STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255292	A. BUILDING _____ B. WING _____	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITATION	1935 NORTH THEOBOLD EXTENSION GREENVILLE, MS 38704

(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 survey at the facility from 08/12/19 to 08/15/19. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA cited regulatoriy deficiencies at F623, F656, F684, F695, and F697. The census at the time of the survey entrance was 58 , and the facility was certified for 60 beds.	F 000		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		9/23/19

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

Electronically Signed | 09/06/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 623	Continued From page 1 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	F 623		

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F 623	Continued From page 2 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review the facility failed to notify the responsible party in a written form when the resident was transferred to the hospital for five (5) of six (6) residents reviewed for hospitalization. Residents #25, #53, #24, #45 and #39. Findings include:	F 623	*Resident #25 were assessed for adverse effects of the deficient practice on 9.4.19 by Licensed Practical Nurse #1 and no adverse effects were noted. Residents # 53 and #24 were assessed for adverse effects of the deficient practice on 9/5/19 and no adverse effects were noted by Registered Nurse #1 and/or Director of	

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F 623	Continued From page 3 Record review of the facility's policy titled, "Transfer Form", with a revision date of 02/17, revealed a copy of the Transfer Form must be given to the resident or resident representative and maintained in the resident's medical record. On 8/14/19 at 2:30 PM, an interview with the Administrator (ADM) confirmed the facility was not sending a written notification to resident's responsible parties when a resident was transferred out of the facility. The ADM revealed she was not aware of the regulation that required a written notice was to be sent to the responsible parties when the resident was transferred to the hospital. Resident #24 Record review of Resident #24's Physician's Orders revealed an order to transfer the resident to the hospital on 4/16/19. Resident #24 was admitted to the hospital for Urinary Tract Infection. Resident #24 did return to the facility on 4/22/19. Review of the Face Sheet revealed Resident #24 was admitted by the facility, on 5/15/18 and readmitted on 9/26/18, with the included diagnoses a Below the Left Knee Amputation (BKA), Hypertension, Heart Failure, Peripheral Vascular Disease, Major Depression, Diabetes Type II, and Urinary Tract Infection. Resident #39 Record review of Resident #39's Physician's Orders revealed an order to transfer the resident	F 623	Nursing. Residents #25, #53, and #24 have not left the facility for a non-scheduled transfer since survey ending, therefore, a written notice of transfer has not been issued. Resident #39 returned to the facility on 8/16/19 and expired in facility on 8/19/19. *Between 8/16/19 through 9/5/19, six (6) residents have been transferred to the emergency room, therefore, six (6) of the fifty-six residents have the potential to be affected by the failure to provide written transfer notice to the resident representative. Of the six residents written notices were provided to the resident/resident representatives and the Ombudsman was notified. *An in-service was conducted on 8/27/19 by the Quality Improvement Nurse, Director of Nursing and/or Staff Development Nurse on the policy/procedure titled Discharge Transfer and Planning revised 6/19 with Social Services and Nursing Staff. The in-service included providing written notice of transfer to the resident, resident representatives and Ombudsman by Social Services.The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director, and Department Heads, reviewed the policy on Discharge Transfer and Planning with revision date of 6/19 on 8/29/19 and did not recommend any changes. *Beginning 9/5/19, performance will be monitored by Administrator, Director of Nursing, and/or Medical Records Nurse to ensure compliance related to providing	

