STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255221	A. BUILDING _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVEN HALL HEALTH CARE CENTER	101 MILLS STREET BROOKHAVEN, MS 39601

(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 10/28/24 through 10/31/24. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F656, F851, and F880. The facility had a census of 73 and was licensed for 81 beds.	F 000		
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 - (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	F 656		12/6/24

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

Electronically Signed | 11/14/2024

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F 656	Continued From page 1 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 ensure care plan interventions related to Enhanced Barrier Precautions (EPB) were implemented for two (2) of three (3) residents reviewed with indwelling devices. Residents #25 and #33 Findings Include: A review of the facility's policy titled, "Using the Care Plan," (undated), revealed, "The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or serviced to the resident ..." Resident #25:	F 656	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Law. This plan of correction constitutes the facilities credible allegation of compliance. F656 Develop/Implement Comprehensive Care Plan * No resident suffered any adverse effects from this deficient practice. On November 12, 2024, Resident #33 and #25 was	

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F 656	Continued From page 2 A record review of Resident #25's Comprehensive Care Plan, with a date initiated of 5/26/23 revealed "... receives PEG (Percutaneous Endoscopic Gastrostomy) tube feeding... Interventions... Maintain set Enhanced Based Precautions, such as washing hands, wearing a gown, wearing gloves, etc. when in resident's room when performing close contact care" During an observation on 10/31/24 at 8:55 AM, Licensed Practical Nurse (LPN) #1 was observed performing PEG tube site care for Resident #25 without wearing a gown. During an interview on 10/31/24 at 9:11 AM, LPN #1 confirmed that she was aware of the EBP signage, however stated that she was uncertain of the requirement of wearing a gown. LPN #1 stated that although she had received EBP training several months prior, she could not recall specific guidelines. During an interview on 10/31/24 at 9:38 AM, the Infection Preventionist/LPN #3 confirmed that staff performing PEG tube care should wear a gown as part of EBP. A record review of the "Admission Record" revealed the facility admitted Resident #25 on 05/17/23. The resident's diagnoses included Aphasia related to Cerebral Infarction, Hemiplegia, and Gastrostomy Status. Resident #33: A record review of Resident 33's Comprehensive Care Plan with a date initiated of 4/24/24 revealed "At risk for complications related to hx (history)	F 656	assessed by Registered Nurse and displayed no complications or adverse effects from this deficient practice. *All residents with a Nephrostomy Drain and a Percutaneous Endoscopic Gastrostomy (PEG) have the potential to be affected by this deficient practice. *On November 1, 2024, Licensed Practical Nurse (LPN) #1 was provided one on one education on following the care plan of residents with Nephrostomy drain/PEG tubes and facility's policy of Enhanced Based Precautions by the Clinical Director of Nursing Services. On November 1, 2024 Infection Preventionist/LPN # 3 was educated by the Clinical Director of Nursing Services on facility's policy of Enhanced Based Precautions with focus on ensuring proper signage on resident's door. On November 1, 2024, Nursing staff education was initiated by the Director of Nursing and Assistant Director of Nursing to include following Care Plan with residents with Nephrostomy drain/PEG tubes and Enhanced Based Precautions. *On November 13, 2024, Director of Nursing and/or Registered Nurse (RN) Supervisor will observe residents with Nephrostomy drain/PEG tubes to ensure staff is wearing appropriate PPE when providing care and proper signage is posted as directed by facilty's policy on Enhanced Based Precaution. This will be completed daily x 8 weeks to ensure	

