STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255314	A. BUILDING _____ B. WING _____	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CARE CENTER	1920 LISA DRIVE EXTENDED GREENVILLE, MS 38703

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 8/20/24 through 8/21/24. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid requirements for participation and deficiencies were cited at F641, F758, and F851. The census at the time of survey was 52 and the facility was licensed for 60 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 resident and staff interview, record review, and facility policy review, the facility failed to accurately code a quarterly Minimum Data Set Assessment (MDS) for one (1) of 16 resident assessments reviewed. (Resident # 11) Findings include: Review of the facility policy titled, "Resident Assessment," with the latest revision 09/19 revealed, " ...The completed assessment guides the staff in identifying key information about the resident's specific issues and objectives to develop a care plan ... Any healthcare professional that completes a portion of the assessment must sign and certify the accuracy of the portion of the assessment that they have completed..."	F 641	F641 Accuracy of Assessments Facility failed to accurately code a quarterly Minimum Data Set Assessment (MDS) for (1) of 16 resident assessments reviewed. (Resident # 11). 1. Resident #11 has had their most recent Minimum Data Set modified to accurately reflect the removal of code Z51.5 Hospice on 8/23/2024 by the Minimum Data Set Coordinator. One on One education completed with the Minimum Data Set Assessment Coordinator by the Director of Nursing on 8/21/24 on proper coding of the Minimum Data Set Assessment. Resident #11 was assessed for any adverse effects from miscoding of	10/1/24

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

Electronically Signed | 09/05/2024

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F 641	Continued From page 1 In an interview with Resident #11 on 8/20/24 at 11:00 AM, she revealed she was not on or receiving Hospice services. Record review of Resident #11's Section C of the Quarterly MDS revealed on 7/08/24 a Brief Interview for Mental Status (BIMS) score was 13 indicating the resident was cognitively intact. Section: O- Special Treatments, Procedures, and Programs was coded "Hospice services while a resident." In an interview with Licensed Practical Nurse (LPN)/MDS Nurse on 8/21/24 at 9:04 AM, she revealed after review of Resident #11's quarterly MDS that she accidentally coded that the resident was on Hospice and confirmed that Resident #11 had never been on Hospice. She then revealed the purpose of accurate coding is to get an accurate picture of the resident's needs and services required. In an interview with the MDS Registered Nurse (RN) Coordinator on 8/21/24 at 12:19 PM, she revealed that Resident #11 has not ever been on Hospice services and confirmed the resident's MDS assessment was coded incorrectly. She stated the purpose of accurately coding the resident assessments is to ensure the facility receives proper payment for care and to ensure the resident receives the individualized care required. Review of the "Admission Record" revealed the facility admitted Resident #11 on 4/21/23 with diagnoses that included End-stage renal disease.	F 641	Minimum Data Set Assessment on 8/21/24 by the Director of Nursing with no negative findings noted. 2. All fifty-two (52) residents currently residing in the 60-bed facility have the potential to be affected by miscoding of the Minimum Data Set Assessment. 3. The Director of Nursing started in-servicing nursing staff (Registered Nurses and Licensed Practical Nurses) on policy titled “Comprehensive Assessment” to include the proper assessment and coding of all sections of Minimum Data Set Assessment on 8/21/2024 and will continue until all nursing staff have been in-serviced. All comprehensive Minimum Data Set Assessment and quarterly Minimum Data Set Assessment completed will now be reviewed each week according to the Minimum Data Set Assessment schedule by the Director of Nursing and/or Medical Records to ensure the hospice is not marked inappropriately on resident data assessment. 4. The Director of Nursing and/or Medical Records are responsible for monitoring compliance. The Minimum Data Set Assessment audit will be completed weekly for four weeks, then monthly for 2 months by the Director of Nursing and/or Medical Records coinciding with the Minimum Data Set Assessment calendar to monitor for compliance and recorded on the utilization review meeting form. All negative findings from the audits will be reported to the Director of Nursing at the	