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F 623	Continued From page 4 to the hospital on 8/4/19 due to the resident was unresponsive to verbal or tactile stimuli. Resident #39 remains in the hospital with expected return to the facility. Review of the Face Sheet revealed Resident #39 was admitted by the facility, on 6/19/19, with the included diagnoses Pneumonia, Parkinson's Disease, and Urinary Tract Infection. Resident #53 Record review of Resident 53's Nurses Notes, dated 3/19/19 at 10:04 AM, revealed the resident was transferred to the hospital due to difficulty breathing and lethargy. Review of the Nurses Notes, dated 3/23/19 at 12:43 AM, revealed Resident #53 returned to the facility after both transfers. Review of Resident #53's Physician's Orders revealed an order to transfer the resident to the hospital, on 5/27/19, for evaluation of generalized weakness and mental status change. Review of the Face Sheet revealed Resident #53 was admitted by the facility, on 3/27/17 and readmitted on 6/14/19, with included diagnoses of Bipolar Disorder, Depression, Anorexia Nervosa, Diabetes Type II, Pressure Ulcers to Right and Left Heel and Sacrum, Hypertension, Peripheral Vascular Disease, and Urinary Tract Infection. Resident #25 Record review of a Nurse's Note, dated 5/11/19, at 5:23 AM, revealed Resident #25 was transferred to the local hospital, on 5/11/19, with increased respiratory congestion and an oxygen	F 623	written notice of transfer to the resident,resident representative and ombudsman weekly for four weeks and then monthly for two months and findings recorded on the transfer notice log that written transfer notices were provided to the resident and resident representative and maintained by Social Services. The Quality Assurance Committee will address concerns identified from the performance monitoring of providing written notice to transfer to resident and resident representative and evaluate the monitoring completed by the Administrator, Director of Nursing, and/or Medical Records Nurse monthly for three months and make any recommendations or changes needed.	

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F 623	Continued From page 5 saturation level of 85 percent. Record review of a Nurse's Note Late Entry, at 5:10 PM on 5/11/19, revealed the resident was admitted to the local hospital. Review of the resident's record revealed the Resident Representative (RR) was not notified in writing of the transfer. On 08/15/19 at 10:00 AM, an interview with the Director of Nursing (DON), revealed the facility did not issue a written notification to the RR at the time of the hospital transfer and that she was not aware of the regulation requiring written notification of RR when a resident was transferred to the hospital. The DON stated the RR would be called, and it should be documented in the record. Record review of Resident #25's Face Sheet revealed the resident was admitted by the facility on 3/7/14, with the included diagnosis of Toxic Encephalopathy. Record review of the Minimum Data Set (MDS) Quarterly Assessment ,with an Assessment Reference Date (ARD) of 5/24/19, Section C, revealed a staff assessment for mental status was conducted and the resident had severely impaired cognitive skills for daily decision making. Resident #45 Record review of a Physician's Order dated 6/5/19, for Resident #45 revealed the resident was transferred to the local hospital emergency room on 6/5/19 for evaluation. On 08/15/19, at 3:46 PM, an interview with Administrator revealed the facility was not notifying the Responsible Party in a written form.	F 623		

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F 623	Continued From page 6 She stated that the facility sends a transfer form with the resident to the hospital. The Administrator stated, she didn't know, and they would get it in order. Record review of the Face Sheet for Resident #45 revealed the resident was admitted by the facility on 11/08/11, with the included diagnoses of Chronic Venous Hypertension with Ulcer of Unspecified Lower Extremity. Review of Section C of the Minimum Data Set (MDS) Prospective Payment System 30 Day Assessment, with an Assessment Reference Date (ARD) of 7/8/19, revealed Resident #45 had a Brief Interview for Mental Status (BIMS) score of 00, indicating severely impaired cognition.	F 623		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		9/23/19

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F 656	Continued From page 7 under §483.10, including the right to refuse treatment under §483.10(c)(6). (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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to develop a Care Plan for Resident #43's skin condition, care and treatment for one (1) of 17 residents reviewed for care plan development. The facility failed to implement the Care Plan related to Resident #36's pain management and changing Resident #25's oxygen tubing for two (2) of 17 care plans reviewed for implementation of care plans. Findings include: Record review of the facility's policy titled, "Care Plan Process", dated 8/17, revealed the facility	F 656	F656 POC * Resident #43 was assessed for adverse effects of the deficient practice on 9/4/19 by Licensed Practical Nurse #2 and no signs and symptoms were present. Resident #43 care plan was updated to include skin condition including care and treatment on 9/4/19 by the Minimum Data Set Nurse. Resident #36 was assessed for adverse effects of the deficient practice on 9/4/19 by Licensed Practical Nurse #2 and no adverse effects were noted. Resident #36 care plan was updated to include pain management on 9/4/19 by the Minimum Data Set Nurse.	

