STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255091	A. BUILDING _____ B. WING _____	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON MANOR SENIOR CARE, LLC	56 ROCKPORT ROAD LEXINGTON, MS 39095

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 10/15/24 through 10/17/24. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F 641, F 656, and F 689. The facility held a license for 60 beds, and had a census of 58.	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 staff interview and record review, the facility failed to accurately complete an Annual Minimum Data Set (MDS) for a resident that had a serious mental illness for one (1) of 17 MDS reviews. Resident #2 Findings Include: The facility provided a statement on letterhead dated 10/16/24, "It is the practice of this facility, Proper Name, to document data for the MDS 3.0 according to the instructions per the RAI (Resident Assessment Instrument) Manual." Record review of Resident #2's Preadmission Screening and Resident Review (PASRR) "Summary of Findings Report" dated 3/23/23 revealed under, "Mental Health: ... The individual meets criteria for having a diagnosis of mental illness as defined by PASRR" with the primary	F 641	1) On 10/16/2024 Minimum Data Set Coordinator and Director of Nursing reassessed section A of the assessment on resident #2 regarding incorrect data collection; the Minimum Data Set coordinator corrected section A “Is the resident currently considered by the state level II PASRR process to have serious mental illness and /or intellectual disability or related condition,” by documenting yes. The Minimum Data Set Coordinator then resubmitted with the correct information on 10/16/24. 2) On 10/17/2024, The Director of Nursing performed an audit on all current residents with serious mental illness and /or intellectual disability, with no further inaccurate assessments related to section A on any other resident. On 10/17/2024,	11/13/24

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

Electronically Signed | 10/29/2024

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F 641	Continued From page 1 diagnosis of Schizophrenia. Record review of the "Transfer/Discharge Report" revealed the facility admitted Resident #2 on 4/6/23 with a medical diagnosis of Schizophrenia. Record review of Resident #2's Annual MDS with an Assessment Reference Date (ARD) of 3/14/24 revealed under section A, "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? No" was documented. An interview with the MDS Nurse on 10/16/24 at 12:00 PM, confirmed she made an error when completing Resident #2's MDS and revealed she must have been rushing and missed it. She explained that the MDS should be accurate so that the residents get the care they need. An interview with the Director of Nursing (DON) on 10/16/24 at 12:11 PM, confirmed the MDS should be completed accurately so that the resident's individualized care needs were met.	F 641	the Administrator, Social Service Director, and Director of Nursing determined that any resident with mental illness and/or intellectual disability or related condition has the potential to be affected. 3) Corporate Compliance Nurse performed one-on-one in-service with Minimum Data Set Coordinator on 10/17/2024, addressing the importance of accurate input of correct data, taking time to review work before submitting and reviewing new policy Conducting Accurate Resident Assessment. 10/17/2024 Conducting Accurate Resident Assessment Policy implemented by the Quality Assurance Performance Improvement Committee and Medical Director. 4) Beginning 10/21/2024, the Director of Nursing or Administrator will conduct a validation checklist of the Minimum Data Set assessment section A on new residents admitted for the next 3 months to ensure accuracy and compliance before submission of the assessment. On 11/11/2024, the monitoring results will be taken to the Quality Assurance Committee for three (3) months (including 11/11/2024) to evaluate the process and effectiveness and make changes as necessary to ensure substantial compliance.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		11/13/24

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F 656	Continued From page 2	F 656		

§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 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

