STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255277	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET LEAKESVILLE, MS 39451

(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 10/07/2024 through 10/10/2024. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F604, F656 and F812. The facility had a census of 56 and was licensed for 60 beds.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that	F 604		11/8/24

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

Electronically Signed | 10/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255277	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET LEAKESVILLE, MS 39451

(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 604	Continued From page 1 are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review, the facility failed to ensure a resident's right to be free from physical restraints by not identifying and documenting the use of a chest harness as a restraint for one (1) of fourteen (14) sampled residents. Resident #38 Findings Include: A review of the facility's policy titled "Use of Restraints," revised April 2017, revealed: "Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully... When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and ongoing re-evaluation for the need for restraints will be documented. 1. Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached to the resident's body that the individual cannot remove... 2. If the resident cannot remove a device in the same manner in which the staff applied it, given the resident's physical condition, and this restricts his/her typical ability to change position or place, that device is considered a restraint...." A record review of Resident #38's medical record revealed there was no documentation regarding	F 604	1. On 10/8/2024, Resident # 38 was assessed for the use of a postural trunk control device using the pre-restraining evaluation, informed consent form and restraint elimination form related to impaired mobility and upper body trunk control as a result of medical diagnosis of Spastic Quadriplegic Cerebral Palsy and Dandy-Walker Syndrome. New orders were received for Postural trunk control device while up in wheel chair with resident observations every 30 minutes and the device released every 2 hours x 15 minutes for safety and socialization. The comprehensive care plan was developed to reflect the use of the postural support device. 2. On 10/8/2024 the Director of Nurses (DON), Quality Assurance (QA) Nurse, and the Registered Nurse (RN) Supervisor assessed all 56 Residents and one (1) Resident was identified as having the potential to be affected. 3. To protect Residents from similar occurrences the Staff Development Nurse provided education on 10/9/2024 to five (5) Licensed Practical Nurses (LPN) and five (5) Registered Nurses (RN) and twelve (12) Certified Nurse Aides (CNA)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255277	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET LEAKESVILLE, MS 39451

(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 604	Continued From page 2 the use of a restraint. On 10/08/24 at 3:50 PM, during an interview with the Administrator, she explained that Resident #38 wore the support straps across her body while sitting in her wheelchair due to her medical condition. The Administrator stated that the facility did not consider the support device, which was a harness, as a restraint. She further explained that if a resident does not have the mental capacity to understand or remove the restraint, it was not considered a restraint by the facility. The Administrator confirmed that Resident #38 could not remove the harness without staff assistance. On 10/09/24 at 7:30 AM, in an observation, Resident #38 was observed sitting in her wheelchair with a cloth cross-body strap support on her upper chest. On 10/09/24 at 7:38 AM, during an interview, Licensed Practical Nurse (LPN) #1 stated that the resident wore the straps across her body when she was in her wheelchair to provide support. LPN #1 reported that Resident #38 was placed in her wheelchair for two (2) hours in the morning and then placed back in bed for two (2) hours, continuing this cycle throughout the day. LPN #1 added that the straps had been used since the resident was admitted to the facility. On 10/09/24 at 7:40 AM, during an interview, Certified Nursing Assistant (CNA) #2 confirmed that the straps were placed across the resident's chest to prevent her from falling out of the chair. CNA #2 also confirmed that Resident #38 could not remove the straps on her own. On 10/09/24 at 11:05 AM, in an interview, the	F 604	regarding the need for assessments to reflect the indication and use for postural support devices, physicians order to apply such device with sufficient monitoring, and care planning to include resident specific interventions for resident safety. All other direct care staff are scheduled for in-service training on 10/23/2024 and 10/25/2024. On 10/17/2024, the quality assurance (QA) committee met and reviewed the policy for Physical Restraints and no changes were recommended. A new policy and procedure for Upper Body Harness was also reviewed and implemented by the QA committee and signed by the Medical Director. 4. An audit tool will be completed by the DON, QA Nurse or the RN Supervisor to monitor and ensure residents with postural support devices are supported with the accurate documentation required for regulatory compliance. Initial monitoring began 10/15/2024 and will be completed weekly x 4 weeks then monthly x 3 months. Audit logs were reviewed by the QA committee on 10/17/2024. The QA committee will review audits logs again on 11/6/2024 and then will be reviewed monthly x 3 months to ensure compliance is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255277	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET LEAKESVILLE, MS 39451