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F 656	Continued From page 8 staff shall follow the care plan. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical nursing, and mental and psychosocial needs. Resident #43 Record review of Resident #43's Care Plan revealed no care plan or interventions were developed to address the resident's lower extremities' skin condition, the visits to the wound clinic, or any treatment for the lower extremities' skin condition. Further review of the Care Plans revealed the skin condition and compression and edema control interventions were not added until 8/14/19, after the surveyor identified there was no care plan or interventions for this concern. On 08/12/19 at 12:33 PM, an observation revealed Resident #43 was sitting in the dining room at a table with noted swelling and blistered areas on her front lower extremities. Review of Resident #43's Physician's Order Details from the (Name of Hospital) Wound Healing Center, dated 8/1/19, revealed: Discharge from wound care clinic. Call for appointment if needed. May shower without dressing. Keep skin clean and well moisturized (with cream such as Aquaphor) daily. ACE 6X5 (Compression Bandage six inches by five feet) to Bilateral Lower Extremity (BLE) as needed (PRN). Compression/Edema Control: Single Layer Compression Wrap to affected Leg(s). Apply compression wrap from mid-foot to knee, covering heel. Apply in the morning. Remove at bedtime. Keep legs elevated. - ACE 6x5 to BLE PRN. Elevate leg(s) above the level of the heart	F 656	Resident #25 was assessed for adverse effects of the deficient practice on 9/4/19 by Licensed Practical Nurse #1 and no adverse effects were noted. Resident #25 care plan was updated to include changing of the oxygen tubing on 9/4/19 by the Minimum Data Set Nurse. *All residents have the potential to be affected by the failure to develop/implement comprehensive care plans. *An in-service was conducted on 8/21/19 by the Quality Improvement Nurse, Director of Nursing and/or Staff Development Nurse on the policy/procedure titled Care Plan Process revised 8/17 with Nursing Staff. The in-service included skin conditions including care and treatment, pain management and oxygen tubing changes to be included on care plans. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director, and Department Heads, reviewed the policy on Care Plan Process with revision date of 8/17 on 8/29/19 and did not recommend any changes. *Beginning 9/5/19, performance will be monitored by Director of Nursing, Staff Development Nurse, Minimum Data Set Nurse, Nurse Case Manager, and/or Nurse Supervisor to ensure compliance related to care plans by reviewing five (5) care plan performances weekly specifically for pain management, skin issues and oxygen for four weeks and then five (5) monthly for two months and findings recorded on the medical record audit form and maintained by the Director	

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F 656	Continued From page 9 when sitting - Monitor fluid intake. On 08/14/19 at 4:09 PM, an interview with RN #1/Case Mix/Care Plan Nurse, revealed there was no care plan developed addressing the skin breakdown on Resident #43's lower extremities, the treatments to the skin or the weekly visits to the wound clinic. On 08/14/19 at 10:15 AM, an interview with Registered Nurse (RN) #2, revealed there was no orders for treatment for the skin issues on Resident #43's lower legs. RN #2 also confirmed after review of the orders on 8/1/19 from the wound healing center that she was not aware of these orders for Resident #43's wound clinic visit on 8/1/19 for a single layer compression wrap to affected legs, apply compression wrap from mid-foot to knee, covering heel. Apply in the morning. Remove at bedtime. Keep legs elevated. RN #2 confirmed the order from the wound clinic was not being implemented. Resident #36 Record review of Resident #36's Care Plan revealed a Care Plan, no date, was developed for pain. Further review of the Care Plan revealed the goal stated Resident #36 would not have any pain through the next review on 11/15/19. The Interventions included: Instructed staff to administer medications as ordered. Record review of Resident #36's August 2019 Electronic Medication Administration Record, revealed on Saturday, August 9, 2019, the medication, Actemra (Given for moderate to severe Rheumatoid Arthritis) 62 milligrams (mg)/0.9 milliliters (ML) subcutaneous injection	F 656	of Nursing. The Quality Assurance Committee will address concerns identified from the performance monitoring of care plans and evaluate the monitoring completed by the Director of Nursing, Staff Development Nurse, Minimum Data Set Nurse, Nurse Case Manager, and/or Nurse Supervisor monthly for three months and make any recommendations or changes needed.	

