STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255308	A. BUILDING _____ B. WING _____	01/25/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 01/23/2024 through 01/25/2024. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F564, F567, and F625. The facility had a census of 45 and was licensed for 59 beds.	F 000		
F 564 SS=D	Inform Visitation Rghts/Equal Visitation Prvl CFR(s): 483.10(f)(4)(vi)(A)-(D) §483.10(f)(4)(vi) A facility must meet the following requirements: (A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section. (B) Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. (C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. (D) Ensure that all visitors enjoy full and equal	F 564		2/29/24

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

Electronically Signed | 02/07/2024

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F 564	Continued From page 1 visitation privileges consistent with resident preferences. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to honor a resident's rights by limiting the resident's visiting hours without clinical or safety reasons for doing so for one (1) of (12) sampled residents residing in the facility. Resident #22 Findings Include: Review of the facility's policy, "Policy: Resident Right to Access and Visitation", revised 3/8/23, revealed " ...It is the policy of this facility to support and facilitate the resident's right to receive visitors of their choosing, at the time of their choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of other residents. Visitation will be person centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life...Policy Explanation and Compliance Guidelines ...2 ...Resident's family members are not subject to visiting hours limitations or restrictions not imposed by the resident, with the exception of reasonable clinical and safety restrictions, placed by the facility according to CDC (Centers for Disease Control) guidelines, and/or our local health department recommendations ...11. The facility will ensure all visitors enjoy full and equal visitation privileges consistent with resident preferences ..." During an interview on 1/23/24 at 2:49 PM, Resident #22 complained that the facility refused to allow her husband to stay with her at night. The	F 564	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: The Administrator and Director of Nursing spoke with the resident and family on January 24, 2024 regarding visitation. The resident and her family understand that facility does not restrict visiting hours. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: The facility has reviewed its policy on Visitation. Education was provided to all staff on January 24, 2024 by the Administrator, Director of Nursing, Assistant Director Of Nursing, Unit Managers and Department Managers regarding visitation with an emphasis on allowing overnight visitation.	

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F 564	Continued From page 2 resident said she does not feel comfortable being in the facility by herself. During an interview on 1/23/24 at 2:52 PM, with Resident #22's husband, he stated that he received phone calls from his wife during the night because she had difficulty sleeping. He said that she was not accustomed to being by herself and he had requested a private room so he could stay with her more often without disturbing another resident. However, after his wife was moved to a private room, the facility still did not permit him to stay with his wife during the nighttime hours. He commented that he had talked to the Director of Nursing (DON), floor staff, the social worker, and everybody that would listen to him because he wanted to be able to stay during the night. He said his wife would call him at night very confused and upset and he would have to drive back to the facility at night to try to calm her down. During an interview on 1/24/24 at 8:00 AM, with License Practical Nurse (LPN) #1, she said Resident #22's husband had expressed that he wanted to stay with the resident at night because she was not used to sleeping alone. LPN #1 said the facility did not allow residents' families to stay in the facility at night and revealed the husband kept Resident #22 calm when she was confused or did not participate with care. LPN #1 stated that the husband did not bother anyone and he stayed in his wife's room and assisted with her needs. During an interview on 1/24/24 at 9:00 AM, with Resident #22's daughter, she said that her mother was confused, tried to get out of bed without assistance, and did not sleep unless there	F 564	4. How the corrective action(s) will be monitored to ensure the practice will not recur: The Administrator is responsible for the Plan of Correction implementation and the ongoing monitoring of this process. Beginning January 29, 2024, and continuing for eight (8) weeks, the Administrator, Director of Nursing, Social Worker and/or Assistant Administrator will conduct weekly reviews with 5 residents to ensure that they have no issues regarding visitation. These reviews will be brought to the Quality Assurance Meeting on February 29, 2024 and March 28, 2024 or until such a time consistent substantial compliance has been met.	

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F 564	Continued From page 3	F 564		

was family around. Her father had asked the facility to allow him to stay with her during the night to help Resident #22 sleep. The daughter said that previously Resident #22 was in a semiprivate room, but there was no other resident in the room. The facility complained because the husband slept in the empty bed, so he requested a private room so he could stay with the resident because of her confusion. The facility placed Resident #22 in a private room, so the daughter brought in a recliner for her father to have a comfortable chair, but the facility still did not allow him to stay. The daughter said her father would leave the facility during the night and sleep in his truck in the parking lot for two or three hours and come back into the facility just so the facility would not say he was staying overnight. The daughter explained that not only would Resident #22 call her father during the night, but the facility would also call her father at night when Resident #22 became confused and would not sleep. The daughter said that her father was 86 years old, and she did not like him to be driving up and down the road at all times of the night. The daughter commented that her mother was calm and rested better when her father was there.

