| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255286 | A. BUILDING _____ B. WING _____ | 06/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PINE VIEW HEALTH AND REHABILITATION CENTER | 1304 WALNUT ST WAYNESBORO, MS 39367 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>The State Agency (SA) conducted an annual recertification survey at the facility from 06/17/2024 through 06/20/2024. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F550, F641, F686, F690, and F812.<br><br>The facility had a census of 90 and was licensed for 90 beds. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights. | F 550 | | 7/24/24 |

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

Electronically Signed | 07/09/2024

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| F 550 | Continued From page 1<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and record review, the facility failed to ensure a resident's right to a dignified experience, as evidenced by not providing a privacy covering for a urinary drainage bag for one (1) of nine (9) residents with an indwelling catheter. (Resident #17)<br><br>Findings include:<br><br>On 6/16/24 11:35 AM, during an observation, Resident #17 was lying in bed and a urinary catheter drainage bag was hanging from the right side of the lower bed. The urinary drainage bag was not covered and the urine in the bag was visible from the hallway.<br><br>On 6/17/24 at 9:15 AM, in an interview and observation with Registered Nurse (RN) #2, she confirmed Resident #17 had an indwelling catheter and the drainage bag was not covered, making the urine visible. RN #2 explained the visible urine was a dignity issue for the resident. | F 550 | Root Cause Analysis was conducted and based on findings Resident #17 was provided a urinary bag cover to ensure privacy and dignity on 6/20/24 by the Unit Manager.<br><br>Residents with urinary catheter bags have the potential to be affected.<br><br>Education was conducted with Licensed Nurses and Certified Nursing Assistants on 6/19/24, 6/20/24, and 6/21/24 by Registered Nurse/Licensed Practical Nurse (RN/LPN) on Resident Right to have their privacy and dignity maintained by having the urinary catheter bag covered. Urinary Catheter bags will be always covered. Certified Nursing assistants and Licensed Nurses will monitor urinary catheter bags when rounding on Residents. Education will be conducted with new hires during | |

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| F 550 | Continued From page 2<br><br>On 6/18/24 at 9:15 AM, in an interview with the Director of Nursing (DON), she revealed urinary drainage bags should have a privacy covering because it was a dignity issue for the resident.<br><br>Record review of the "Admission Record" revealed the facility admitted Resident #17 on 10/19/23 with current Paraplegia and Neuromuscular Dysfunction of Bladder.<br><br>Record review of the "Order Listing Report" revealed Resident #17 had a Physician's Order, dated 5/10/24, for a Foley (Indwelling) catheter. | F 550 | orientation.<br><br>Quality Monitoring will be conducted by the Director of Nursing (DON) , Assistant Director of Nursing or the Unit Manager starting 6/24/24 by the Registered Nurse (RN) 3 x weekly for 4 weeks ; then weekly for 2 months to ensure urinary catheter bags are covered to maintain privacy and dignity for the Residents .Findings will be reported to Quality Assurance Performance Improvement (QAPI) Committee starting 7/19/24 and monthly for 3 months . | |
| F 641 SS=E | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, record review and facility policy review, the facility failed to accurately code a Minimum Data Set (MDS) regarding anticoagulant medication for one (1) of 18 residents reviewed. Resident #10<br><br>Findings include:<br><br>A record review of the facility's policy "MDS" with a revision date of 09/25/2017 revealed "Policy: The center conducts initial and periodic standardized, comprehensive and reproducible assessments ...Procedure ...Each person completing a section or portion of a section of the MDS signs the Attestation Statement indicating its accuracy ..." | F 641 | Root Cause Analysis was conducted and based on findings Resident #10's Minimum Data Set (MDS) with an Assessment Referenced Date (ARD) 5/15/24 was corrected on 6/25/24 by the Minimum Data Set (MDS) Nurse to accurately reflect Residents medications.<br><br>Current Residents on census have the potential to be affected.<br><br>Education was conducted by the Regional Minimum Data Set (MDS) Nurse on 6/25/24 with the MDS Nurse #1 and MDS Nurse #2 on ensuring Residents MDS is coded accurately. Residents MDS' will be | 7/24/24 |