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F 641	Continued From page 2	F 641	time of discovery for immediate correction. A Quality Assurance Committee Meeting was conducted on 9/4/2024 with the Administrator, Director of Nursing, Medical Director, Accounts Manager, Medical Records, Social Services Director, Infection Control Nurse, Assessment Nurse and Activity Director. A follow-up Quality Assurance Committee Meeting will be conducted again on 9/24/2024 and again two additional months after the follow-up Quality Assurance Committee Meeting. Administrator will report any recurring problem to the monthly Quality Assurance Committee. Administrator will take necessary corrective action such as: Individual in-service and initiate Quality Assurance Committee to ensure compliance is resolved.	
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---	F 758		10/1/24

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F 758	Continued From page 3 §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 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 interview, record review, and facility policy review, the facility failed to ensure a resident on a PRN (as needed) psychotropic medication had a stop date for one (1) of five (5)	F 758	F758 Free from Unnec Psychotropic Meds/PRN Use	

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F 758	Continued From page 4 medication reviews. Resident #40 Findings Include: Review of the facility policy titled, "Psychotropic Medication," revised 10/22, revealed "Residents do not receive psychotropic drugs pursuant to a PRN (as needed) order unless that medication is necessary to treat a diagnosed a specific condition that is documented in the clinical record; and PRN orders for psychotropic drugs are limited to 14 days." Review of the "Order Summary Report" with active orders as of 8/21/24 for Resident #40 revealed an order dated 7/5/2024, "Xanax oral tablet 0.5 mg (milligram) (Alprazolam) give (1) tablet by mouth every 6 (six) hours as needed for agitation ..." There was no stop date for the order. Review of the August 2024 Medication Administration Record (MAR) for Resident #40 revealed the resident received Xanax 0.5 mg on the following dates: 8/3, 8/4, 8/8, 8/9, 8/10, 8/13, 8/14, 8/15, 8/16, 8/18, 8/19, 8/20, 8/21. An interview with the Director of Nursing (DON) on 8/21/2024 at 12:08 PM confirmed Resident #40's PRN Xanax order did not have a stop date. She revealed the resident was on hospice and should have been re-evaluated by hospice within the 14 days to ensure the medication was needed and it could have been continued at that point. Review of the "Admission Record" revealed the facility admitted Resident #40 on 3/14/24 with a medical diagnosis of Aftercare following joint replacement surgery.	F 758	Facility failed to ensure a resident on PRN (as needed) psychotropic medication had a stop date for one (1) of five (5) medication reviews. Resident #40. 1. Resident #40's attending physician was notified that resident #40 received as needed Xanax with no stop date. The attending physician changed her status use of Xanax to routine on 8/21/2024. Resident #40 was assessed for any adverse reactions on 8/21/2024 by the Director of Nursing with no negative findings noted. 2. One of fifty-two (52) residents currently residing in the 60-bed facility with as needed psychotropic orders have the potential to be affected. 3. The facility Psychotropic Policy and Procedure was reviewed and in service started on 8/21/24 by the Director of Nursing with Licensed Nursing Staff. Licensed Nursing Staff (Registered Nurses & Licensed Practical Nurses) have been in-serviced on the Psychotropic Policy and Procedure and the intent of F758, related to ensuring that any as needed order for psychotropic medication received from any attending physician or prescribing practitioner will be given an automatic 14 day stop date. It will be the responsibility of the charge nurse to notify the attending physician or prescribing practitioner that a rational will be required to continue the as needed psychotropic medication beyond the 14 days and this in service will continue until all nurses have	

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F 758	Continued From page 5	F 758	been in serviced. 4. Physician orders for PRN (as needed) psychotropic medications will be reviewed Monday through Friday at the morning meeting. The Director of Nursing and/or Medical Records will review any as needed psychotropic medication orders to ensure there is an automatic 14 day stop date. If the physician had decided that the medication is to be extended, this review will ensure that the physician or prescribing practitioner has documented a rationale to continue the medication beyond the 14 days. This audit will continue Monday through Friday for 4 weeks, then 3 times a week for 3 weeks, and finally 2 times in 2 weeks. This review will be documented on the Stand-Up Meeting form. A Quality Assurance Committee Meeting was conducted on 9/4/2024 with the Administrator, Director of Nursing, Medical Director, Accounts Manager, Medical Records, Social Services Director, Infection Control Nurse, Assessment Nurse and Activity Director. A follow-up Quality Assurance Committee Meeting will be conducted again on 9/24/2024 and again two additional months after the follow-up Quality Assurance Committee Meeting. Administrator will report any recurring problem to the monthly Quality Assurance Committee. Administrator will take necessary corrective action such as: Individual in-service and initiate Quality Assurance Committee to ensure	