During an interview on 1/24/24 at 12:30 PM, with Certified Nursing Aide (CNA) #1, she said Resident #22's husband had complained that the facility would not allow him to stay with his wife during the night. CNA #1 said the facility does not allow families to stay all night. CNA #1 stated that Resident #22's husband assisted the resident with her needs and helped her to stay calm when she had periods of confusion.

During an interview on 1/24/24 at 2:00 PM, with the Social Services Director (SSD), she

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F 564	Continued From page 4	F 564		

confirmed Resident #22's husband had complained about not being able to stay with his wife during the night. The SSD stated that the resident was originally in a semiprivate room, which would have interfered with the privacy of a roommate. She confirmed that the resident was given a private room on 1/5/2024 at the husband's request and she was not aware that the facility staff were still not allowing the husband to stay with the resident. The SSD confirmed she had not talked with the Administrator or the other facility staff to ensure the resident's husband had been allowed to stay with the resident during the night since obtaining the private room and she would get with the Administrator, DON, and other staff members to have this corrected as soon as possible.

During an interview on 1/24/24 at 2:15 PM, with the Care Plan Nurse/LPN #2, he confirmed Resident #22's husband complained in a care plan meeting about the facility not allowing him to stay in the room with his wife at night. LPN #2 said the Resident's husband had commented that the resident would not sleep without his being there and she was confused and acted out at night. LPN #2 said he advised the husband that he would need to work something out with the Administrator and the DON.

During an interview on 1/24/24 at 2:30 PM, with the Administrator and the DON, they confirmed the facility limited the time Resident #22's husband could stay with her. The Administrator said she was under the impression the resident's husband wanted to move in. The Administrator also confirmed the resident was a short-term resident at the facility and was there for skilled therapy. The Administrator stated that families

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F 564	Continued From page 5 were discouraged from staying overnight with the residents. The DON stated that after Resident #22 was moved into a private room, her husband did not ask about staying overnight. The DON and Administrator confirmed they did not follow up with the resident's husband regarding staying with the resident overnight. A record review of the "Face Sheet" revealed the facility admitted Resident #22 on 12/15/23 with a diagnosis of Nontraumatic Hematoma of Soft Tissue. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/22/23 revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated her cognition was severely impaired.	F 564		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(	F 567		2/29/24

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F 567	Continued From page 6 l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure residents had access to their personal funds on weekends for two (2) of 17 residents reviewed with a personal fund account (Resident #11 and Resident #34). This deficient practice had the potential to affect all 17 residents with a personal trust fund account. Findings include: Review of the facility's policy, "Resident Trust Fund", revised 3/23/23, revealed, " Policy: The resident has a right to manage his or her financial affairs...After Business Hours ... 1. Residents will	F 567	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. 1. Immediate actions taken for those residents identified: On January 24, 2024, the Administrator implemented funds to be available every night and weekend effective immediately.	

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F 567	Continued From page 7 have reasonable access to their personal funds after business office hours." On 1/24/24 at 1:00 PM, during the Resident Council Meeting, Resident #11, and Resident #34 reported they were not able to withdraw their personal funds on Saturday and Sunday. They explained they were told to ask a certain nurse if they wanted money on the weekend but were unable to recall the nurse's name. Both residents reported they did not have clear information from the facility on how to get their money on the weekend. Record review of the "Open Balance Report", with "Balances as of 1/24/2024", revealed Resident #11 and Resident #34 had a personal trust fund account at the facility. On 1/24/24 at 2:02 PM, an interview with the Business Office Manager (BOM) revealed she worked Monday through Friday and was the only person designated to dispense funds to the residents from their personal accounts. The BOM revealed if a resident wanted money from their account for the weekend, they should get the money on Friday. The BOM stated if a resident requested money from their account on a weekend, she could be contacted by a nurse, and she would come to the facility to dispense the funds. The BOM acknowledged there was no staff member designated to dispense funds to the residents on Saturday and Sunday. On 1/24/24 at 2:07 PM, in an interview with the Administrator, she acknowledged there was no staff member designated to dispense funds to residents on Saturday and Sunday. The Administrator reported the facility once had a	F 567	On January 24, 2024, residents who have funds were identified through a resident funds audit. Residents with a trust fund have been placed in a binder for management staff to have access to the information. A secure method has been authorized by the administrator to ensure monies are secure and available for residents during the week/weekend. Funds will be available via the 100 hall Nurse outside of normal business office hours. 2. How the facility identified other residents: The facility has determined that all residents have the potential to be affected. 3. Measures put into place/ System changes: The Resident Funds policy has been reviewed and special attention was given to Access to Personal Funds: ¿Residents will have access to petty cash on an ongoing basis and be able to arrange for access to larger funds. Resident requests for access to their funds should be honored by facility staff as soon as possible but no later than: ¿The same day for amounts less than $100.00 ($50.00 for Medicaid residents); ¿Three banking days for amounts of $100.00 ($50.00 for Medicaid residents) or more. 4. How the corrective actions will be monitored: Beginning January 29, 2024, the Administrator, Business office Manager, or Assistant Administrator will perform an audit of resident fund	

