STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255344	A. BUILDING _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUITMAN COUNTY HEALTH & REHAB LLC	350 GETWELL DRIVE MARKS, MS 38646

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F 000	INITIAL COMMENTS ***REVISED 9/20/24*** The CMS-2567 was revised by the State Agency 9/20/24. F851 was deleted. The State Agency (SA) conducted an annual re-certification survey at the facility from 8/26/24 through 8/29/24. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid cited F578, F656, and F677. The census at the time of the survey was 45 and the facility is licensed for 60 beds.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578		10/7/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/12/2024

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F 578	Continued From page 1 and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, record reviews, and facility policy review the facility failed to verify the documented advance directives signed by the Resident Representative (RR) were the preferences of a cognitively intact resident for one (1) of 16 Advance Directives reviewed. Resident #148. Findings Included: Review of the facility policy, titled "Advanced Directives", revealed "...Policy Interpretation and Implementation 1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate and advance directive if he or she chooses to do so ...4. If the resident becomes able to receive and understand this information later, he or she will be	F 578	**On 8/27/2024 The Social Service Director, Administrator and Registered Nursing Consultant spoke with resident #148 and explained the difference between Full Code Status and Do Not Resuscitate. Advance Directive/Code Status was verified with resident #148, Responsible Representative, and Medical Director. A new copy of Advance Directive/Code Status was placed on the chart by the Social Service Director due to deficient practice for compliance. **All residents have the potential to be affected by this deficient practice **On 8/28/2024 The Administrator in-serviced the Social Service Director and Medical Records Nurse on facility	

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F 578	Continued From page 2 provided with the same written materials as described above, even if his or her legal representative has already been given the information..." Record review of the "Order Summary Report" with active orders as of 8/27/24 revealed an order dated 8/19/24 "Code Status; DNR (Do Not Resuscitate) EFF(effective) 081424." An additional order dated 8/2024 revealed "DNR." Record review of a "Nurse Note" dated 8/7/24 at 6:19 PM revealed " ...States that she is not a DNR ..." Record review of the "Resident/Representative Consent for Cardiopulmonary Resuscitation (CPR)" form, dated 8/7/24, indicated the RR, rather than the resident herself, had signed the document upon admission. The form contained a statement that read, "I understand that CPR constitutes an extraordinary measure and SHOULD NOT be done on this resident..." Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/14/24 revealed Resident #148 had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact. During an interview on 8/27/24 at 11:30 AM, Social Services stated that the "Resident/Representative Consent for CPR" was signed by the resident's representative at the time of admission and not by the resident. She admitted that she did not discuss CPR with Resident #148 upon admission. Considering Resident #148's BIMS score of 15, which demonstrates cognitive intactness, she agreed	F 578	policy of Advance Directives/Code Status and reviewing Advance Directives during admission. On 8/28/2024 Administrator in-serviced licensed nurses and certified nursing assistance on Advanced Directive/Code Status Policy. On 8/29/2024 100% of resident's medical records were audited by Administrator, Director of Nursing, Medical Records Nurse and Social Service Director to ensure correct Advance Directive/Code Status was currently in place in residents' medical record. On 8/30/2024 Quality Assurance Performance Improvement Committee which includes Administrator, Director of Nurses, Charge Nurse, Social Service Director, Infection Preventionist, Medical Records Nurse and Medical Director reviewed Advance Directive/Code Status policy with no recommended changes at this time. **8/29/2024 Administrator to review all new admissions and changes in status weekly times 4 then monthly times 2 Starting on 9/9/2024 with Quality Assurance Performance Improvement Committee to review monitoring logs completed by Administrator on 10/07/2024 then will review quarterly times 2	

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F 578	Continued From page 3 that she should have followed up with the resident directly to verify her preferences regarding CPR. In an interview with Resident #148 on 8/27/24 at 12:10 PM, the resident confirmed that no one had discussed CPR with her or asked for her wishes regarding resuscitation. She expressed that depending on the circumstances, she might want CPR performed. A review of the "Admission Record" revealed that Resident #148 was admitted to the facility on 8/7/24 with diagnoses that included Unspecified dementia.	F 578		
F 656 SS=E	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 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	F 656		10/7/24