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| F 641 | Continued From page 3<br><br>Record review of the Quarterly MDS with an Assessment Reference Date (ARD) of 05/15/24 indicated Resident #10 received anticoagulant medication for seven (7) days during the look back period.<br><br>Record review of Resident #10's " ...Order Review Batch Update" revealed she had Physician's Orders for Aspirin 81 milligram (mg) (non-steroid anti-inflammatory medication) and Plavix Tablet 75 mg (anti-platelet medication). There were no orders for anticoagulant medications.<br><br>On 06/19/24 at 2:00 PM, during an interview with the MDS Nurse/Licensed Practical Nurse (LPN) #1, she confirmed the MDS with an ARD of 05/15/24 for Residents #10 was inaccurately coded because she did not receive anticoagulant medications.<br><br>On 6/19/24 at 2:15 PM, during an interview with the MDS Coordinator/Registered Nurse #1, she explained the facility completes a "scrub" report prior to submitting the MDS. She confirmed Resident #10's MDS was coded in error and missed on the review.<br><br>On 6/19/24 at 3:20 PM, during an interview with the Director of Nursing (DON), she confirmed the MDS was coded inaccurately for Resident #10, and she expected all MDS assessments to be coded accurately.<br><br>Record review of the "Admission Record" revealed the facility admitted Resident #10 on 11/02/2006 with diagnoses including Hemiplegia and Hemiparesis. | F 641 | reviewed prior to submission to ensure accuracy. The center conducts initial and periodic standardized, comprehensive, and reproducible assessments for each resident including, but not limited to, the collection of data regarding functional status, strengths, weaknesses, and preferences using the federal and/or state, required Resident Assessment Instrument (RAI) manual. Education with new hires will be conducted during orientation.<br><br>Quality Monitoring will be conducted starting 6/24/24 by the Regional MDS Nurse or the Traveling MDS nurse with a sample of 2 MDS' 2x weekly for 2 weeks then a sample of 1 record 2 x weekly for 4 weeks then a sample of 1 MDS monthly x 2 months to ensure Residents MDS' are coded accurately. Findings will be reported to Quality Assurance Performance Improvement (QAPI) Committee starting 7/19/24 and monthly for 3 months . | |

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| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, record review, and facility policy review, the facility failed to implement a Nurse Practitioner's (NP) recommendation for a specialty mattress for a resident with a pressure ulcer (PU) for one (1) of three (3) residents reviewed with PUs. Resident #32<br><br>Findings include:<br><br>A review of the facility's policy "Skin and Wound" with revision date of 01/24/2022 revealed "Policy: To provide a system for ...implementing resident centered interventions to promote skin health, prevention, and healing of pressure injuries ..."<br><br>A record review of a timeline provided by the facility of Resident #32's PUs revealed Resident #32 acquired a deep tissue injury (DTI) (a type of pressure injury) to the right and left heel and a left lateral heel DTI on 03/11/24. On 04/02/24, | F 686 | Root Cause Analysis was conducted and based on findings Resident #32 was provided an air mattress on 5/22/24.<br><br>Current Residents with pressure ulcers have the potential to be affected.<br><br>Education was conducted by RN/LPN on 6/19/24 and 6/20/24 with the Licensed Practical Nurses (LPN) and the Registered Nurses (RN) on following Nurse Practitioner (NP) recommendations to promote healing of Pressure Ulcers. When a recommendation for air mattress is received the Maintenance Supervisor will be notified to place air mattress on bed. If there is no air mattress is available there will be one ordered. New hires will be educated in orientation.<br><br>Quality Monitoring will be conducted | 7/24/24 |

