STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A414	A. BUILDING _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METHODIST SPECIALTY CARE CENTER	1 LAYFAIR DRIVE SUITE 500 FLOWOOD, MS 39232

(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 04/09/24 through 04/11/24. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F689, F758, and F880. The facility held a license for 60 beds, with a census of 58.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and facility policy review, the facility failed to secure smoking materials in a safe manner for one (1) of two (2) smokers in the facility. Resident #15 Findings Include: Review of facility policy titled "Smoking Program" with a revision date of 3/10/2023 revealed under, "Procedure... Residents should have smoking materials labeled and locked in the medication room. Residents should not have smoking, vaping, lighters or other smoking devices or material in their possession or in their room..."	F 689	This Plan of Correction is being submitted in accordance with specific regulatory requirements. It should not be construed as an admission of any deficiency cited. 1. On 04/10/24, Resident # 15 was noted by the surveyor with a pack of cigarettes in his lap and stated he had a lighter hidden in the side pocket of his wheelchair cushion. Smoking paraphernalia was confiscated from resident and resident was educated to the policy of not having smoking materials in his room or on his person.	5/11/24

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

Electronically Signed | 04/19/2024

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F 689	Continued From page 1 An observation and interview on 4/10/2024 at 9:15 AM, with Resident #15 revealed he was sitting in a motorized wheelchair in his room. A small green box that was labeled "(proper name of cigarette brand)" was lying on his lap. The contents of the box contained 10 cigarettes and the resident acknowledged that he had a cigarette lighter in his possession as well. An observation and interview on 4/10/2024 at 9:20 AM, with Registered Nurse (RN) #1, confirmed Resident #15 had a pack of cigarettes and a lighter in his possession, which was a fire hazard for the facility. She revealed smoking materials were to be kept locked at the nurse's desk and never in the possession of the resident. An interview with the Director of Nursing (DON) on 4/10/2024 at 4:50 PM, confirmed smoking materials were to be stored in the medication room due to potential accident hazards. Record review of Resident #15's "Safe Smoking Assessment" dated 3/11/2024 revealed "... Resident Observation...Does resident attempt to keep smoking paraphernalia on self or in room? No" was answered. Record review of Resident #15's "Face Sheet" revealed the facility admitted the resident on 11/06/2008 with medical diagnoses that included Quadriplegia and Tobacco use.	F 689	2. One resident, #15, had the potential to be affected by the cited deficient practice. Although no other residents were affected by the cited deficient practice, the facility had determined that one other resident had the potential to be affected. 3. A complete and comprehensive review of the Smoking Program and the Smoking Policy was conducted on 04/10/24 by the Facility Administrator, the Director of Nursing and The Quality Assurance Nurse. Revisions to policies were made to reflect all current safety interventions. Resident #15 was educated to the content of both policies and voiced understanding. On 4/18/24 the other resident identified was educated as to the content of both policies, including revisions; the resident voiced understanding of policies and procedures and was left copies of both policies On 4/10/24 a complete and comprehensive review of Resident #15's Tobacco Use care plan was conducted by the Facility Administrator, Director of Nursing and MDS Nurse, to ensure appropriate interventions have been put into place. On 04/18/24, an intervention was added to Resident #15 plan of care stating resident will be asked on each shift if resident has any type of smoking materials on their person or in their room. Intervention will be placed residents' treatment record to ensure continued compliance. Resident #15 was informed	

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F 689	Continued From page 2	F 689	and educated on new care plan intervention and a copy was left in resident's room. On 04/18/24 a complete and comprehensive review of the other resident identified was conducted by the Facility Administrator, the Director of Nursing and the Minimum Data Set Nurse to ensure that appropriate interventions have been put into place. An intervention was added to the care plan stating resident will be asked on each shift if resident has any type of smoking materials on their person or in their room. Resident was educated to new plan of care. Resident voiced understanding a copy was left with resident. Intervention will be placed on resident's treatment record to ensure continued compliance. 4. The Director of Nursing, the Quality Assurance Nurse and Minimum Data Set Nurse will conduct weekly chart audits of interventions 3 x weekly for 3 weeks, then monthly x 2 to begin on 04/22/24. The Director of Nursing, the Nursing Supervisor or the Quality Assurance Nurse will educate all nursing staff on new interventions for both identified residents including documentation on treatment record. Training will begin on 04/18/24 to be completed by 05/06/24. Findings of observations will be brought to the Quality Assurance Committee by the Director of Nursing, the Nursing Supervisor, the Quality Assurance Nurse or the Minimum Data Set Nurse beginning on May 10th 2024 times 3 months to ensure compliance.	

