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	255214	A. BUILDING _____ B. WING _____	02/01/2024

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LAWRENCE CO NURSING CENTER	700 JEFFERSON STREET SOUTH MONTICELLO, MS 39654

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 01/29/2024 through 02/01/2024. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F623, F812, F851 and F880. The facility had a census of 54 and was licensed for 60 beds.	F 000		
F 623 SS=D	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		3/14/24

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

Electronically Signed | 02/23/2024

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F 623	Continued From page 1	F 623		

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

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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 interviews, record review and facility policy review, the facility failed to provide the Resident and/or the Resident's Representative with written notification for the reason the resident was transferred to a local hospital for one (1) of one (1) record reviewed for hospitalization. Resident #39	F 623	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations.	

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F 623	Continued From page 3 Findings include: Record review revealed the facility provided a copy of the bed hold policy instead of the transfer policy. Record review of the "Physician's Telephone Order", dated 12/12/23 at 8:31 AM revealed "Send to ER (Emergency Room) for evaluation 12/12/2023." Review of a transfer letter, for Resident #39, dated 12/12/23 revealed, "This letter is to inform you of the facility initiated transfer/discharge to (Name of local hospital) on 12/12/23 due to an emergency situation for the following reasons(s): We are no longer able to meet your needs in this facility and the transfer is necessary for your welfare." Record review of the "Face Sheet" for Resident #39 revealed the facility admitted the resident to the facility on 3/31/23, with diagnoses that included Anemia in Chronic Kidney Disease, End stage Renal disease, Peripheral Vascular Disease, Raynaud's Syndrome with Gangrene, and Peripheral Vascular Disease. Record review of the Minimum Data Set (MDS) for Resident #39, with an Assessment Reference Date (ARD) of 12/12/23 revealed a discharge assessment, with return anticipated. On 01/31/24 at 11:09 AM, in an interview with Licensed Practical Nurse (LPN) #2, stated resident is on dialysis and has been hospitalized several times related to dialysis. She stated he was hospitalized for low hemoglobin and hematocrit, low potassium, and his fingers	F 623	It is the policy of this facility to properly notify the resident and responsible representative, in writing of their transfer and/or discharge. *Nursing staff will document the specific reason for the transfer on the Discharge/Transfer Notice Form NS-789 at the time of transfer/discharge. Resident #39□s daughter, a Licensed Practical Nurse (LPN) on staff here was on duty on 12/12/23 and was informed of the reason for transfer that day. *All residents have the potential to be affected by lack of proper notice of transfer and/or discharge. *All nurses were inserviced on 2/5/24 and 2/20/24 by the Director of Nursing (DON) to document at the time of transfer/discharge, the reason for the resident□s transfer/discharge on the Discharge/Transfer Notice Form NS-789. Admissions staff and Nurses were inserviced by the DON 2/5/24 and on 2/20/24 on the procedure of proper notification of the resident and responsible representative of the resident□s transfer/discharge. *The Medical Records Clerk, starting 2/5/24, will daily check as part of her ongoing duties, the Resident Medical Record and Discharge/Transfer Notice form of those discharge/transferred residents in the previous 24 hours, Monday through Friday to assure notification, including reason for transfer	

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F 623	Continued From page 4 eventually had to be amputated related to Raynaud's. On 01/31/24 at 2:55 PM, in an interview with the Director of Nurses (DON), she stated that when a resident is transferred to the hospital for 24 hours, Social Service fills out the transfer letter and bed hold and sends it to the family. She stated Social Services keeps a copy in a binder in his office. On 01/31/24 at 3:00 PM, in an interview with Social Services, he revealed he fills out the transfer and bed hold letters and the Administrator signs off on the letter and he sends it to the family. He commented he was not aware the form had to include the reason for transfer to the hospital, as he uses the standard transfer form provided by the company.	F 623	and/or discharge was provided to the resident and Responsible Representative. The Quality Assessment and Assurance (QAA) Committee met 2/21/24 to review and approve the plan of correction. The DON, starting 2/9/24, in order to monitor compliance, will check all discharge/transfers for appropriate notification weekly for 1 month then check a minimum of 5 resident transfer/discharges documentation weekly for 2 months and report findings to the Quality Assessment and Assurance (QAA) Committee at its special called March 2024 meeting to be held no later than March 13, 2024 and to its April and July 2024 meetings.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		3/14/24