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F 656	Continued From page 10 every week was documented as not given. On 08/14/19 at 3:50 PM, an interview with RN #1 revealed she was one of the nurses responsible for developing Care Plans, and she confirmed Resident #36's Care Plan had an intervention that instructed staff to administer medications as ordered for pain. RN #1 confirmed the nursing staff did not give an ordered medication to Resident #36 for pain related to her arthritis. Resident #25 Review of Resident #25's Care Plans revealed a care plan, with a problem onset date of 12/07/16, for oxygen therapy with the included approach: Change tubing to oxygen every seven (7) days. An observation, on 8/12/19 at 4:51 PM, revealed there was no date on Resident #25's oxygen (O2) tubing. There was a piece of tape wrapped around the O2 tubing at the connection site to the humidifier bottle, which was torn. The Humidification bottle was dated 8/6/19. An observation, on 8/13/19 at 11:08 AM, revealed the humidification bottle had been changed, but there was no date on the bottle. The O2 tubing with the torn tape was still around the tubing. On 08/13/19 at 1:53 PM, an interview with the Director of Nursing (DON), revealed the care plan was not followed for changing the O2 tubing every seven (7) days. Record review of the August 2019 Physician's Orders revealed an order with a start date of 12/21/18, for Humidified Oxygen at two (2) liter	F 656		

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F 656	Continued From page 11 per minute continuously for Dyspnea. Record review of Resident #25's Face Sheet revealed the resident was admitted by the facility on 3/7/14, with the included diagnosis of Toxic Encephalopathy. Record review of the Minimum Data Set (MDS) Quarterly Assessment, with an Assessment Reference Date (ARD) of 5/24/19, Section C, revealed that a staff assessment for mental status was conducted and the resident had severely impaired cognitive skills for daily decision making.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657		9/23/19

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LEGACY MANOR NURSING AND REHABILITATION	1935 NORTH THEOBOLD EXTENSION GREENVILLE, MS 38704

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F 657	Continued From page 12 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to revise a care plan for oxygen therapy when the order for oxygen was changed from as needed to continuous for (1) of 17 resident care plans reviewed, Resident #25. Findings include: Review of the facility's policy titled, "Care Plan Process", with the latest revision of 08/17, revealed "The care plan must be reviewed and revised periodically, on an ongoing basis to reflect the services provided or arranged, and must be consistent with each resident's written plan of care". Record review of Resident #25's Care Plan revealed a Problem/Need for oxygen therapy as needed due to shortness of breath while lying flat. The Onset Date was 12/07/16. The Goal & Target Date stated Resident #25 would receive adequate oxygen saturation, and would have no complications with oxygen therapy thru the next review on 8/27/19. An observation, on 8/12/19 at 4:51 PM, revealed Resident #25 was lying in bed, positioned on his right side with pillows. The head of the bed was elevated approximately 30 degrees. Resident #25 had oxygen (O2) on at two liters per minute (2	F 657	*Resident #25 was assessed for adverse effects of the deficient practice on 9/4/19 by Licensed Practical Nurse #1 and no adverse effects were noted. Resident #25 care plan was updated to include continuous oxygen on 9/4/19 by the Minimum Data Set Nurse. *Twelve of the fifty-six residents have the potential to be affected by the failure to revise the care plan for oxygen therapy. *An in-service was conducted on 8/21/19 by the Quality Improvement Nurse, Director of Nursing and/or Staff Development Nurse on the policy/procedure titled Care Plan Process revised 8/17 with Nursing Staff. The in-service included changes in oxygen orders to be included on care plans. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director, and Department Heads, reviewed the policy on Care Plan Process with revision date of 8/17 on 8/29/19 and did not recommend any changes. *Beginning 9/5/19, performance will be monitored by Director of Nursing, Staff Development Nurse, Minimum Data Set Nurse, Nurse Case Manager, and/or Nurse Supervisor to ensure compliance related to revising care plans related to	