(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 604	Continued From page 3 Director of Nursing (DON) acknowledged that Resident #38 was unable to remove the harness from her wheelchair without staff assistance. The DON confirmed that the facility had not previously identified the strapping device as a restraint. The DON explained that, moving forward, the facility would conduct pre-restraint evaluations, obtain physician's orders, secure consents from the resident's representative, and ensure proper documentation. Additionally, the DON committed to providing in-service training to staff on identifying and documenting restraints. A record review of the "Admission Record" revealed that the facility admitted Resident #38 on 04/19/19 with diagnoses including Spastic Quadriplegic Cerebral Palsy. A record review of the "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/24/24 revealed that Resident #38's cognitive skills for daily decision-making were severely impaired. The resident required a staff interview for cognitive status.	F 604		
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 -	F 656		11/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255277	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET LEAKESVILLE, MS 39451

(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 (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 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 interview, record review, and facility policy review, the facility failed to develop and implement a comprehensive, person-centered care plan to reflect the use of a	F 656	1. The comprehensive care plan for Resident #38 was developed to reflect the accurate use of a postural trunk control device to include interventions for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255277	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET LEAKESVILLE, MS 39451

(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 restraint for one (1) of fourteen (14) sampled residents, Resident #38. Findings Include: A review of the facility's policy titled "Use of Restraints," revised April 2017, revealed " ...17. Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom(s) but the underlying problems that may be causing the symptom(s)... 18. Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use ...." During an observation on 10/09/24 at 7:30 AM, Resident #38 was sitting in her wheelchair with a cloth cross-body strap support on her upper chest. A record review of the "Comprehensive Care Plan" revealed that there was no care plan developed related to the use of a physical restraint. During an interview on 10/09/24 at 11:05 AM, the Director of Nursing (DON) acknowledged Resident #38 was unable to remove the harness restraint while in her wheelchair. The DON confirmed Resident #38 had not previously been care planned for the restraint and explained the reason of care planning is to note the focus area with goals and interventions for the staff. The DON stated her expectation going forward is to care plan focus areas promptly so that staff can be aware of how to care for the residents. A record review of the "Admission Record" revealed that the facility admitted Resident #38	F 656	monitoring to ensure Resident safety on 10/8 2024 by the Care Plan Nurse. 2. On 10/8/2024 the Director of Nurses (DON), Quality Assurance (QA) Nurse, and the Registered Nurse (RN) Supervisor assessed all 56 Residents and one (1) Resident was identified as having the potential to be affected. 3. To protect Residents from similar occurrences the Staff Development Nurse provided education to 10 of 22 Nurses regarding the need for developing comprehensive care plans to reflect the indication and use for postural support devices to include Resident specific interventions and monitoring of the device for Resident safety on 10/9/2024. All other direct care staff are scheduled for in-services on 10/23/2024 and 10/25/2024. The QA committee reviewed the policies on developing comprehensive care plans on 10/17/2024 and no changes were recommended. 4. An audit tool will be completed by the DON, QA Nurse or the RN Supervisor to monitor and ensure residents with postural support devices are accurately reflected on the comprehensive care plan. Initial monitoring began 10/15/2024 and will be completed weekly x 4 weeks then monthly x 3 months. Audit logs were reviewed by the QA committee on 10/17/2024. The QA committee will review audit logs again on 11/6/2024 and then will be reviewed monthly x 3 months to ensure compliance is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255277	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET LEAKESVILLE, MS 39451