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F 567	Continued From page 8 system in place to allow the residents to withdraw funds on Saturday and Sunday, whereby a designated nurse would have a locked box on the medication cart with $100 for residents who wanted to get their money. The Administrator stated the facility stopped this practice because it was seldom used. The Administrator stated her expectation was for residents to have access to their money on the weekends. The Administrator stated she would resume the facility's past practice of designating a nurse to keep a locked box with $100 on a medication cart in the event resident funds needed to be dispersed on the weekend. Resident #11 A record review of the "Face Sheet" revealed the facility admitted Resident #11 on 07/07/21 with diagnoses that included Parkinson's Disease. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/15/23 revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact. Resident #34 A record review of the facility's "Face Sheet" revealed the facility admitted Resident #34 on 08/18/21 with diagnoses that included Alzheimer's Disease. A record review of the Quarterly MDS with an ARD of 01/19/24 revealed Resident #34 had a BIMS score of 9, which indicated his cognition was moderately impaired.	F 567	availability weekly for eight (8) consecutive weeks to ensure that adequate funds are available for resident fund requests. The results of these audits will be reviewed in the Quality Assurance Meeting on February 29, 2024 and March 28, 2024 or until such a time consistent substantial compliance has been met.	

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F 625	Continued From page 9	F 625		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide written notification of the facility's bed hold policies to a resident or the Resident Representative (RR) upon the resident's transfer to the hospital for (1) of two (2) residents reviewed for hospitalization.	F 625	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals	2/29/24

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F 625	Continued From page 10 Resident #10 Findings include: A review of the facility's "Bed Hold Policy", revised 2/20/2023, revealed, "Policy: It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold policies prior to transferring a resident to the hospital or the resident goes on therapeutic leave...6. The facility will provide this written information to all facility residents ..." On 1/23/24 at 2:42 PM, a phone interview with RR revealed the facility did not provide her with written notification regarding the facility's bed hold policies when he was transferred to the hospital. A record review of the facility's "Notice of Facility Initiated Transfer of Discharge", dated 7/22/23, for Resident #10, revealed he was sent to an acute care hospital for shortness of breath on 7/22/23. A review of the medical record revealed there was no documentation indicating the resident or the RR was provided with the facility's bed hold policies when Resident #10 was transferred to the hospital on 7/22/23. On 1/24/24 at 7:25 AM, an interview with the Director of Nursing (DON) revealed the facility sent a Transfer/Discharge Summary to the RR. The DON reported there was no bed hold notification provided to the RR in writing. The DON acknowledged the facility did not have an established written notification of the facility's bed hold policies to send to the resident or the RR in the event the resident is transferred to the	F 625	who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility□s credible allegation of compliance. 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #10 record was reviewed for notification of Bed Hold. The resident and representative were notified of the facility□s bed hold policy on January 26, 2024 by the Assistant Administrator. 2. Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: On January 26, 2024, all resident records were reviewed for notification of bed hold policy by the Administrator and Assistant Administrator. On January 26, 2024, an in-service was conducted by the Administrator with the Assistant Administrator, Social Services Director and Care Plan Nurse, addressing the facilities□ notification of bed hold policy. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning January 29, 2024, The Administrator, Assistant Administrator, Social Services Director or Care Plan Nurse will conduct an audit of five (5) residents that have been admitted or discharged weekly for eight (8)	

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STONE COUNTY REHABILITATION AND NURSING CTR INC	1436 EAST CENTRAL AVENUE WIGGINS, MS 39577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 11 hospital. On 1/25/24 at 8:35 AM, an interview with the Assistant Administrator (AA) revealed she was responsible for sending out Transfer/Discharge notifications to the resident or the RR. She stated that the bed hold policies are covered as part of the admission process when a resident is admitted to the facility. The AA reported that most of the time the RR would get a phone call regarding bed hold. The AA acknowledged that there was no written notification of the bed hold policies provided to the resident or the RR when resident is transferred to the hospital. On 1/25/24 at 10:00 AM, in an interview with the Administrator, she stated that her expectation moving forward was to provide clear communication regarding the facility's bed hold policies, in writing, to the resident or the RR when a resident is transferred to the hospital. The Administrator stated the facility will generate a form to be used immediately. A record review of the "Face Sheet" revealed the facility admitted Resident #10 on 06/23/22 with diagnoses that included Vascular Dementia.	F 625	consecutive weeks. These residents charts will be audited to ensure proper notification of bed hold was provided to the resident and/or legal representative upon admission and at which time an emergent transfer is needed. Documentation of this will be kept by the Assistant Administrator. This plan of correction will be monitored at the monthly Quality Assurance meetings on February 29, 2024 and March 28, 2024 or until such a time consistent substantial compliance has been met.	