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F 657	Continued From page 13 L/M) via a nasal cannula attached to an O2 concentrator. Record review of the August 2019 Physician's Orders revealed an order, dated 12/21/18 for humidified O2 at 2 L/M continuously for Dyspnea (Difficulty Breathing). During an interview with the Director of Nursing (DON), on 8/13/19, at 1:53 PM, she confirmed that Resident #25's care plan for oxygen therapy had not been revised to reflect the current oxygen order and that it would be important that the care plan reflect the current condition of the resident. Record review of Resident #25's Face Sheet revealed the resident was admitted to the facility, on 3/7/14, with the included diagnosis of Toxic Encephalopathy. Record review of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 5/24/19, Section C, revealed that a staff assessment for mental status was conducted and the resident had severely impaired cognitive skills for daily decision making.	F 657	oxygen orders by reviewing five (5) care plan performances weekly for four weeks and then five (5) monthly for two months and findings recorded on the medical record audit form and maintained by the Director of Nursing. The Quality Assurance Committee will address concerns identified from the performance monitoring of care plans and evaluate the monitoring completed by the Director of Nursing, Staff Development Nurse, Minimum Data Set Nurse, Nurse Case Manager, and/or Nurse Supervisor monthly for three months and make any recommendations or changes needed.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		9/23/19

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F 684	Continued From page 14 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, record review and facility policy review, the facility failed to provide a skin treatment as ordered by a physician for one (1) of three (3) resident skin observations. Resident #43 Findings include: Record review of the facility's policy titled, " Prevention and Treatment of Skin Issues", dated 2/17, revealed it is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures: and to provide appropriate treatment modalities for wounds according to industry standards of care. On 08/12/19 at 12:33 PM, an observation revealed Resident #43 was sitting in the dining room at a table with noted swelling and blistered areas on her front lower extremities. Review of Resident #43's Physician's Order Details from the (Name of Hospital) Wound Healing Center, dated 8/1/19, revealed: Discharge from wound care clinic. Call for appointment if needed. May shower without dressing. Keep skin clean and well moisturized (with cream such as Aquaphor) daily. ACE 6X5 (Compression Bandage six inches by five feet) to Bilateral Lower Extremity (BLE) as needed (PRN). Compression/Edema Control: Single Layer Compression Wrap to affected Leg(s). Apply compression wrap from mid-foot to knee, covering heel. Apply in the morning. Remove at	F 684	*Resident #43 was assessed for adverse effects of the deficient practice on 9/4/19 by Licensed Practical Nurse #2 and no adverse effects were noted. Resident #43 had orders implemented for care and treatment of her skin condition on 8/14/19 by Medical Records Licensed Practical Nurse. * Seventeen of the fifty-six residents have the potential to be affected by the failure to implement orders for care and treatment of skin conditions. *An in-service was conducted on 8/21/19 by the Quality Improvement Nurse, Director of Nursing and/or Staff Development Nurse on the policy/procedure titled Prevention and Treatment of Skin Issues revised 2/17 with Nursing Staff. The in-service included implementing orders for the care and treatment of skin conditions. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director, and Department Heads, reviewed the policy on Prevention and Treatment of Skin Issues with revision date of 2/17 on 8/29/19 and did not recommend any changes. *Beginning 9/5/19, performance will be monitored by Director of Nursing, Staff Development Nurse, Medical Records Nurse, Nurse Case Manager, and/or Nurse Supervisor to ensure compliance related to implementing orders for the care and treatment of skin conditions by	