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F 656	Continued From page 3 Acute Renal Failure ...Nephrostomy drain... Interventions: Signage to be placed on outside of residents door. Labeling as a room for EBP." Observations of the door of Resident #33 on 10/28/24 at 12:57 PM and 10/31/24 at 8:50 AM revealed there was no signage on Resident #33's door related to EBP. During an interview on 10/31/24 at 9:35 AM, Infection Preventionist/LPN #3 confirmed that Resident #33 should have EBP signage on the door due to the nephrostomy catheter. She stated that EBP signage should be maintained for residents with indwelling devices to protect against infection. During an interview on 10/31/24 at 12:14 PM, the Director of Nurses (DON) acknowledged the importance of staff following guidelines for EBP. She emphasized she expects staff to follow a resident's care plan. During an interview on 10/31/24 at 12:30 PM, the Care Plan Nurse/LPN #2 stated that the care plans are written as a guide for nursing care and that staff are expected for follow the care plans. A record review of the "Admission Record" revealed the facility admitted Resident #33 on 04/24/24. The resident's diagnoses included Acute Kidney Failure, Unspecified and Infection and Inflammatory Reaction Due to Nephrostomy Catheter.	F 656	compliance. Any adverse findings will be presented to the Quality Assurance and Performance Committee on December 5, 2024 for review action if indicated x 8 weeks.	
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing	F 851		12/6/24

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F 851	Continued From page 4	F 851		

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 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).

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F 851	Continued From page 5 §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 interviews and Certification and Survey Provider Enhanced Reports (Casper) reporting data review, the provider failed to ensure their Payroll-Based Journal (PBJ) data, containing staffing hours for the appropriate care of residents, was corrected before submission to the Centers for Medicare and Medicaid Services (CMS) for one (1) of four (4) quarters in 2024. 3rd (Third) Quarter Findings Include: A review of the facility policy titled, "Reporting Direct Care Staffing Information (Payroll-Based Journal)," revised August 2022, revealed, " ... Complete and accurate direct care staffing information is reported electronically to CMS through the Payroll-Based Journal (PBJ) system in a uniform format specified by CMS..."	F 851	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Law. This plan of correction constitutes the facilities credible allegation of compliance. * No residents suffered any adverse actions to this deficient practice. * All residents has the potential to be affected by this deficient practice. * On November 14, 2024, Facility Human	

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F 851	Continued From page 6 Record review of the "PBJ Staffing Data Report FY (fiscal year) Quarter 3 2024 (April 1-June 30)" revealed One star staffing rating and excessively low weekend staffing "triggered". Triggered= Star Staffing Rating equals 1; Submitted weekend staffing data is excessively low." During an interview on 10/31/24 at 9:17 AM, the Human Resources Director explained that she does not handle anything directly related to the PBJ. She stated that her role involves compiling information that is automatically calculated within the payroll system, which she then submits to the corporate office for processing in the PBJ. During an interview on 10/31/24 at 9:23 AM, the Administrator confirmed that she does not view or process PBJ reporting, as all PBJ data is managed by the corporate office. During a phone interview on 10/31/24 at 1:33 PM, the Corporate Payroll Representative confirmed that he receives the daily staffing sheets from the facility. He reviewed the staffing grid with the State Agency (SA), selecting random dates to verify that the information submitted matched the data provided by the facility during the recertification survey. He noted that the facility's daily staffing punches are automatically uploaded to their payroll system through a second and third party. However, he acknowledged that a glitch appears to exist within either the second or third party's system, leading to discrepancies between the data extracted from the facility and what was exported to PBJ. He indicated that this issue requires resolution to ensure accurate reporting.	F 851	Resource Director and Corporate was educated on facility's policy of Reporting Direct Care Staffing Information by the Administrator and Chief Operations Officer. On November 5, 2024, Administrator, Human Resources Director, Chief Operations Officer, and Corporate Director of Human Resources conducted a Zoom call with facility's Payroll Based Journal(PBJ) submission vendor and facility's payroll vendor to discuss system glitch. Facility's payroll vendor system error caused employee payroll hours not to transfer to PBJ submission vendor. System error was resolved on November 5, 2024. *On November 6, 2024, Human Resource Director and Corporate Director of Human Resource conducted 100% audit of all employee payroll hours and agency invoices to ensure hours are calculated and accurate to PBJ. All errors were corrected. Facility's Human Resource Director will conduct audit of payroll hours monthly x 2 months to ensure hours are correct in facility payroll vendor and PBJ submission vendor. Administrator will review audit findings to ensure accuracy monthly x 2 months. Any adverse findings will be presented to the Quality Assurance and Performance Improvement Committee on December 5, 2024 for review if indicated x 8 weeks.	
F 880 SS=D	Infection Prevention & Control	F 880		12/6/24