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F 656	Continued From page 3 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 implement a smoking care plan for one (1) of 17 care plans reviewed. Resident #44 Findings include: A review of a facility policy titled, "Comprehensive Care Plans," reviewed 10/23 revealed, "Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident...." An observation on 10/16/24 at 10:00 AM, revealed Resident #44 smoking with the supervision of Housekeeper #1. During the observation it was revealed that Resident #44 was observed to not be wearing a smoking vest while he was smoking a lit cigarette. A review of the care plan titled, "Resident #44 is at risk for injuries related to smoking," revealed, Interventions: Resident #44 will require a smoking apron due to falling asleep while smoking initiated 5/28/24. In an interview with the Minimum Data Set (MDS) Coordinator on 10/16/24 at 10:53 AM, it was revealed after review of Resident #44's smoking care plan that staff were not following the care	F 656	1) On 10/16/2024, the Director of Nursing immediately placed a protective smoking apron on resident #44. Then, the Director of Nursing and the Treatment nurse performed a body audit on resident # 44 to assess for injury, with no injury noted. 10/16/2024 Director of Nursing: Updated and corrected the smoking list of residents who require the use of a smoking apron according to the current smoking assessment. 2) On 10/16/2024, the Minimum Data Set Coordinator audited the care plans of all residents who smoke cigarettes. After the audit was complete, the Director of Nursing determined that all residents who require a smoking apron have the potential to be affected. 3) On 10/16/2024, the Administrator in Training and Director of Nursing performed in-service with all employees responsible for taking residents to smoke regarding the updated smoking list and facility Smoking policy. Residents on the smoking list with two asterisks next to their name require a smoking apron. This practice is in place to ensure accurate	

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F 656	Continued From page 4 plan to wear a smoking apron. She then revealed the purpose of the care plan is to let staff know of the specific care a resident requires. Record review of the "Admission Record" revealed the facility admitted Resident # 44 on 12/02/22 with a diagnosis of Nicotine Dependence. Record review of Resident # 44's Section C of the Annual MDS with an Assessment Reference Date of 10/14/24 revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident was moderately cognitively impaired.	F 656	communication so that staff adheres to the care plan. On 10/18/2024, the Quality Assurance and Performance Improvement Committee reviewed the smoking policy and procedure, but no recommendations for changes were made. 4) The Director of Nursing, or Administrator in Training, will review the care plans of 3 residents with smoking care plans weekly for six (6) consecutive weeks beginning 10/21/2024, then monthly for three (3) consecutive months beginning 12/2/2024 on all residents with smoking care plans to ensure that comprehensive care plans are being followed for residents who smoke. On 11/11/2024, the monitoring results will be taken to the Quality Assurance Committee for three (3) months (including 11/11/2024) to evaluate the process and effectiveness and make changes as necessary to ensure substantial compliance.	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		11/13/24

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F 689	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to promote an environment as free of accident hazards as possible, when the facility failed to provide a resident a smoking protection assistive device to prevent accidents for one (1) of three (3) residents reviewed for accidents and hazards. (Resident #44) Findings include: A review of the facility policy titled, Smoking/Tobacco Use Policy, last review 2024 revealed, "Procedure: 5.) Smoking aprons will be provided for residents who are evaluated to need them by the smoking safety assessment. Wearing of the apron will be assisted by staff during smoking times for those residents who require them..." An observation of Resident #44 on 10/15/24 at 12:52 PM, revealed small cigarette burn holes on the blanket covering his legs. A record review of a Smoking Safety Screen for Resident #44 dated 5/28/24, revealed the resident needed adaptive equipment during smoking with a smoking apron and supervision. ... Notes on safety from Interdisciplinary team: Staff noted that Resident #44 fell asleep while holding a lit cigarette. Due to the risk of injury, Resident #44 will be required to wear an apron while smoking. Review of the Smoking Safety Screen for Resident #44 dated 10/14/24 revealed resident need for adaptive equipment needed was a	F 689	1) On 10/16/2024, the Director of Nursing immediately placed a protective smoking apron on resident #44, and then the Director of Nursing and Treatment nurse performed a body audit on resident # 44 to assess for injury. No injury was noted. Resident Brief Interview for Mental Status Score of 12, Moderate impairment Cognition. He denied any past or current injuries to his skin/self while smoking. Also, on 10/16/2024, the Administrator in Training and Social Service Director performed one-on-one with housekeeper #1 regarding the importance of a smoking apron and that resident # 44 requires a smoking apron prior to lighting a cigarette. 2) On 10/16/2024, the Administrator in Training, Social Service Director, and Minimum Data Set nurse reviewed the current smoking list of residents and performed an audit reviewing each resident’s smoking assessment and care plan. Twelve residents smoke cigarettes, and two chew tobacco. Six of the twelve residents require a smoking apron. In the review of the smoking list, resident #44 was on the list but was not listed as requiring an apron. The list had not been revised, indicating resident #44 required an apron. All other eleven residents on the list were accurate and current. On 10/16/2024, the Social Service Director revised and updated the Smoking List and placed it in the smoking box, nurse supervisor's office, first nurses’ station, and second nurses’ station.	