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F 684	Continued From page 15 bedtime. Keep legs elevated. - ACE 6x5 to BLE PRN. Elevate leg(s) above the level of the heart when sitting - Monitor fluid intake. Further review of the (Name of Hospital) Wound Healing Center revealed Physician Orders Details dated 7/18/19 and 7/25/19. Both orders stated: Return appointment in one week. Wound Cleansing & Dressings: Dressing/wrap to be changed in seven (7) days, by nurse, upon arrival to the wound healing center. Do not get wrap wet. Xerofoam to wound covered with ABD pads, triamcinolone cream, viscopaste, and ACE 6x5 (Compression bandage six inches by five feet) to RLE (Right Lower Extremity). Compression and Edema Control: Multi Layer Wrap to affected leg(s) - Do not get leg(s) with wrap wet. If wraps are too tight, elevate leg(s) and the call the wound center. Remove wrap if discomfort continues. ABD pads, triamcinolone cream, viscopaste, and ACE 6x5 to RLE. Elevate the leg(s) above the level of the heart when sitting - Monitor fluid intake. Physician Review: Discussed Plan of Care at bedside with patient/caregiver. Orders sent to the nursing home, as they provide care for the patient. On 8/12/19 at 3:00 PM, an interview with Resident #43 revealed the nurses do not do any treatments to her legs. On 08/14/19 at 10:15 AM, an interview with Registered Nurse (RN) #2/Treatment Nurse confirmed there were no orders for treatment to Resident #43's lower legs. After review of the orders on 8/1/19, RN #2 confirmed she was not aware of the orders from the wound clinic, dated 8/1/19, for Resident #43 to apply a single layer compression wrap to affected legs, apply compression wrap from mid-foot to knee,	F 684	reviewing skin reports and making observations to ensure all areas have care and treatment orders weekly for four weeks and then monthly for two months and findings recorded on the medical record audit form and maintained by the Director of Nursing. The Quality Assurance Committee will address concerns identified from the performance monitoring of ensuring skin conditions have care and treatment orders and evaluate the monitoring completed by the Director of Nursing, Staff Development Nurse, Medical Records Nurse, Nurse Case Manager, and/or Nurse Supervisor monthly for three months and make any recommendations or changes needed.	

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F 684	Continued From page 16 covering heel. Apply in the morning. Remove at bedtime. Keep legs elevated. RN #2 confirmed the order from the wound clinic was not being implemented. On 8/15/19 at 11:32 AM, an interview with the Director of Nursing (DON) confirmed the order from the Physician at the wound clinic, on 8/1/19, after Resident #43 was treated there, did not get processed or implemented after she returned to the facility. Record review of Resident #43's August 2019 Physician's Orders revealed an order noted on 6/21/9 and discontinued on 7/11/19 to clean the right leg with normal saline pat dry, apply Vit. D ointment twice daily and monitor leg for drainage, open wounds or bleeding. Further review of the orders revealed no orders for treatment to Resident #43's lower legs were written until 8/14/19, after the surveyor brought the absence of orders for the resident's lower leg treatment. Review of the Face Sheet revealed Resident #43 was admitted by the facility, on 7/16/15, and readmitted on 8/26/15, with included diagnoses Dementia, Cellulitis, Nicotine Dependence, Edema, Diabetes Mellitus Type I with Hyperglycemia, and Convulsions.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		9/23/19

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F 695	Continued From page 17 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review and record review the facility failed to change the oxygen tubing every seven (7) days for 1 of five (5) residents reviewed with oxygen. Resident # 25 Findings include: Review of the facility's policy titled, "Infection Control Oxygen Equipment Cleaning", latest revision of 03/18, revealed: "Use disposable tubing, masks, and cannulas for patients receiving oxygen therapy. This equipment is to be discarded as this procedure dictates: 7. Tubing should be replaced every 7 (seven) days". An observation, on 08/12/19 at 4:51 PM, revealed Resident #25's oxygen (O2) tubing was attached to an O2 concentrator by his bed. The O2 tubing had not date to indicate the date it was connected to the O2 concentrator. There was a piece of torn white tape wrapped around the O2 tubing at the connection to the humidifier bottle. On 08/13/19 at 11:08 AM, an observation revealed the same O2 tubing with the torn tape around the tubing at the connection to the humidifier bottle remained attached to the concentrator. Record review of the August 2019 Physician's Orders revealed an order with a start date of 12/21/18, for "Humidified Oxygen at two (2) liters per minute continuously for Dyspnea".	F 695	*Resident #25 was assessed for adverse effects of the deficient practice on 9/4/19 by Licensed Practical Nurse #1 and no adverse effects were noted. Resident #25 had his oxygen tubing changed on 8/19/19 by Licensed Practical Nurse #3. * Twelve of the fifty-six residents have the potential to be affected by the failure to change oxygen tubing per policy. *An in-service was conducted on 8/21/19 by the Quality Improvement Nurse, Director of Nursing and/or Staff Development Nurse on the policy/procedure titled Infection Control Oxygen Equipment Cleaning revised 3/18 with Nursing Staff. The in-service included changing oxygen tubing weekly. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director, and Department Heads, reviewed the policy on Infection Control Oxygen Equipment Cleaning with revision date of 3/18 on 8/29/19 and did not recommend any changes. *Beginning 9/5/19 , performance will be monitored by Director of Nursing, Staff Development Nurse, Medical Records Nurse, Nurse Case Manager, and/or Nurse Supervisor to ensure compliance related to changing oxygen tubing weekly for four weeks and then monthly for two months and findings recorded on the medical record audit form and maintained	

