STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255234	A. BUILDING _____ B. WING _____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN HEALTH AND REHABILITATION	60 SHADY LAWN PLACE VICKSBURG, MS 39180

(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 #24624 at the facility from 4/30/24 through 5/2/24. During the recertification survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited deficiencies at F641 and F656. The SA found the facility to not be in compliance during the complaint investigation (CI MS #24624) for activities of daily living and cited F656 and F677. The census at the time of the survey was 80 and the facility was licensed for 100 beds.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review the facility failed to transmit accurate assessments for two (2) of 2 residents reviewed for Minimum Data Set (MDS) assessments. Resident #5 and Resident #10. Findings include: Review of the facility policy titled, "Medicare Management" with a revision date of 10-2023 revealed, "...b ...Coding of Assessment: i. All disciplines shall follow the guidelines in Chapter 3 of the current Resident Assessment Instrument (RAI) Manual for coding each assessment."	F 641	1. On 5/1/24, the Minimum Data Set (MDS) Coordinator immediately reviewed the Admission 5-day Assessment, dated 4/3/24, for Resident #5 and revised Section H to reflect that the resident was coded as frequently incontinent of bowel and bladder instead of coded as always incontinent. Resident #10 Quarterly MDS assessment, dated 4/17/24 was revised to reflect accurate coding of Section P to indicate a wanderguard bracelet was in use during the seven day look back period. Inaccurate MDS assessments were modified immediately upon	6/12/24

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

Electronically Signed | 05/14/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255234	A. BUILDING _____ B. WING _____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN HEALTH AND REHABILITATION	60 SHADY LAWN PLACE VICKSBURG, MS 39180

(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 641	Continued From page 1 Review of the facility policy titled, "Chapter 3: Overview to the item-by-item guide to the MDS 3.0" dated October 2023 revealed, "This chapter provides item-by-item coding instructions for all required sections and items in the MDS Version 3.0 item sets. The goal of this chapter is to facilitate the accurate coding of the MDS resident assessment and to provide assessors with the rationale and resources to optimize resident care and outcomes..." Resident #5 A record review of Admission 5-day MDS with an Assessment Reference Date (ARD) of 4/3/2024 revealed, Section H-Bladder and Bowel that Resident #5 was coded under Urinary and Bowel Continence as always incontinent. A record review of the Documentation Survey Report dated March 2024 and April 2024 for the seven (7)-day look back period of March 27-April 2 for Resident #5 revealed the resident had 13 bladder incontinent episodes, nine (9) continent bladder episodes and had 10 bowel incontinent episodes and eight (8) continent bowel episodes. During an interview on 5/01/24 at 11:40 AM, Resident #5 revealed "I usually use my bedside commode or ask for a bedpan. Still, I occasionally have an accident which is why I wear briefs." During an interview and record review on 5/01/24 at 2:40 PM, the MDS Nurse confirmed during the seven-day look-back period documentation from March 27 through April 2, Resident #5 was continent of the bladder 9 times and incontinent 13 times. She confirmed the resident was	F 641	discovery. Both modifications were submitted and accepted the same day errors were identified, 5/1/24. 2. All residents have the potential to be affected by this deficient practice of allegation of failure of accuracy of assessments. 3. A 100% audit of MDS Assessments on the coding of Section H and Section P was conducted by Director of Nursing and MDS department for the open assessments of all residents with an MDS in-progress on 5/2/24. No additional negative findings were noted. An in-service was conducted on 5/2/24 by the Director of Nursing with Interdisciplinary team responsible for MDS coding addressing the importance of coding MDS assessments accurately. The facility□s Medicare/Resident Assessment Instrument policy was discussed during this in-service as well. 4. Over a period of twelve (12) weeks, start date beginning the week of 5/13/24 and ending the week of 7/29/24, MDS Coordinator to print Skilled Nursing Facility Evaluation History and ADL charting on the 5 selected residents chosen by DON weekly. DON will verify accuracy of coding for section H on each MDS before approving for submission; DON will also verify the accurate coding of section P by comparing MDS coding during that week with an order for a wanderguard listed on the Order Listing Report. Prevention of reoccurrence efforts	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255234	A. BUILDING _____ B. WING _____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN HEALTH AND REHABILITATION	60 SHADY LAWN PLACE VICKSBURG, MS 39180