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F 689	Continued From page 6 smoking apron and supervision. ... Notes on safety from the Interdisciplinary team: Resident #44 has a history of dropping ashes on clothing. Resident requires supervision and an apron. Record review of the Smoking and Tobacco/Snuff list of residents revealed Resident #44 was listed but did not have two (2) asterisks next to his name to indicate he required a smoking apron. On 10/16/24 at 10:00 AM, an observation revealed Resident #44 smoking with the supervision of Housekeeper #1 and it was observed that Resident #44 was not wearing a smoking apron while he was smoking a lit cigarette. It was observed that there were two small burn holes on the blanket covering Resident #44's legs. Interview with Housekeeper #1 on 10/16/24 at 10:04 AM, revealed the Social Service Director lets him know who requires a smoking vest, and confirmed he was unaware that Resident #44 needed a smoking vest. He then revealed he was unaware of a smoking list that reflected which residents required a smoking vest. In an interview with the Social Service Director on 10/16/24 at 10:10 AM, she confirmed Resident #44 was to wear a smoking vest and stated the housekeeper was unaware that the resident required a smoking vest. She confirmed that she updated the smoking list as changes occurred. In a review of the smoking list with the Social Service Director, she confirmed the smoking list did not reflect that Resident# 44 required a smoking vest. She then revealed that by not applying the smoking apron, the staff placed Resident #44 at risk for burning himself.	F 689	3) On 10/16/2024, the Administrator in Training and Director of Nursing performed in-service with all employees responsible for taking residents to smoke regarding the updated smoking list and facility Smoking policy. Residents on the smoking list with two asterisks next to their name require a smoking apron. This practice is in place to ensure accurate communication so that staff adheres to the care plan. The Quality Assurance Performance Improvement Committee reviewed the smoking policy and procedure on 10/18/2024, and no recommendations for changes were made. 4) Beginning 10/21/2024, the Director of Nursing or Administrator in Training will observe residents' smoking three (3) days a week for four (4) weeks, following weekly observations beginning 11/18/2024 for four (4) weeks, then monthly beginning on 12/16/2024 for three (3) months to ensure safety for those residents who require the use of a smoking apron and staff competency and knowledge of the requirements of the comprehensive care plan. 10/21/2024 The Minimum Data Set Coordinator or Social Service Director will begin reviewing the assessments and care plans of residents who smoke quarterly, annually, and as needed to ensure compliance. On 11/11/2024, the monitoring results will be taken to the Quality Assurance Committee for three (3) months (including	

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F 689	Continued From page 7 An interview with the Minimum Data Set (MDS) Coordinator on 10/16/24 at 10:53 AM she revealed after review of the Smoking Assessment for Resident # 44 he should have been wearing a smoking apron and stated the smoking list should have been updated by the Social Service Director. Review of the "Admission Record" revealed the facility admitted Resident # 44 on 12/02/22 with a diagnosis of Nicotine Dependence. Record review of Resident # 44's Section C of the Annual MDS with an Assessment Reference Date of 10/14/24 revealed a Brief Interview for Mental Status (BIMS) score was 12, indicating the resident was moderately cognitively impaired.	F 689	11/11/2024) to evaluate the process and effectiveness and make changes as necessary to ensure substantial compliance.	