(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 on 04/19/19 with diagnoses including Spastic Quadriplegic Cerebral Palsy. A record review of the "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/24/24 revealed that Resident #38's cognitive skills for daily decision-making were severely impaired. The resident required a staff interview for cognitive status.	F 656		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to follow proper sanitation and food handling practices to prevent the possible outbreak of foodborne illnesses, as evidenced by a foreign	F 812	1. On 10/7/2024 Dietary Staff removed foreign object (hard crystalized object) from storage bin filled with sugar used for sweet tea the remaining sugar was emptied into the trash by Dietary Aide.	11/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255277	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET LEAKESVILLE, MS 39451

(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 812	Continued From page 7 object observed in the sugar bin for one (1) of four (4) kitchen observations. Findings Include: A review of the facility's policy titled "Storage of Canned and Dry Food," revised 10/17, revealed, " ...The facility ensures the quality, nutritive value, and safety of canned and dry food through accepted storage practices. Procedure: 1. Dry storage is designated for the storage of dry goods such as single-service items, canned goods, and packaged or containerized bulk food ...2. The dry storage room is a clean, dry area free from contaminants ...10. Dry food products such as flour, cornmeal, sugar, etc., are removed from their original packaging and stored in bins. These bins are cleaned and sanitized according to the facility's cleaning schedule ..." On 10/07/24 at 10:36 AM, during an observation and interview of the dietary department, the State Agency (SA) observed what appeared to be a rock (foreign object) in the sugar bin. Dietary Staff #1 and Dietary Staff #2 confirmed during an interview that the foreign object was in the sugar bin. Dietary Staff #1 stated that she did not know how the object got into the sugar, but she explained that all staff members are responsible for checking the sugar. Dietary Staff #2 stated that she had used sugar from the second bin in the kitchen to make tea for the residents but was unsure how the object entered the sugar and emphasized that everyone who uses the dry goods should examine the products. During an interview on 10/08/24 at 2:00 PM, Dietary Staff #2 reported that she had dumped the contaminated sugar the previous day,	F 812	The storage bin was washed, sanitized and left to air dry. The Dietary Supervisor refilled the storage bin with sugar on 10/8/2024. 2. On 10/8/2024 all Resident□s beverage preferences were reviewed by Dietary Manger (DM) and determined nineteen (19) of fifty-six (56) Residents having the potential to be affected. 3. To protect Residents from similar occurrences the (DM) in-serviced/educated six (6) of ten (10) dietary employees on inspection of dry storage bins daily and all storage bins to be cleaned and sanitized weekly as indicated on cleaning schedules on 10/7/2024. The remaining four (4) employees were in-serviced/educated on 10/9/2024 per the (DM) prior to performing duties. This in-service will be a part of the orientation process for all newly hired dietary employees. On 10/17/2024 the Quality Assurance (QA) committee reviewed policies and procedures on dry food storage with no changes recommended. 4. Audit tool will be completed by the (DM), the Quality Assurance (QA) Nurse, or the Administrator to monitor and ensure dry food storage is free from contaminants. Initial monitoring began 10/14/2024 and will be completed weekly x 4 weeks then monthly x 3 months. Audit logs were reviewed by the QA committee on 10/17/2024. The QA committee will review audit logs again on 11/6/2024 and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255277	A. BUILDING _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENE COUNTY HEALTH AND REHABILITATION	1017 JACKSON STREET LEAKESVILLE, MS 39451

(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 812	Continued From page 8 cleaned the container, and refilled it halfway. Dietary Staff #2 also confirmed that residents could become ill from consuming food contaminated with foreign objects. During an interview on 10/08/24 at 2:55 PM, the Administrator expressed her expectations for staff to examine all food before serving it to residents. She further stated that it is the staff's responsibility to ensure that all food is sanitary and free from foreign objects for the residents, and she expects all staff members to examine dry goods. A record review revealed the facility conducted an in-service training on 03/25/24. The kitchen staff was trained to check containers of sugar, flour, and cornmeal, clean and sanitize containers, and refill them. Staff members signed to confirm their understanding and agreement.	F 812	then will be reviewed monthly x 3 months to ensure compliance is sustained.	