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F 695	Continued From page 18 On 08/13/19 at 11:10 AM, during an interview with Licensed Practical Nurse (LPN) #2 revealed she confirmed the tape looked as if it had been torn off, and that there was no date on the oxygen tubing. LPN #2 stated the whole system is usually changed every Sunday on the 11/7 shift. She stated it was important to change the tubing weekly because we want to be sure they are getting proper air flow. If it has been on too long they may not get the proper air they need, sometimes it will make their nose dry out, and also for sanitary issues, it may cause an infection. LPN #2 confirmed that there would be no way of knowing how long the tubing had been in use without a date. On 08/13/19 at 1:53 PM, in an interview with the Director of Nursing (DON), she stated that the oxygen tubing should be changed weekly on the 11/7 shift, and it should be dated on a piece of tape. The DON stated that it's important to have clean tubing. Record review of Resident #25's Face Sheet revealed the resident was admitted by the facility, on 3/7/14, with a diagnosis of Toxic Encephalopathy. Record review of the Minimum Data Set (MDS) Quarterly Assessment, with an Assessment Reference Date (ARD) of 5/24/19, Section C, revealed that a staff assessment for mental status was conducted and the resident had severely impaired cognitive skills for daily decision making.	F 695	by the Director of Nursing. The Quality Assurance Committee will address concerns identified from the performance monitoring of changing oxygen tubing and evaluate the monitoring completed by the Director of Nursing, Staff Development Nurse, Medical Records Nurse, Nurse Case Manager, and/or Nurse Supervisor monthly for three months and make any recommendations or changes needed.	
F 697 SS=D	Pain Management CFR(s): 483.25(k)	F 697		9/23/19

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F 697	Continued From page 19 §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, record review and facility policy review, the facility failed to administer pain medication as ordered by the physician for one (1) of two (2) residents monitored for pain. Resident #36 Findings include: Record review of the facility's policy titled, "Pain Screen and Management", dated 9/18 revealed all residents who experience routine pain receive a comprehensive pain screening and a treatment plan until acceptable level of relief is achieved. On 08/12/19 at 04:07 PM an interview with Resident #36 revealed she had arthritis and pain in her hands and wrist, and she was supposed to receive a shot on Saturday for her arthritis, but she did not. Resident #36 revealed she was told by the nurse she did not have any, and she would take care of it on Monday. Record review of Resident #36's Medication Administration record revealed on Saturday, August 10th 2019 the medication Actemra was not administered. Record review of Resident #36's Physician Orders for August 2019 revealed an order dated 5/8/19 for Actemra 162 mg/0.9 ML syringe give subcutaneous injection every week.	F 697	*Resident #36 was assessed for adverse effects of the deficient practice on 9/4/19 by Licensed Practical Nurse #2 and no adverse effects were noted. Resident #36 received her arthritis injection on 8/14/19 by Licensed Practical Nurse #4 and received her Norco as needed for complaints of pain. *Thirty-nine of the fifty-six residents have the potential to be affected by the failure to administer pain medications. *An in-service was conducted on 8/21/19 by the Quality Improvement Nurse, Director of Nursing and/or Staff Development Nurse on the policy/procedure titled Pain Screen and Management revised 9/18 with Nursing Staff. The in-service included administration of pain medications as ordered, ordering medications, notifying the physician when medication is out and the utilization of the backup pharmacy. The Quality Assurance Committee, which includes the Administrator, Director of Nursing, Medical Director, and Department Heads, reviewed the policy on Pain Screen and Management with revision date of 9/18 on 8/29/19 and did not recommend any changes. *Beginning 9/5/19 , performance will be monitored by Director of Nursing, Staff	