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F 812	Continued From page 5 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and facility policy review the facility failed to remove expired foods from the dry food storage area for one (1) of four (4) kitchen observations. This has a potential to affect all residents receiving meals prepared by the facility's dietary department. Findings include: Review of the facility's policy, "Food Storage Labeling", with a revision date of 10/23, revealed, "POLICY: The facility will ensure the safety and quality of foods by following good storage and labeling procedures. PROCEDURE: ... 8... iv. Foods stored in storage units will be surveyed routinely to identify and discard foods that have passed its manufacturers use-by date or expiration date. Suggested Time frames: 1. Dry Storage - Weekly ..." On 01/29/24 at 9:50 AM, during the initial tour of the kitchen with the Dietary Manager (DM), observation of the dry goods storage area revealed the following: a. (1)- 10-ounce bottle of A-1 Original Steak Sauce® with an expiration date of 1/2/21, without an open date. b. (1) quart Classic Imitation Vanilla Flavor, with an open date of 12/2021 and no expiration date c. Two (2)- 16 ounce bottles of yellow food color, without open or expiration or open dates d. (2)- 24 ounce bottles of Hershey's Syrup®, with an expiration date of 4/20 e. 4.5 pounds of Minors Sweet and Sour Sauce®	F 812	It is the policy of this facility to procure, store, prepare and serve food in accordance with professional standards for food service safety. *Expired foods found during survey inspection on 1/29/24 were discarded. Inspection of stored food inventory on 2/2/2024 did not reveal any expired items or storage issues. *All residents have the potential to be affected by failure to procure and store food in accordance with professional standards for food service safety. Dietary Manager (DM) will inspect dietary department food storage weekly to check for expired or improperly stored food items in accordance with facility policy. *Dietary staff were inserviced by the Registered Dietician Consultant on 2/21/24 to observe food storage guidelines and to inspect the inventory weekly, checking for proper storage of food items including checking and disposing of expired food items. *The DM, starting 2/2/24, will check the dietary inventory weekly and notate findings on the Expired Foods inspection log for 4 months at which time the duty can be delegated to other dietary staff. The Quality Assessment and Assurance	

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F 812	Continued From page 6 ready to use sauce, with an expiration date of 12/21/17, without an open date. On 01/29/24 at 10:25 AM, during an interview, the DM revealed expired foods should be removed from the storage room on the date of expiration. She stated expired foods are not safe for residents to eat, as they could get sick from eating expired foods. The DM confirmed it is her responsibility to discard expired food. On 02/01/24 at 11:09 AM, in an interview with the Administrator, he stated that he expects the dietary staff to promptly remove expired foods and to follow food storage protocol.	F 812	(QAA) Committee met 2/21/24 to review and approve the plan of correction. The Administrator, beginning 2/16/24 will check the Dietary Department weekly for3 months, then monthly for 3 months to assure compliance and report findings to the QAA Committee at its special called March 2024 meeting to be held no later than March 13, 2024 and to its quarterly meeting in April and July 2024.	
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long	F 851		3/14/24

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term care facility (for example, housekeeping).

§483.70(q)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(q)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(q)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

§483.70(q)(5) Submission schedule.
The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.
This REQUIREMENT is not met as evidenced by:

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F 851	Continued From page 8 Based on interviews, record review and Certification and Survey Provider Enhanced Reports (Casper) reporting data review, the facility failed to ensure payroll-based journal (PBJ) direct care staffing information was submitted accurately to the Centers for Medicare and Medicaid Services (CMS) for nine (9) of nine (9) months reviewed. Findings include: On 01/29/24 at 11:27 AM, during an interview with the Licensed Practical Nurse (LPN) #1 who is the Infection Preventionist (IP) and Staffing Coordinator, she stated that she is responsible for scheduling Certified Nurse Aides (CNAs) and nurses. She explained some of the nurses are on a "Baylor" schedule which means they work 16-hour shifts on weekends. LPN #2 and LPN #3 are LPNs that work the Baylor schedule. She reported that the facility's Administrative Aide (AA) enters the PBJ information. An interview on 01/30/24 at 11:34 AM, with the AA revealed the AA enters the staffing hours using the employee's punches to a spreadsheet and those numbers are maintained by the corporate office. During an interview on 01/30/24 at 3:30 PM, the Administrator reviewed the PBJ audit report and stated there was a glitch in the system and prior to reviewing the audit report, he was not aware that there were errors in reporting. The Administrator confirmed that he has access to the reporting system, can run audit reports as needed, and was responsible for checking the reports for accuracy. He confirmed that LPNs #2 and #3, which are on the Baylor schedule, are	F 851	It is the policy of this facility to comply and submit staffing data based on payroll data in a uniform format. *An audit of employee payroll classifications was completed 2/1/24 by the Administrative Assistant and Administrator to assure staff were coded to the correct Payroll Based Journal (PBJ) category as specified by CMS. *All residents have the potential to be affected by incorrectly coded payroll data. *On 2/1/24 the facility business office was inserviced by the Administrator to input staff and contract staff hours into the correct Payroll Based Journal (PBJ) category. The Quality Assessment and Assurance (QAA) Committee met 2/21/24 to review/approve the plan of correction for F 851. *Beginning 2/13/24 the Administrator will monitor PBJ entries 5 days a week for 4 weeks and weekly for 2 months to assure ongoing compliance with F 851 and will report findings to the QAA Committee at its special called March 2024 meeting to be held no later than March 13, 2024 and at its quarterly meeting in April 2024 and July 2024.	

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F 851	Continued From page 9 classified in the PBJ data as Registered Nurses (RNs) and not LPNs, which makes the PBJ information submitted to CMS inaccurate. A record review of the PBJ Audit report provided by the facility revealed LPNs #2 and #3 have hours entered each month from January 2023 through September 2023 as RNs and not LPNs.	F 851		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		3/14/24

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F 880	Continued From page 10 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review,	F 880	It is the policy of this facility to establish	

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F 880	Continued From page 11 and facility policy review, the facility failed to ensure infection control measures were consistently implemented to prevent the development and/or transmission of infection, while providing care for one (1) of 15 sampled residents (Resident #1) and two (2) unsampled residents (Unsampled Residents #20 and #46) Findings include: Review of facility policy, "Infection Prevention and Control Program", dated 06/14, revealed, "This facility has developed and maintains an infection prevention and control program that provides a safe, sanitary, and comfortable environment to help prevent the development and transmission of infection. This program will ... Develop specific policies and procedures governing such activities as aseptic technique ..." Review of the facility's policy, "Hand Hygiene," with a revision date of 01/24, revealed, "Purpose ... To cleanse hands to prevent transmission of infection or other conditions. To provide a clean, health environment for residents, staff, and visitors ...INDICATIONS FOR HAND WASHING...2. Hand hygiene should be performed between all contact with residents or when entering and exiting a resident's room ...4. Before and after applying gloves ..." An observation on 1/29/24 at 10:55 AM, revealed Certified Nurse Aide (CNA) #3 and CNA #4 entered the room of Resident #1 to provide perineal care and applied clean gloves without performing hand hygiene. During the procedure, when the gloves of CNA #3 became visibly soiled with feces, CNA #3 removed her gloves and applied clean gloves without performing hand	F 880	and maintain in infection prevention and control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. *Resident #20 and #46 were examined 2/5/24 by the Infection Preventionist Nurse (IPN) and resident #1 was examined 2/9/24 by the IPN and found to be free of any ill effects of improper hand hygiene. *All residents have the potential to be affected by inadequate infection prevention and control. *Nursing staff have been inserviced 2/05/24 by the IPN, on proper hand hygiene between all contact with residents or when entering and exiting a resident□s room and before and after applying gloves. Staff were also inserviced on 2/5/24 by the IPN on proper hand hygiene protocol involving food and feeding residents. Inservice training on proper perineal care skills provided to Certified Nursing Assistants (CNA) beginning on 2/5/24 by the IPN and will continue until all CNAs are reviewed. The Quality Assessment and Assurance (QAA) Committee met 2/21/24 to review and approve the plan of correction for F880. *Effective 2/5/24, the nurse assigned to the dining room will daily observe for compliance as part of her permanent duties, to assure proper feeding and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255214	A. BUILDING _____ B. WING _____	02/01/2024