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| F 686 | Continued From page 5<br>Resident #32 acquired a sacrum wound that was a Stage II PU. She received a specialty (air) mattress on 05/22/24.<br><br>Record review of Resident #32's "Progress Note Details" of the wound care NP revealed " 4/30/24 ... Will order patient air mattress... 5/14/24 ...patient has not received air mattress ...5/21/24 ...The patient has not received the air bed ..."<br><br>A record review of the 5-Day (Reentry from an acute hospital) Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/30/24 revealed Resident #32 was severely cognitively impaired and had three (3) unstageable pressure wounds and indicated there were no pressure devices for her bed or chair coded in Section M for skin conditions.<br><br>A record review of the "Customer Portal" maintenance list revealed Resident #32 received an APM2 (type of specialty air mattress) and pump on 5/22/24.<br><br>On 06/19/24 at 4:30 PM, during an interview with the Director of Nursing (DON), she stated she did not understand or know why Resident #32 did not receive an air mattress after the nurse practitioner ordered it on 4/30/24. She explained she expected the staff to follow the NP's recommendations and to place orders as soon as possible.<br><br>On 06/19/24 at 5:00 PM, during an interview with Licensed Practical Nurse (LPN) #2/Wound Care nurse she confirmed the NP indicated in her progress notes on two (2) different dates that Resident #32 did not have an air mattress in place. She explained she remembered the NP | F 686 | starting 6/24/24 by the Director of Nursing (DON) , Assistant Director of Nursing (ADON) 3 x weekly for 4 weeks ; then monthly for 2 months on ensuring NP recommendations are followed for intervention to promote healing of pressure wounds . Findings will be reported to Quality Assurance Performance Improvement (QAPI) Committee starting 7/19/24 and monthly for 3 months . | |

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| F 686 | Continued From page 6<br>asking about the air mattress, but it was forgotten about or maybe it was on order from maintenance.<br><br>On 06/20/24 at 11:45 AM, during an interview with the Maintenance Director, he explained the facility always had low air loss mattresses in-house. The facility placed orders for new mattresses in November 2023. He explained currently there were four (4) low air loss mattresses that are available for use. He stated he always tries to keep one or two low air loss mattresses available but if the facility did not have any mattresses in house, he could order them and have them available the next day.<br><br>On 06/20/24 at 2:00 PM, during an interview with the Wound Care NP, she explained when Resident #32 first got the PUs, she mentioned to LPN #2/Wound care nurse a verbal order to get the resident a low air loss mattress and after seeing resident a few more times she mentioned the air loss mattress again. She confirmed that she did not follow up on the reason why Resident #32 did not have a specialty mattress.<br><br>Record review of the "Admission Record" revealed the facility admitted Resident #32 on 01/03/24 with current diagnoses including of Unspecified Dementia. | F 686 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical | F 690 | | 7/24/24 |

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| F 690 | Continued From page 7<br>condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and record review, the facility failed to maintain proper placement of urinary drainage tubing to prevent the possible spread of infection for one (1) of nine (9) residents with an indwelling catheter. (Resident #17)<br><br>Findings include: | F 690 | Root Cause Analysis was conducted and based on findings Resident #17 's urinary catheter bag was changed and suspended off floor on 6/19/24 by the Registered Nurse (RN).<br><br>Residents with urinary catheter bags have the potential to be affected. | |