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F 758	Continued From page 6	F 758	compliance is resolved.	
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(p)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(p)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and	F 851		10/1/24

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F 851	Continued From page 7 tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(p)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(p)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(p)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to submit accurate staffing information into the Payroll-Based Journal (PBJ) system for one (1) of four (4) quarters reviewed. Second (2nd) Quarter 2024. Findings include: Review of the facility PBJ (Payroll-Based Journal) Instructions with a revision date of February 3, 2020 revealed, "PBJ = Payroll-Based Journal - Mandated by CMS (Centers for Medicare and Medicaid Services). Each location must collect time worked by "contract" workers. The corporate	F 851	F851 Payroll-Based Journal Facility failed to submit accurate staffing information into the Payroll-Based Journal system for one (1) of four (4) quarters reviewed. Second (2nd) Quarter 2024. 1. On 8/21/2024, the Administrator in-serviced the Administrative Assistant on verifying staffing agency hours prior to entering into Payroll -Based Journal. The facility was unable to make data entry corrections for the second quarter in 2024	

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F 851	Continued From page 8 office will submit at regular intervals ...." Review of the PBJ (Payroll-Based Journal) Staffing Data Report revealed the facility triggered for excessively low weekend staffing data for the 2nd Quarter 2024 Casper report from CMS."Triggered=Submitted Weekend Staffing data is excessively low." An interview with the Administrator on 8/20/2024 at 9:25 AM, revealed, she was not aware of the facility triggering on the Casper report for low weekend staffing data and stated the corporate office was responsible for submitting the PBJ. She revealed the facility had been using agency staff and to her knowledge the agency hours were added by the Business Office. A telephone interview with Corporate Special Projects on 8/20/2024 at 3:36 PM, revealed, she was responsible for submitting the PBJ. She revealed she was not aware the facility triggered for low weekend staffing data and stated she had not received any kind of notification. She explained that she did not have contact with anyone at the facility to ensure contract/agency hours were being captured in the PBJ. She revealed the facility was responsible for adding the agency hours into the (proper name of system) and the system would automatically do a payroll interfaced sweep over every night to capture those hours. She confirmed if the agency hours were not entered manually at the facility, they would not be captured. Review of the PBJ total daily staffing hours submitted to CMS for the 2nd Quarter 2024 did not match the facility's staffing grid hours, which indicated inaccurate information was submitted in	F 851	because of the data entry ending date in Payroll-Based Journal. 2. All 52 residents resides in the facility has potential to be affected by the deficient practice. 3. The Administrator in-serviced the Staff Development Nurse and Director of Nursing on 8/21/2024 to communicate any changes or additions with the agency staff schedule to Administrative Assistant so she can make sure the data is accurate. 4. The Administrator will audit employee and agency staff timesheets against the Payroll-Based Journal entries for accuracy 4 times a week for 2 weeks, 3 times a week for 2 weeks, and 2 times a week for 2 weeks to ensure time is entered accurately. Results of these audits will be reviewed by the facility quality assurance committee. A Quality Assurance Committee Meeting was conducted on 9/4/2024 with the Administrator, Director of Nursing, Medical Director, Accounts Manager, Medical Records, Social Services Director, Infection Control Nurse, Assessment Nurse and the Activity Director. A follow-up Quality Assurance Committee Meeting will be conducted again on 9/24/2024 and again two additional months after the follow-up Quality Assurance Committee Meeting. Administrator will report any recurring problem to the monthly Quality Assurance	

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F 851	Continued From page 9 the PBJ. An interview with the Regional Supervisor on 8/21/2024 at 2:25 PM revealed, she had not received any information that the facility was triggering for low weekend staffing. She stated she was unsure how contract hours were handled, but she knew the Business Office added the agency hours into the (proper name of system) after receiving the information from the shift worked. She confirmed there could be a breakdown and revealed that was something they would have to look into.	F 851	Committee. The Administrator will take necessary corrective action such as: Individual in-service and/or one on one initiate Quality Assurance Committee to ensure compliance is resolved.	