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F 656	Continued From page 4 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 observation, staff and resident interview, record review and facility policy review the facility failed to implement an Activity of Daily Living (ADL) care plan related to removal of facial hair (Resident #3) and nail care (Resident #44) for two (2) of 13 sampled residents. Findings Included: Record review of the facility policy, "Care Plans, Comprehensive Person-Centered" with revision date of March 2022 revealed, "... A comprehensive, person-centered care plan that includes measurable objectives and timetables to	F 656	**On 8/28/2024 Director of Nursing along with Minimum Set Data Nurse immediately reviewed Care Plans for resident #3 and resident #44 and were implemented by discussing care plan with assigned certified nursing assistant due to deficient practice for compliance **All residents have the potential to be affected by this deficient practice. **On 8/29/2024 Director of Nurses and Minimum Set Data Nurse in serviced all Licensed Nurses and Certified Nursing	

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F 656	Continued From page 5 meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident..." Resident #3 Record review of Resident #3's Care Plan with a problem onset date of 04/19/2022 revealed " ...requires assistance with ADLs (Activities of Daily Living) ... Approaches ... Total assistance x 1 staff for all ADLs (Bed Mobility, Transfers, Locomotion, Dressing, Eating, Toileting, Hygiene, Bathing) ..." On 08/26/24 at 12:14 PM, an observation of Resident #3 revealed her sitting in her geri chair in the hall and she had scattered white facial hairs above her lip and two white chin hairs which were approximately one (1) inch long. On 08/27/24 at 8:45 AM, an observation of Resident #3 revealed her lying in her bed asleep and she had scattered white facial hairs above her upper lip and two chin hairs which were approximately one (1) inch long. On 08/27/24 at 10:27 AM, an interview with Certified Nursing Assistant (CNA)#1 revealed that Resident #1's scheduled shower days were Monday, Wednesday, and Friday and the CNAs were supposed to take care of facial hair during that time. CNA #1 confirmed that Resident #3 had white facial hair to her upper lip and chin and that her facial hair had not been shaved during her bath the day before. Record review of Resident #3's "Admission Record" revealed an admission date of 08/07/2008 with diagnoses that included	F 656	Assistants on Comprehensive Person-Centered Care Plans according to policy. On 8/29/2024 and 08/30/2024 the Director of Nursing and Minimum Set Data Nurse reviewed 100% of all resident Activities of Daily Living care plans for compliance. On 8/30/2024 Quality Assurance Performance Improvement Committee which included Administrator, Director of Nurses, Charge Nurse, Minimum Set Data Nurse, Infection Preventionist Nurse and Medical Director reviewed Comprehensive Care Plan Policy with no recommended changes at this time **Director of Nursing and MDS Nurse will review 3 care plans per week and scheduled care plans starting on 9/9/2024 for 4 weeks then monthly times 2. Quality Assurance Performance Improvement Committee will review completed monitoring logs from Director of Nursing and MDS Nurse on 10/7/2024 then review quarterly times 2.	

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F 656	Continued From page 6	F 656		

Huntington's Disease, Dementia, and Heart Failure.

Record review of Resident 3's MDS with an Assessment Reference Date (ARD) of 07/31/2024, Section C revealed a Brief Interview for Mental Status (BIMS) should not be conducted because the resident was rarely or never understood. Section GG - Functional Abilities and Goals revealed Resident #3 was dependent in maintaining personal hygiene.

Resident #44

Record review of Resident #44's "Care Plan" with a problem onset undated, revealed " ...is at risk for impaired function/Daily ADL abilities and requires assistance to complete Activities of Daily Living (ADLs) ...Approaches ...Inspect nails daily, clean and cut as needed..."

An observation on 08/26/24 at 12:17 PM, revealed Resident #44 sitting up in his wheelchair in his room and his fingernails were long, jagged and had a brown substance underneath them. His fingernails were approximately one-half (1/2) to three-fourths (3/4) inch long. Resident #44 revealed that they had not cut his nails in a while and stated, "Sometimes I scratch myself." He also confirmed that the staff did not check his nails every day.

On 08/27/24 at 10:24 AM, an interview with CNA #1 revealed that they were supposed to provide for resident needs such as nail care and shaving facial hair during their bath or shower time. She confirmed that Resident #44 had long, jagged nails with a brown substance underneath and that

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F 656	Continued From page 7	F 656		

his nails should have been addressed yesterday during his shower time. CNA #1 revealed that not doing nail care could cause the resident to scratch himself, it could cause skin tears and possible infection. CNA #1 revealed Resident #44 should have gotten his shower yesterday on the evening shift on 08/26/24 and she agreed that Resident #44 had not received nail care and stated that it did not look like his nails had been cleaned or clipped.

