weekly of all residents that are admitted to ensure that all residents that meet the criteria for having a diagnosis of mental illness has	

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F 641	Continued From page 5 A record review of Resident #4's Face Sheet revealed Resident #4 was admitted to the facility on 7/22/11 with diagnoses that included Schizoaffective Disorder and Schizophrenia, Paranoid Type. During an interview on 11/20/23 at 10:19 AM, with the MDS/Care Plan Nurse (MDS/CP), she reviewed the annual MDS and confirmed it was inaccurate. She verified it was coded in error as Resident #4 had been approved for a Level II PASRR and determined to have a serious mental illness. Resident #15 A record review of Resident #15's "Summary Findings Report," dated 4/25/2023, revealed ... Mental Health: ...The resident meets criteria for having a diagnosis of mental illness as defined by Preadmission Screening Resident Review (PASRR)..." A record review of Resident #15's admission MDS with an ARD of 7/28/2023, indicated a "No" to A1500, "Is the resident currently considered by the state level II PASRR process to have serious mental illness ..." A record review of Resident #15's Face Sheet revealed Resident #15 was admitted to the facility on 4/07/2023, with diagnoses that included Bipolar disorder, current episode hypomanic and Delusional disorder. During an interview on 11/20/23 at 10:21 AM, with the Licensed Practical Nurse (LPN) #2 she reviewed the admission MDS and confirmed it	F 641	the question A1500 answered correctly on the MDS. 4. The Director of nursing will monitor the "Summary Findings Reports" weekly, beginning on December 1, 2023 for 3 months per (MDS) calendar to ensure that question A1500 has accurate information submitted. The Director of Nursing will submit findings to the Quality Assurance Committee on December 18, 2023 and for the next three months to ensure issue is resolved and compliance is sustained.	

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F 641	Continued From page 6	F 641		

was inaccurate. She verified it was coded in error as Resident #15 had been approved for a Level II PASRR and determined to have a serious mental illness.

During an interview on 11/20/23 at 10:23 AM, with the MDS/Care plan nurse and MDS LPN #2 they stated that the purpose of the MDS assessment was to determine the care the resident should receive and stated that an inaccurate MDS assessment could lead to the resident not receiving the care they needed.

During an interview on 11/20/23 at 10:25 AM, with the Director of Nursing (DON) she acknowledged Resident #4 and Resident #15's MDS was inaccurately coded. She verified that it is her expectation that the MDS should be coded accurately.