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F 758	Continued From page 3	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		5/11/24

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F 758	Continued From page 4 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to ensure an as-needed (PRN) psychotropic medication had a stop date for two (2) of five (5) residents reviewed for unnecessary medications. Resident #27 and Resident #33 Findings Include: Review of the facility policy titled "Medication Management" dated 1/2024 revealed, "Based on a comprehensive assessment of a resident, the facility must ensure: ... PRN (as needed) orders for psychotropic drugs are limited to 14 days. Exceptions: If the attending physician or prescribing practitioner believes that it is appropriate for the PRN (as needed) order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN (as needed) order." Resident #27 Record review of the April 2024 "Physician Orders" for Resident #27 revealed an order	F 758	This Plan of Correction is being submitted in accordance with specific regulatory requirements. It should not be construed as an admission of any deficiency cited. 1. On 04/11/24, clarification orders were obtained by Physician to ensure a stop date was obtained for the cited deficient practice. 2. Although two residents, #27 and #33, had the potential to be affected by the cited deficient practice, the facility has determined that all residents have the potential to be affected. 3. A complete and comprehensive review of all PRN, as needed, psychotropic drugs was conducted on 04/11/2024 by the Director of Nursing, the Minimum Data Set Nurse, the Consultant Pharmacist, and the Medical Director to ensure a stop date for all psychotropic medications. All Licensed nursing staff will be in-serviced on the regulation for Use of Psychotropic	

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F 758	Continued From page 5 dated, 10/25/23, "Xanax (antianxiety) 0.5 - 1.0 MG (milligram) tablet: Administer 0.5 - 1.0 milligram(s) by mouth PRN Q (every) 8 HRS (hours) PRN (as needed) for anxiety" with no stop date. Record review of Resident #27's "Face Sheet" revealed the facility admitted the resident on 11/03/2017 with medical diagnoses that included Quadriplegia, Post-traumatic stress disorder, Generalized anxiety disorder, and Major depressive disorder. Resident #33 Record review of the April 2024 "Physician Orders" revealed an order dated 8/3/23 for "Clonazepam 0.5 mg (milligram) tablet Administer 0.5 milligram(s) by mouth as necessary daily PRN". There was not a stop date for this medication. Record review of "Face Sheet" revealed Resident #33 was admitted to the facility on 8/14/19 with diagnoses of Quadriplegia, Major depressive disorder, and Generalized anxiety disorder. An interview on 4/10/24 at 4:25 PM, with the facility's Pharmacy Consultant revealed he was aware of the regulations requiring a stop date for PRN psychotropic medications. He stated these residents were a special population that had been on those medications for a long period of time. He confirmed Resident #27's PRN order for Xanax did not have a stop date and confirmed Resident #33 had an active order for PRN Clonazepam, which was a psychotropic medication, that did not have a stop date as required. He also revealed he had not notified	F 758	medications beginning 04/18/2024 to be complete by 05/06/24. A copy of the regulation was provided to the physician as a resource. 4. The Director of Nursing, the Quality Assurance Nurse, and the Minimum Data Set Nurse will conduct a weekly audit on any new prn, as needed, psychotropic medication orders to begin on 04/15/24, for a duration of 3 weeks, then monthly x 2 months, to ensure a stop date for all prn, as needed, psychotropic medications are clearly documented. Findings of audits will be brought to the Quality Assurance Committee by the Director of Nursing, the Quality Assurance Nurse or the Minimum Data Set Nurse beginning on May 10, 2024 times 3 months, to ensure compliance.	

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F 758	Continued From page 6 the physician that PRN psychotropic medications required a stop date. During an interview on 4/10/24 at 4:30 PM, the DON revealed she was unaware of the requirement for PRN psychotropic medications to have a stop date.	F 758		
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 possible communicable diseases or	F 880		5/11/24

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F 880	Continued From page 7 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, staff interviews, record review, and facility policy review, the facility failed	F 880	This plan of correction is being submitted in accordance with specific regulatory	