On 08/27/24 at 10:30 AM, an observation and interview with Registered Nurse (RN) Supervisor, confirmed that Resident #44's fingernails were long and jagged. She also confirmed the brown substance under his nails. The RN Supervisor revealed that personal hygiene included nail care, grooming, and facial hair and the CNAs were supposed take care of these needs during their baths or showers. The RN Supervisor revealed that long, jagged, and dirty fingernails could cause skin tears, abrasions, and she agreed that it could cause infection if nails were not cared for properly. She also agreed that Resident #44's nails were not clipped nor cleaned during his shower he received the day before and stated, "I will get someone on this now."

On 08/27/24 at 10:40 AM, an interview with Administrator (ADM) revealed that personal hygiene included mouth care, nail care, and shaving facial hair on men and ladies. She revealed that during resident showers, it was the CNAs responsibility to check the fingernails and to take care of facial hair. She revealed that the CNAs were supposed to check the residents from head to toe while they had them in the shower and take care of any concerns which included fingernails and facial hair. She revealed that they

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F 656	Continued From page 8 were also supposed to report any other concerns to the nurse. The ADM confirmed Resident #3 and Resident #44's ADL Care Plan was not followed related to nail care and removal of facial hair. On 08/27/24 at 2:52 PM, an interview with Minimum Data Set (MDS) Coordinator revealed that the purpose of the comprehensive care plan was to ensure continuity of care for the residents. She confirmed that Resident #3's ADL care plan was not implemented related to her personal hygiene needs which included removal of facial hair. She also agreed that Resident #44's Care Plan was not followed when the staff failed to clean and clip his fingernails. Record review of Resident #44's "Admission Record" revealed an initial admission date of 03/01/2023 with diagnoses that included Cerebral Infarction, Dysphagia and Chronic Systolic Heart Failure. Record review of Resident #44's Physician Orders revealed an order with start date of 07/01/2024, to inspect nails daily, clean, and cut as needed. Record review of Resident #44's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/26/2024. Section C - Cognitive Patterns, revealed a Brief Interview for Mental Status (BIMS) Score of 07 which indicated Resident #44 had severe cognitive deficits. Section GG- Functional Abilities and Goals revealed that he was dependent on staff to maintain personal hygiene.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents	F 677		10/7/24

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F 677	Continued From page 9 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, record review and facility policy review the facility failed to provide Activity of Daily Living (ADL) care related to removal of facial hair (Resident #3) and nail care (Resident #44) for two (2) of 13 sampled residents. Findings Included: Record review of the facility policy titled "Activities of Daily Living (ADL)s" with revision date of March 2018, revealed "Policy Statement: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene..." Resident #3 An observation on 08/26/24 at 12:14 PM, revealed Resident #3 sitting in her geri chair in the hall and she had scattered white facial hairs above her upper lip and two white chin hairs that were approximately one (1) inch long. An observation on 08/27/24 at 8:45 AM, revealed Resident #3 lying in her room asleep. She had scattered white facial hairs above her upper lip and two chin hairs that were approximately 1 inch long.	F 677	**On 8/27/2024 Nail care was provided for resident #44 by Licensed Practical Nurse. Resident's fingernails were trimmed and cleaned. Resident #3 nail care was conducted by Licensed Practical Nurse. Resident's fingernails were trimmed and cleaned. Certified Nursing Assistant removed facial hair from Resident #3 due to deficient practice for compliance. **All residents have potential to be affected by this deficient practice. **On 8/29/2024 Director of Nursing in serviced all Nursing Staff on ADL Care. On 8/29/2024 Director of Nursing and Charge Nurse audited 100% of all Residents for proper ADL care which included Nail Care and unnecessary facial hair with any issues noted corrected immediately. On 8/30/2024 Quality Assurance Performance Improvement Committee which included Administrator, Director of Nursing, Charge Nurse, Infection Preventionist, a Certified Nursing Assistant and Medical Director reviewed ADL care Policy with no recommended changes at this time. **Starting on 9/9/2024 Director of Nursing	