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| F 690 | Continued From page 8<br><br>Review of the facility's policy, "Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing", revised 9/2017, revealed, " ... The purpose of this procedure is to provide guidelines for the prevention of catheter-associated urinary tract infections (CAUTIs) ...Steps in Procedure ...6 ...Do not place the drainage bag on the floor ..."<br><br>Record review of the "Order Listing Report" revealed Resident #17 had a Physician's Order, dated 5/10/24, for a Foley (Indwelling) catheter.<br><br>On 6/16/24 at 11:35 AM, during an observation, Resident #17 was lying in bed and a urinary catheter drainage bag was hanging from the right side of the lower bed and the drainage tubing on the floor.<br><br>On 6/17/24 at 9:15 AM, in an interview and observation with Registered Nurse (RN) #2, she confirmed Resident #17 had an indwelling catheter and the drainage tubing was on the floor of the resident's room. RN #2 stated the tubing on the floor was an issue with infection control.<br><br>On 6/18/24 at 9:15 AM, in an interview with the Director of Nursing (DON), she revealed catheters could be a cause of infection and the tubing should not touch the floor. She stated it was the responsibility of all nursing staff to ensure catheter drainage tubing was not touching the floor.<br><br>Record review of the "Admission Record" revealed the facility admitted Resident #17 on 10/19/23 with current diagnoses that included Paraplegia and Neuromuscular Dysfunction of | F 690 | Education was conducted with Licensed Nurses and Certified Nursing Assistants on 6/19/24, 6/20/24, and 6/21/24 by Registered Nurse (RN)/ Licensed Practical Nurse (LPN) on Resident Right to have their privacy and dignity maintained by having the urinary catheter bag covered and Urinary Catheter bags to be suspended.<br>below bladder off floor or other services to prevent the spread of infection. Urinary Catheter bags will be always covered and suspended below bladder off of floor or other services. Certified Nursing assistants and Licensed Nurses will monitor urinary catheter bags when rounding on Residents. Education will be conducted with new hires during orientation.<br><br>Quality Monitoring will be conducted by the Director of Nursing (DON) , Assistant Director of Nursing or the Unit Manager starting 6/24/24 by the Registered Nurse 3 x weekly for 4 weeks ; then weekly for 2 months to ensure urinary catheter bags are covered and suspended below bladder off of floor or other services to maintain dignity and prevent the spared of infection . Findings will be reported to Quality Assurance Performance Improvement (QAPI) Committee starting 7/19/24 and monthly for 3 months . | |

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| F 690 | Continued From page 9<br>Bladder. | F 690 | | |
| F 812 SS=D | Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and facility policy review, the facility failed to ensure the chemical sanitizer for a low-temperature dishwasher had a concentration of at least 50 parts per million (ppm) for (1) of two (2) dishwasher observations.<br><br>Findings include:<br><br>A review of the facility's policy, "Isolation/Infection Control - Non-Disposal Service Ware", Effective Date 11/30/2014, revealed, "Policy: Isolation and Infection Control guidelines issued by the Center | F 812 | Root Cause Analysis was conducted and based on findings the dish machine sanitizer pump was not dispensing the correct amount of sanitizer, on 6/17/24 the Dietary Department began using disposable dining ware. On 6/19/24 Ecolab came to the facility to inspect and repair the dish machine sanitizer pump.<br><br>Residents of the facility that require dietary services have the potential to be affected. | 7/24/24 |

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| (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 |
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| F 812 | Continued From page 10<br>for Disease Control are followed ...Procedure ...Low temperature dish machines ...use a chemical sanitizer ...The required chemical sanitizer concentration is 50 ppm for a chlorine based sanitizer ..."<br><br>On 6/17/24 at 10:07 AM, during an interview and observation with the Dietary Manager (DM), the low-temp dishwasher Hypochlorite (chlorine) on the dish surface final rinse was below 10 ppm. The DM confirmed the chlorine ppm was registering below 10. The DM explained adequate chlorine levels were important to help with infection control and stated she would call the Maintenance Director regarding the sanitation concentration.<br><br>On 6/17/24 at 10:36 AM, an interview with the Maintenance Director revealed the low-temperature dishwasher chlorine was registering below 10 ppm. He advised he would contact the manufacturer to provide further maintenance and a representative would come to the facility.<br><br>On 6/20/24 at 11:40 AM, an interview with the Administrator, he stated he was aware the low temperature dishwasher chlorine level was below 10 ppm when SA observed the DM test the sanitation on 6/17/24. The Administrator stated he planned to personally in-service the staff on requirements for dishwasher sanitation. | F 812 | Executive Director began education with all dietary staff on 6/18/24 to ensure the Hypochlorite was at 50 parts per million (ppm) and if below 50 ppm to begin using disposable products, until Hypochlorite was above 50 ppm.<br><br>Quality Monitoring will be conducted starting on 6/24/24 by the Executive Director or Maintenance Director 5 times a week for 2 weeks, then 3 times a week for 2 weeks, then weekly for 4 weeks, then every other week for 2 months to ensure dish machine Hypochlorite is at least 50 ppm. Findings will be reported to Quality Assurance Performance Improvement (QAPI) Committee starting 7/19/24 and monthly for 3 months . | |