STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255192	A. BUILDING _____ B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAIBORNE COUNTY SENIOR CARE	2124 OLD HWY 61 SOUTH PORT GIBSON, MS 39150

(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 and a Complaint Investigation (CI MS #239891), at the facility from 2/26/24 through 2/29/24. The SA investigated CI MS #23989 for Physical Environment related to the facility being dirty, Accidents related to fall, Misappropriation of Property related to narcotic diversion and Quality of Care related to treatment related to residents left wet for extended periods. There were no citations related to the complaint investigation. During the annual recertification survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F640, F697, and F804. The facility held a license for 75 beds, with a census of 60 residents.	F 000		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §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 observation, interviews, record review, and policy review the facility failed to ensure the resident received treatment and care in accordance with professional standards of practice and the comprehensive care plan to manage pain for one (1) of seventeen (17) sampled residents. Resident #47	F 697	A. Resident #47 was given pain medication 2-26-2024 at 1:00 PM. Thirty (30) minutes after receiving pain medication resident stated "My toe is getting better." Resident was wearing her shoe and ambulating in the room.	4/8/24

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

Electronically Signed | 03/20/2024

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F 697	Continued From page 1 Findings include: Record review of the facility policy titled, "Pain Assessment/Management," revised 9/10, revealed, "It is the policy of this facility to provide guidelines in the identification and treatment of residents a risk for acute and chronic pain. Each residents pain will be assessed in an approach designed to increase comfort and promote dignity through administering alternative interventions or medications ...Staff members providing direct care ...will use an interdisciplinary approach observing pain symptoms in the resident and report it to the nurse. If possible, the nurse will discuss with the resident the severity and quality of pain using the pain reference scale. This will be documented on the pain assessment and a plan of care will be initiated. Thereafter pain will be assessed and recorded on the Medication Administration Record ...When a resident demonstrates pain, whether verbal or written, the nurse is to administer pain med per PRN orders. Record review of the facility policy titled, "Lab Monitoring and Follow-up Policy," revised 10/2019, revealed, "It is the policy of this facility to obtain blood samples per physician order, monitor all resident's lab results for abnormal values. All abnormal values will be communicated to the physician in a timely manner. All critical values will be communicated to the licensed responsible caregiver (MD/NP) upon receipt of results, to ensure appropriate, timely patient care ... All abnormal will be called in to the licensed responsible caregiver (MD/NP) within a timely manner but no longer than 24 hours of receiving ..." On 2/26/24 at 1:45 PM, during an observation	F 697	B. All residents have the potential to be affected. C. Director of Nursing (DON) gave in-service beginning 3-1-2024 and 3-4-2024 to nurses regarding Pain Assessment/Management to all licensed nurses. All residents will be asked and observed for pain. Each shift and PRN (as needed) results will be documented on resident's Medication Administration Mar (MAR) beginning 3-1-2024 and follow up to any pain management given will be documented on resident's Medication Administration MAR . D. Director of Nursing or supervising nurse will interview three (3) residents 5 times a week for 4 weeks then monthly for 3 months beginning 3-1-2024 to determine if they have experienced pain and if medication was given and if relief was obtained. Results of the pain monitoring will be brought to Quality Assurance Performance Committee in weekly meeting beginning 3-29-2024 for 4 weeks then monthly for 3 months to ensure continued compliance.	

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and interview, Resident #47 was seated in a bedside chair in her room with her left shoe off. The resident stated that the fourth toe on her left foot was hurting. The resident had facial grimacing and furrowed brow as she described the pain in her left foot. It was noted that there was a small black scab on the toe, on the top on what appeared to be a pencil eraser size corn. However, it was noted that the entire left foot was swollen.

On 2/27/24 at 8:45 AM, during an observation and interview, Resident #47 was seated in a bedside chair in her room, wearing both of her shoes. Without prompting, the resident stated that her toe was hurting very badly, while removing her left shoe and pointing to the fourth toe of her left foot.

On 2/28/24 at 3:00 PM, during an interview with a family member in the room visiting Resident #47, it was revealed that the resident frequently complains of pain in her left foot. The family member stated that they had not reported it to the nursing staff because the staff already knew about it and the family member stated they assumed the staff were giving the resident something for pain. At that point, the resident spoke up and stated that she could not keep a shoe on her left foot, because it burns so badly.

On 2/28/24 at 4:00 PM, during an observation and interview with Licensed Practical Nurse (LPN) #2, she was observed administering routine medications to Resident #47 in the resident's room. It was noted that the LPN did not ask the resident about pain during the interaction. LPN #2 confirmed that the resident had been assessed by the Nurse Practitioner on or around

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2/12/24 for inflammation and pain related to Gout. The nurse revealed that she had not administered any medication for inflammation or pain to Resident #47 during February 2024.

On 2/29/24 at 2:40 PM, an observation and interview with the Director of Nurses (DON) in the room of Resident #47 revealed that upon entering the room the resident immediately told the DON that her toe was hurting. The DON assessed the resident's left foot and when she touched the resident's toe, the resident jerked the left foot back and yelled out.

Record review on 2/29/24 of the electronic health record, for Resident #47, revealed that there were no lab results for the uric acid level that was ordered by the physician on 2/13/24.

Record review of the "Order Summary Report," with active orders as of 2/29/2024, revealed a physician order, dated 12/7/2023, for Resident #47 to be evaluated pain per pain scale (0-10), every shift and prn. The order revealed that if pain is present, document interventions and follow up on effects and notify the physician of persistent pain unrelieved by intervention.

A record review of the Medication Administration Record (MAR), dated 2/1/2024 through 2/29/24, revealed that Resident #47 was assessed for pain, using the 0-10 pain scale every shift for the month of February and each time, the nurses recorded that the resident reported "0", indicating no pain at that time.