(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 641	Continued From page 2 incontinent of bowel 10 times and had 8 continent bowel episodes. She confirmed Resident #5 should have been coded as frequently incontinent of bowel and bladder instead of coded as always incontinent. An interview on 5/01/24 at 3:05 PM, the Director of Nurses (DON) confirmed Resident #5's Bowel and Bladder (Section H) MDS assessment was coded inaccurately and failed to represent an accurate assessment of the resident. A record review of Resident #5's Admission Record revealed the resident was admitted to the facility on 3/27/24 with diagnoses that included Fracture of the right Patella, End Stage Renal Disease, and Diastolic (Congestive) Heart Failure. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/3/24 revealed in Section C, a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident is cognitively intact. Resident #10 Record review of the "Order Summary Report" with active orders as of 4/17/24 for Resident #10 revealed orders dated 11/21/2023, "Wanderguard: Check placement and function every shift" and "Wanderguard: Monitor residents whereabouts q (every) 2 (two) hrs (hours)". An observation on 4/30/2024 at 10:40 AM, revealed Resident #10 sitting in a chair in the activity room. A wander alert bracelet was observed on his right arm.	F 641	will focus on correctly identifying all residents at risk for elopement on daily clinical meeting form which is utilized in each morning stand-up meeting. Each resident identified as utilizing a wanderguard bracelet will be identified on a wanderguard list and will have section P reviewed by DON prior to closing MDS to assure accurate capturing of device. All MDS assessments will be refreshed prior to beginning section H to assure the entire lookback period for supporting documentation is available to be included in the coding of section H. Section H of each MDS assessment will also undergo a four-eye check for accuracy in which both MDS team members will review the supportive documentation prior to coding MDS. The Quality Assurance Performance Improvement committee will review weekly monitoring results monthly for a period 3 months during scheduled QA meetings for a period 3 months beginning 6/12/24.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255234	A. BUILDING _____ B. WING _____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN HEALTH AND REHABILITATION	60 SHADY LAWN PLACE VICKSBURG, MS 39180

(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 641	Continued From page 3 Record review of Resident #10's Quarterly MDS with an ARD of 4/17/2024 revealed under section P, wander/elopement alarm was indicated "not used" during the assessment look back period. An interview with the MDS Nurse on 5/1/2024 at 12:00 PM, confirmed an error was made on Resident #10's Quarterly MDS. She revealed that the wanderguard should have been marked as used daily. She revealed the purpose of the MDS was to paint a complete picture of the resident. An interview with the Director of Nursing (DON) on 5/1/2024 at 3:12 PM, confirmed an error was made on Resident #10's MDS and the wanderguard was not captured. She revealed the MDS did not represent an accurate assessment of the resident. Record review of the "Admission Record" revealed the facility admitted Resident #10 on 8/21/2023 with medical diagnoses that included Schizophrenia and Mild intellectual disabilities.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		6/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255234	A. BUILDING _____ B. WING _____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN HEALTH AND REHABILITATION	60 SHADY LAWN PLACE VICKSBURG, MS 39180

(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 656	Continued From page 4 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interview, record review, and facility policy review the facility failed to develop a smoking care plan for Resident #36 and failed to develop a care plan for nail care for Resident #63 for two (2) of 19	F 656	1. Immediate corrective actions were implemented on 5/1/24 which included the Minimum Data Set (MDS) Coordinator immediately reviewed and updated resident #36 comprehensive care plan to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255234	A. BUILDING _____ B. WING _____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN HEALTH AND REHABILITATION	60 SHADY LAWN PLACE VICKSBURG, MS 39180