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F 677	Continued From page 10 During an interview on 08/27/24 at 10:27 AM, Certified Nursing Assistant (CNA) #1 revealed that Resident #3's scheduled shower days were Mondays, Wednesdays, and Fridays. She confirmed that Resident #3 had white facial hair on her upper lip and chin and she revealed that her facial hair should have been shaved during her bath the day before. CNA #1 confirmed that her facial hair had not been taken care of. Record review of Resident #3's "Admission Record" revealed that she admitted to the facility on 08/07/2008 with diagnoses that included Huntington's Disease, Dementia, and Heart Failure. Record review of Resident 3's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/31/2024, Section C revealed a Brief Interview for Mental Status (BIMS) should not be conducted because the resident was rarely or never understood. Section GG - Functional Abilities and Goals revealed Resident #3 was dependent in maintaining personal hygiene. Resident #44 During an observation on 08/26/24 at 12:17 PM, revealed Resident #44 sitting up in his wheelchair in his room and his fingernails were long, jagged and had a brown substance underneath them. His fingernails were approximately one-half to three-fourths inch long. Resident #44 revealed that they had not cut his nails in a while and stated, "Sometimes I scratch myself." He also confirmed that the staff did not check his nails every day. During an interview on 08/27/24 at 10:24 AM,	F 677	and Charge Nurse will monitor 100% of residents daily times 1 week then 3 times weekly times 2weeks then 2 times weekly times 1 week then weekly times 2 months. Quality Assurance Performance Improvement Committee will review monitoring logs from Director of Nursing and Charge Nurse on 10/7/2024 then quarterly times 2	

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F 677	Continued From page 11 CNA #1 revealed that they were supposed to provide for the resident's needs such as nail care and shaving facial hair during their bath or shower time. She confirmed Resident #44 had long, jagged nails with brown substance underneath and that his nails should have been addressed yesterday during his shower time. CNA #1 revealed that by not doing nail care could cause the resident to scratch himself, it could cause skin tears and possible infection. CNA #1 revealed that Resident #44 should have gotten his shower yesterday on the evening shift on 08/26/24 and stated that it did not look like his nails had been cleaned or clipped. On 08/27/24 at 10:30 AM, during an observation and interview with the Registered Nurse (RN) Supervisor, confirmed that Resident #44's fingernails were long, jagged and had brown substance underneath. The RN Supervisor revealed that personal hygiene included nail care, grooming, and facial hair and that the CNAs were supposed take care of these needs during their baths or showers. The RN Supervisor revealed that long, jagged, and dirty fingernails could cause skin tears, abrasions, and she agreed that it could cause infection if nails were not cared for properly. She also agreed that Resident #44's nails were not clipped nor cleaned during his shower he received the day before and stated, "I will get someone on this now." During an interview on 08/27/24 at 10:40 AM, the Administrator (ADM) revealed that personal hygiene included nail care and shaving facial hair on men and ladies. She revealed that during resident showers, it was the CNAs responsibility to check the residents from head to toe and to take care of any issues that included fingernails	F 677	On 8/27/2024 Nail care was provided for resident #44 by Licensed Practical Nurse. Resident's fingernails were trimmed and cleaned. Resident #3 nail care was conducted by Licensed Practical Nurse. Resident's fingernails were trimmed and cleaned. Certified Nursing Assistant removed facial hair from Resident #3 due to deficient practice for compliance. All residents have potential to be affected by this deficient practice. On 8/29/2024 Director of Nursing in serviced all Nursing Staff on ADL Care. On 8/29/2024 Director of Nursing and Charge Nurse audited 100% of all Residents for proper ADL care which included Nail Care and unnecessary facial hair with any issues noted corrected immediately. On 8/30/2024 Quality Assurance Performance Improvement Committee which included Administrator, Director of Nursing, Charge Nurse, Quality Assurance Nurse, a Certified Nursing Assistant and Medical Director reviewed ADL care Policy with no recommended changes at this time. Starting on 9/9/2024 Director of Nursing and Charge Nurse will monitor 100% of residents daily x 1 week then 3x week x 2weeks then 2x week x 1 week then weekly x 2 months. Quality Assurance Performance Improvement Committee will review monitoring logs from Director of Nursing and Charge Nurse on 10/7/2024 then quarterly x 2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255344	A. BUILDING _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUITMAN COUNTY HEALTH & REHAB LLC	350 GETWELL DRIVE MARKS, MS 38646

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F 677	Continued From page 12	F 677		

and facial hair.

Record review of Resident #44's "Admission Record" revealed an initial admission date of 03/01/2023 with diagnoses that included Cerebral Infarction, Dysphagia, and Chronic Systolic Heart Failure.

Record review of Resident #44's Physician Orders revealed an order with start date of 07/01/2024, to inspect nails daily, clean, and cut as needed.

Record review of Resident #44's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/26/2024. Section C - Cognitive Patterns, revealed a Brief Interview for Mental Status (BIMS) Score of 07 which indicated Resident #44 had severe cognitive deficits. Section GG- Functional Abilities and Goals revealed that he was dependent on staff to maintain personal hygiene.