During an interview on 2/29/24 at 3:45 PM, the DON, confirmed that Resident #47 continued to exhibit signs and symptoms of a Gout flareup,

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F 697	Continued From page 4	F 697		

including pain. She confirmed that the resident had physician orders for pain medication to be given as needed (PRN) and said that it was the nurses' responsibility to assess for pain, administer the pain medication, assess for effectiveness, and notify the resident's physician of unrelieved pain. The DON also confirmed that the resident had a physician order to obtain a laboratory test to measure the uric acid level related to Gout and that no results had been obtained or reported to the resident's physician. She stated that the results were supposed to be communicated to the physician through a telephone call by the nursing staff.

During an interview on 2/29/24 at 5:10 PM, with LPN #4 confirmed that she had administered pain medication to Resident #47 at or around 3:15 PM. She stated she had assessed the resident for effectiveness of the pain medication and Resident #47 rated the pain in her left toe a 10 on a 0-10 pain scale. The nurse revealed she had not notified the resident's physician of unrelieved pain because, "she has dementia."

A record review of the MAR for Resident #47 revealed the only medication ordered for pain was Tylenol Extra Strength 500 mg, to be given every 6 hours as needed for pain or fever. During the month of February 2024, the only time pain medication administered was the Tylenol administered by LPN #4 on 2/29/24 at 3:18 PM.

Further review of the MAR for Resident #47 revealed Resident #47 received Colchicine-Probenecid Oral Tablet 0.5-500 mg (milligrams) two times a day related to Gout for two (2) weeks during the month of February 2024. The medication was administered from

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F 697	Continued From page 5 2/14/24 to 2/27/24. Record review of the Admission Record for Resident #47 revealed that the facility admitted Resident #47 on 6/16/23 and had diagnoses that included Osteoarthritis, Type 2 Diabetes, Dementia, Gout, and Osteoarthritis. Record review of the Quarterly Minimum Data Set (MDS) for Resident #47, with an Assessment Reference Date (ARD) of 12/20/23, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment.	F 697		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and facility policy reviews the facility failed to serve the residents food in a manner that was appetizing and palpable, for one (1) of 17 residents reviewed for palatable meals. Resident #7 Findings Include: Review of the facility's policy, "Food Preparation for Menu Items and Special Request", with a	F 804	A. Resident #7 was offered a substitute tray and consumed and fifty percent (50%) of tray. On 2-26-2024 at 2:00 PM resident at all of snacks offered, including chocolate milk and sandwich. B. All residents that receive a meal tray from dietary have the potential to be affected.	4/8/24

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F 804	Continued From page 6 revised date of 10/17, revealed "POLICY ...Food is prepared by methods that preserve the nutritive value, flavor and appearance and meet standards for food safety... PROCEDURE:...5. A food service employee tastes all food items, including modified food items, to confirm acceptable quality..." On 02/26/24 at 01:03 PM, in an interview with Resident #7, the resident stated the food is not good, as a lot of times it does not have any taste. On 02/27/24 at 11:20 AM, an observation and interview of Resident #7 eating lunch in the dining room, revealed the resident only ate baked apple slices. He stated this food is not worth eating. Resident #7 did not eat anything else on the tray. The lunch tray consisted of breaded baked fish, wild rice, broccoli, a roll, baked apple slices, water and tea. The broccoli was observed to be mushy. On 02/27/24 at 12:14 PM, the lunch meal was observed and tasted, along with the Dietary Manager (DM). The main meal broccoli was mushy and bland, and the breaded baked fish was bland. The DM confirmed that the fish was bland, and the broccoli was mushy and also bland. On 02/27/24 at 3:55 PM, in an interview with Cook #2, she revealed she did not have all the seasoning she needed to cook the fish. She confirmed the fish needed more seasoning, as it tasted bland. She also stated the broccoli could have tasted better. On 02/27/24 at 4:02 PM, in an interview the DM stated they were not out of the seasoning needed	F 804	C. Menu is discussed at Resident Council Meeting held monthly to review menu and residents are given the opportunity to voice their likes and dislikes of menu. Menu posted in dining room and in each resident's room for the month. If a resident consumes less than twenty-five percent (25%) of diet a substitute is offered. Residents are offered alternate menu if menu is not to their liking. One-on-one Inservice was given on 2-27-2024 by Dietary Manager (DM) to dietary cook #2 to ensure standard recipes with proper seasonings are being followed. D. Dietary Manager will observe dietary cook 5 days a week for 4 weeks then monthly for 3 months to ensure recipes are being followed appropriately beginning 3-1-2024. Dietary Manager or dietary cook will taste the prepared meal to ensure meal is appetizing 5 days a week for 4 weeks then monthly for 3 months beginning 3-1-2024. Results of Dietary Manager monitoring of food for nutritive value appearance palatable and temp will be brought to Quality Assurance Performance Committee in weekly meeting beginning 3-29-2024	

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F 804	Continued From page 7 for the fish. However, Cook #1 told her she did not see the seasoning until after the fish had been cooked. The DM revealed that Cook #2 told her she had used onion and garlic powder on the fish, but the DM admitted that she could not taste any onion or garlic powder on the fish, and stated it was bland. Review of the Admission Record for Resident #7 revealed the facility initially admitted the resident on 10/28/2021 with current diagnoses that included Essential Hypertension, Type 2 Diabetes Mellitus and Heart Failure. Review of the Order Summary Report, with active orders as of 02/29/2024, for Resident #7, revealed a Physician Order, dated 11/27/2021, "NAS Carb (No Added Salt Carbohydrates) Consistent diet, Regular texture, Regular liquids consistency." Review of the quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) 12/27/23, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.	F 804	weekly for 4 weeks then monthly for 3 months to ensure continued compliance.	