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F 880	Continued From page 12 hygiene. When additional gloves were needed, CNA #4 removed her gloves and exited the room without performing hand hygiene, nor did she perform hand hygiene when she returned to the room prior to applying clean gloves. When Resident #1's care was completed, CNA #3 removed her gloves and exited the room without performing hand hygiene. CNA #4 removed her gloves, exited the resident's room, and performed hand hygiene in the hallway. On 1/29/24 at 11:30 AM, an observation of lunch being served in the dining room revealed CNA #1 cutting a sandwich in half for Unsampled Resident #20 and CNA #2 cutting a sandwich in half for Unsampled Resident #46. Both CNAs were observed placing their bare hands on the sandwiches. On 1/29/24 at 1:20 PM, in an interview with CNA #4, she stated she forgot to perform hand hygiene when assisting CNA #3 with providing perineal care for Resident #1. She confirmed she did not perform hand hygiene after removing gloves at any time, during the procedure. CNA #4 revealed she should have performed hand hygiene. CNA #4 stated without performing hand hygiene, there is a possibility of infection being spread to other residents. On 1/29/24 at 1:30 PM, in an interview with CNA #3, she confirmed she should have performed hand hygiene before beginning care for Resident #1 and when changing gloves. She stated her actions could cause cross contamination and residents could get an infection. On 01/29/24 at 1:37 PM, in an interview with CNA #1, she confirmed she touched the sandwich of	F 880	dietary service to residents. Starting 2/5/24, the IPN will observe performance of peri care and dining room or in-room dining performance by 3 CNAs each week for 4 weeks, then observe 2 CNAs per week for 2 months and report the findings to the QAA Committee at its special called March 2024 meeting to be held no later than March 13, 2024 and at its April and July quarterly meetings.	

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F 880	Continued From page 13	F 880		

Unsampled Resident #20 with her bare hands. She stated she should not have touched the sandwich with her hands, as her actions could result in cross contamination, causing the resident to get sick.

On 01/29/24 at 1:48 PM, in an interview with CNA #2, she confirmed she should not have touched the sandwich of Unsampled Resident #46 with her bare hands. She stated that it was unsanitary to touch a resident's food with her hands and she should have used a fork and knife to cut the sandwich. CNA #2 stated it could cause the resident to get sick.

On 02/01/24 at 10:12 AM, in an interview with License Practical Nurse/ Infection Preventionist (LPN/IP), she confirmed CNAs should never touch residents' food with their bare hands. She stated they should have used a fork and knife to cut the sandwich. The LPN/IP revealed their actions could cause the residents not to eat their food or get sick. She stated whatever is on the CNA's hands has been transferred onto the resident's food. She stated that CNA #3 and #4 should have performed hand hygiene each time they removed their soiled gloves while providing perineal care, as improper perineal care could cause residents to get urinary tract infections. The LPN/IP confirmed that by not performing hand hygiene upon completion of care could cause spread infections to other residents.

On 02/01/24 at 11:12 AM, in an interview with the Administrator, he revealed he expects the staff to serve food in a sanitary manner. He also commented that he expects staff to follow protocol when providing all care.

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F 880	Continued From page 14 On 02/01/24 11:48 AM, in an interview with the Director of Nurses (DON), she stated the CNAs performing perineal care should have performed hand hygiene prior to beginning care and when changing gloves, as improper hand hygiene during perineal care could cause urinary tract infections. The DON confirmed the CNAs touching residents' food with their bare hands, as well as improper hand hygiene while providing resident care, was an infection control issue. Record review of the "Face Sheet," for Resident #1, revealed the facility admitted the resident to the facility on 4/25/13, with diagnoses that included Joint Derangement, Contractures, and Cerebral Palsy. Record review of the Minimum Data Set (MDS), with Assessment Reference Date (ARD) 10/30/23, for Resident #1, revealed a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. Review of Section GG revealed Resident # 1 was dependent for all care.	F 880		