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F 880	Continued From page 8 to prevent the possible spread of infection as evidenced by lack of a biohazard container in one (1) of three (3) residents on transmission-based precautions on initial entrance to the facility. Resident #25 Findings include: Record review of facility policy titled, "Tracheostomy Care" revised 4/11/24, revealed, " Procedure: Remove and throw away inner cannula... i. If resident is on MDRO (multi-drug resistant organism) isolation, dispose of in biohazard bag." Record review of facility policy titled, "Isolation - Categories of Transmission-Based Precautions", dated 4/1/24, revealed, " ...Policy Interpretation and Implementation: 1. Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent or control the spread of infection." An observation and interview on 04/09/24 at 10:40 AM, revealed signage on Resident #25's door for droplet isolation. An interview with the Respiratory Therapy (RT) Supervisor revealed the resident had bacteria in his sputum that required droplet isolation and gowns, gloves, masks, and goggles were needed when entering room. Record review of lab results of the sputum culture dated 3/15/24, revealed result of "Carbapenem-resistant pseudomonas aeruginosa Heavy growth". Record review of the April 2024 "Physician	F 880	compliance. It should not be construed as an admission of any deficiency cited. 1. Trach inner cannula was changed for resident #25 on 04/10/24 during observation by survey staff. The Respiratory Therapist was immediately educated on the proper procedure for disposal of inner cannula for residents with a Multi-Drug Resistant Organism and a red biohazard can was placed in resident's room. Nursing staff will monitor and document for signs and symptoms of infection for 3 days, to be reviewed by the Director of Nursing and/or Infection Preventionist. 2. One resident, #25 had the potential to be affected by the cited deficient practice. Although no other residents were affected by the cited deficient practice, the facility has determined that all residents have the potential to be affected. 3. A complete and comprehensive review of the Trach Change Policy was conducted on 04/10/24 and 04/11/2024 by the Facility Administrator, the Director of Nursing, the Respiratory Therapy Supervisor and the Infection Preventionist. Revisions to the policy were made on 04/11/24 to reflect all current infection control guidelines. A complete and comprehensive review of the Infection Control Transmission based Precautions Policy was conducted on 04/10/24 and 04/11/24 by the Facility Administrator, the Director of Nursing, and the Infection Preventionist. Revisions were made to	

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F 880	Continued From page 9 Orders" revealed an order dated 2/17/24 for Droplet isolation due to carbapenem-resistant pseudomonas aeruginosa in sputum. An observation and interview on 4/10/24 at 10:45 AM, with Licensed Practical Nurse (LPN) #1 revealed there was not a biohazard container for trash in the resident's room and the personal protective equipment (PPE) was being discarded in a regular trash can with a white plastic liner. LPN #1 revealed this resident was in droplet isolation and the infection control staff determined what to use for disposal of items in the isolation rooms and she was unsure why a red biohazard container was not used. An interview with the Infection Preventionist on 4/10/24 at 10:55 AM, revealed only residents in isolation for clostridium difficile colitis (C-diff) used a red biohazard trash system. She revealed Resident #25 tested positive for carbapenem-resistant pseudomonas aeruginosa in his sputum and for that bacteria, the staff contained the trash in a regular trash bag and it was disposed of with the regular trash. During an interview on 4/10/24 at 3:30 PM, the Director of Nursing revealed she thought items from a resident positive for carbapenem-resistant pseudomonas aeruginosa could be disposed of in the regular trash if there was not a large amount of bodily fluid on the items. She confirmed that the inner trachea cannula of Resident #25 contained sputum fluid from the trachea and had the potential to spread infection. She stated the regular trash bag had no identifying information that would alert others of the infectious waste. She confirmed that by not disposing of infectious material properly, the potential for the spread of	F 880	reflect all current infection control guidelines. All Respiratory staff will be in-serviced on the Trach Change Policy updates beginning on 04/11/24 to be completed by 05/06/24. All staff will be in-serviced on Transmission-Based Precautions policy updates beginning on 04/11/24 to be completed by 05/06/24 to ensure continued compliance. 4. Observation of inner cannula change and placement of biohazard container will be completed by the Respiratory Therapy Supervisor and/or the Infection Preventionist 3 x weekly x 3 weeks, then monthly x 2 months to ensure continued compliance, to begin on 04/22/24. Findings of observations will be brought to the Quality Assurance Committee by the Respiratory Therapy Supervisor, the Infection Preventionist or the Director of Nursing beginning on 05/10/24 times 3 months to ensure compliance.	

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F 880	Continued From page 10 infection could increase. Record review of "Face Sheet" revealed the resident was admitted to the facility on 8/8/17 with the diagnoses of Hemiplegia, dependence on respirator ventilator status, and Tracheostomy status.	F 880		