(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 656	Continued From page 5 care plans reviewed. Resident #36 and Resident #63. Findings include. A review of the facility policy with a revision date of 03/2019, titled "Comprehensive Care Plan", revealed: "Standard: It is the policy of this facility to develop and implement a comprehensive person - centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the resident's comprehensive assessment..." Resident #36 Record review of Resident #36's care plan with a date initiated:5/4/22 and a resolved date: 9/29/22 revealed "Focus RESOLVED: The resident is at risk for injury r/t (related to) smoking Cigarettes and keeps a Cigar in his mouth ..." The desired outcome and all interventions were marked "RESOLVED." Record review of Resident #36's " ...Smoking and Safety" evaluation dated 3/20/24 revealed " ...2. Which of the following products does the Resident use?" The response was checked "1. Tobacco" An interview on 05/01/24 at 3:50 PM, with the Minimum Data Set (MDS) Nurse confirmed that Resident #36 does smoke tobacco occasionally and that he does not have a current care plan for smoking but that he should. The MDS nurse confirmed that the resident had a care plan for smoking that was resolved 9/29/22. The MDS	F 656	reflect resident□s actual current smoking status and resident #63 Activities of Daily Living (ADL) care plan was updated to address resident #63 nailcare issues and personal hygiene. 2. Upon review, the Interdisciplinary Team determined that all residents have the potential to be affected. 3. Nursing Administration, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Nurse Educator (NE) conducted an Inservice on 5/1/24. Interdisciplinary team members and clinical personnel were educated on facility□s policy and procedure for formulating and updating comprehensive care plan. 4. The Director of Nursing or Staff Educator will complete weekly audits of five (5) care plans for twelve (12) consecutive weeks. Audits will be completed beginning the week of 5/13/24 and ending the week of 7/29/24 to ensure that comprehensive care plans are developed and/or accurately updated. Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS department. Activities Director to provide current list of smokers weekly to MDS department. MDS Coordinator will run Care Plan Focus Summary Report. DON will compare most recent smokers list to Summary Report to assure a completed smoking Care Plan is in use for any resident identified as a smoker,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255234	A. BUILDING _____ B. WING _____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN HEALTH AND REHABILITATION	60 SHADY LAWN PLACE VICKSBURG, MS 39180

(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 656	Continued From page 6 nurse revealed that the purpose of having a care plan is to guide the residents care safely and that without a care plan a resident can receive care the wrong way. An observation and interview, on 05/01/24 at 4:00 PM with Licensed Practical Nurse (LPN) #1 confirmed Resident #36 does smoke tobacco occasionally, but not every day. LPN #1 stated "We offer him to go for each smoke break, sometimes he does and sometimes he doesn't go. LPN #1 revealed that the resident has one full unopened pack of cigarettes and one pack of cigarettes that is open and has cigarettes missing from the pack. Both packs of cigarettes had the residents name written on them and they were located inside of the facility smoke box. An interview, on 05/01/24 at 4:05 PM with Resident #36 confirmed that he does smoke tobacco occasionally. An interview on 05/02/24 at 8:00 AM, with the Administrator confirmed that the purpose of the care plan is to guide the residents care safely and without the care plan the resident can receive the wrong care. Resident #63 Record review of the care plans revealed "(Proper name of Resident #63) has an ADL (Activities of Daily Living) deficit ...Desired Outcome ...The resident will maintain or improve current ability in ...Personal Hygiene ..." There were no interventions/task developed for nail care for Resident #63 included in the care plan. During an observation on 4/30/2024 at 2:42 PM,	F 656	regardless of frequency of tobacco use. All care plans will be reviewed and updated as indicated. Reoccurrence will be prevented by continuing current measures for all future residents. Personal Hygiene tasks will continue to be added to all POCs upon admission. An order for the nurse to clean and cut nails will be initiated upon admission and resumed upon any readmission. MDS team to perform all smoking screenings/evaluations upon admission and with each quarterly MDS for residents identified as an active smoker. Activities Director will be notified of any new smokers to assure the list of smokers accurately identifies all potential residents. All residents identified on the list of smokers will have a care plan focus summary report presented to DON for review with each MDS, excluding discharge assessments. MDS team to notify DON upon completion of comprehensive MDS assessments. DON to review comprehensive care plans to assure ADL care plans reflect nail care and personal hygiene. The Quality Assurance Performance Improvement committee will review weekly monitoring results monthly for a period 3 months during scheduled QA meetings for a period 3 months beginning 6/12/24.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255234	A. BUILDING _____ B. WING _____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHADY LAWN HEALTH AND REHABILITATION	60 SHADY LAWN PLACE VICKSBURG, MS 39180

(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 656	Continued From page 7 Resident #63 was sitting in a wheelchair in the activity room. Excessively long, thick, discolored fingernails observed on both hands measuring approximately one-half (1/2) inch in length. An observation and interview on 5/1/2024 at 10:35 AM, with Licensed Practical Nurse (LPN) #2, confirmed Resident #63 had long nails that needed to be cut. An interview with the Minimum Data Set Nurse (MDS) on 5/2/2024 at 10:01 AM, confirmed the resident did not have a care plan developed for nail care. She revealed they did not have the nail care task developed for Resident #63; therefore, a care plan had not been developed. She explained the purpose of the care plan was to guide the staff with the resident care to be given.	F 656		