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F 697	Continued From page 20 On 8/15/19 at 11:45 AM, a phone interview with Licensed Practical Nurse (LPN) #1 confirmed she did not give Resident #36 her ordered and scheduled Actemra injection on Saturday at 9:00 AM due to there was none in the facility. LPN #1 revealed she checked in the medication storage room refrigerator, where it was kept, and it was not there. LPN #1 revealed she attempted to call Resident #36's physician but was unable to get him, and she called the pharmacy and was told they did not have the medication in stock and would have to order it and it should be delivered on Monday. LPN #1 confirmed she did not document she attempted to call the physician, that she called the pharmacy and did not document being out of the medication on the 24 hour report. On 08/12/19 at 4:36 PM, an interview with the Director of Nursing (DON) confirmed Resident #36's Electronic Medication Administration Record (EMAR) for Saturday August 10th revealed an N was documented for the medication of Actemra 162 milligrams (MG)/0.9 millimeters (ML) syringe give subcutaneous injection every week was not given. The DON revealed the last injection was given August 3, 2019, and should have been reordered at that time but was not. On 8/15/19 at 11:32 AM, an interview with the DON confirmed Resident #36 did not receive her Actemra on Saturday as ordered. The DON revealed the nurse that gave the last injection should have ordered another injection for the next week. The DON revealed Resident #36's physician was notified on 8/13/19.	F 697	Development Nurse, Medical Records Nurse, Nurse Case Manager, and/or Nurse Supervisor to ensure compliance including resident interviews related to administration of pain meds for five residents weekly for four weeks and then monthly for two months and findings recorded on the medical record audit form and maintained by the Director of Nursing. The Quality Assurance Committee will address concerns identified from the performance monitoring of administration of pain meds and evaluate the monitoring completed by the Director of Nursing, Staff Development Nurse, Medical Records Nurse, Nurse Case Manager, and/or Nurse Supervisor monthly for three months and make any recommendations or changes needed.	

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F 697	Continued From page 21 mg/0.9 ml scheduled for 8/10/19 was not administered Record review of Resident #36's Nurses Notes, dated 8/10/19 at 10:15 AM, revealed LPN #1 documented the Actemra 162 .	F 697		

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to properly perform fire drills as per NFPA section 19.7.1.2. This deficiency affected all residents in the facility on the day of survey. Findings Include: On August 13, 2019 at 11:45 AM, the facility was unable to provide documentation of fire drills conducted on the 1st & 3rd shifts in the 2nd quarter of year 2019. All other drills in the past year 2018 were performed correctly and the personnel responded correctly well to a drill conducted during the survey.	K 712	#1 Fire drill was conducted by Maintenance Supervisor on 8/16/19 at 3:36 PM and at 5:55 PM. Fire Drill was conducted on 8/20/19 at 8:21 AM.Fire Drill was also conducted on 8/13/19 during Life Safety Code Survey on first shift. #2 Fifty-eight out of fifty-eight residents had the potential to be affected by this deficient practice. #3 In-service was conducted by administrator with maintenance supervisor on 8/13/19 at 12:45 PM on fire drills occurring each shift per quarter. Monthly record of drills using index log will be used	9/23/19

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

Electronically Signed | 09/06/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255292	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/13/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY MANOR NURSING AND REHABILITATION	**1935 NORTH THEOBOLD EXTENSION GREENVILLE, MS 38704**

(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
K 712	Continued From page 1 The finding was acknowledged by the Administrator and Maintenance Director verified this observation during the exit interview on 8-13-19.	K 712	by maintenance supervisor and administrator to monitor timeliness of the quarterly fire drills. #4 The administrator will monitor fire drill log monthly for three months, quarterly for six months to ensure a fire drill has been conducted on each shift per quarter. Any variance from fire drill schedule will be brought to the Quarterly Assurance committee by administrator for needed improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 000	Initial Comments ********** Survey conducted on 08/23/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

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