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F 880	Continued From page 7 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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F 880	Continued From page 8 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were followed by staff when providing direct care for residents with indwelling devices for two (2) of three (3) residents reviewed with indwelling devices. Residents #18 and #25 Findings Include:	F 880	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Law. This plan of correction constitutes the facilities credible allegation	

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F 880	Continued From page 9 A review of the facility's policy titled, "Enhanced Barrier Precautions," (undated) revealed, "It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs) ... Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents colonized or infected with MDRO as well as those at increased risk for MDRO acquisition (e.g., residents with wounds or indwelling medical devices) ..." Resident #18 During an observation of catheter care on 10/30/24 at 10:46 AM, revealed Certified Nursing Assistant (CNA) #1 or CNA #2 did not put on a gown prior to beginning catheter care. The care was completed without either CNA ever putting on a gown. During an interview on 10/30/24 at 2:05 PM, CNA #1, an agency staff member with six years of experience, stated that she had not received training on Enhanced Barrier Precautions and confirmed that she did not apply a gown before providing care. A record review of the "Admission Record" revealed the facility admitted Resident #18 on 06/05/24. The resident's diagnoses included Urine Retention, Unspecified. A record review of Resident #18's "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/03/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Section H of the MDS was coded for Foley catheter use.	F 880	of compliance. F880 Infection Prevention and Control * No resident suffered any adverse effects from this deficient practice. On November 12, 2024, Resident #18 and #25 was assessed by Registered Nurse and displayed no complications or adverse effects from this deficient practice. *All residents with catheters and percutaneous endoscopic gastrostomy tubes (PEG) have the potential to be affected by this deficient practice. *On October 31, 2024, Certified Nursing Assistant (CNA) #1, CNA #2, and Licensed Practical Nurse #1 was provided one on one education on following the care plan of residents with PEG tubes and catheters and facility's policy of Enhanced Based Precautions. On November 1, 2024, the Clinical Director of Nursing Services educated the Director of Nursing, Assistant Director of Nursing/Infection Preventionist, and Registered Nurse (RN) Supervisor on the facility's policy of Enhanced Based Precautions to include the criteria. On November 1, 2024, Nursing staff education was initiated by the Director of Nursing and Assistant Director of Nursing to include Infection Control and Enhanced Based Precautions with focus on Residents with catheters and peg tubes. On November 13, 2024, Director of	

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F 880	Continued From page 10 Resident #25 On 10/31/24 at 8:55 AM, during an observation , Licensed Practical Nurse (LPN) #1 was observed performing PEG (Percutaneous Endoscopic Gastrostomy) tube care for Resident #25 without wearing a gown. During an interview on 10/31/24 at 9:11 AM, LPN #1 confirmed that she was aware of the EBP signage on Resident #25's door but was unsure if she was supposed to wear a gown. She stated that she had received EBP training but was uncertain of the requirements. Record review of the "Order Review History Report" dated 10/31/24 revealed a physician order dated 4/12/24 "Enhance Barrier Precautions as of 4/1/2024 related to gastronomy status ..." A record review of the "Admission Record" revealed the facility admitted Resident #25 on 05/17/23 with diagnoses that included Aphasia related to Cerebral Infarction, Hemiplegia, and Gastrostomy Status. During an interview on 10/31/24 at 9:38 AM, the Infection Preventionist/LPN #3 confirmed that the facility had instituted EBP in March and conducted in-services. She stated that conditions requiring EBP include chronic wounds, catheters, and PEG tubes, and she expected staff to follow these guidelines. During an interview on 10/31/24 at 12:09 PM, the Director of Nursing (DON) stated that when performing resident care that involves close	F 880	Nursing and/or Registered Nurse (RN) Supervisor will observe residents with catheters and peg tubes to ensure staff is wearing appropriate Personal Protective Equipment (PPE) when providing care as directed by facilty's policy on Enhanced Based Precaution. This will be completed 5 times a week x 8 weeks to ensure compliance. Any adverse findings will be presented to the Quality Assurance and Performance Committee on December 5, 2024 for review action if indicated x 8 weeks.	

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F 880	Continued From page 11 contact, staff are required to wear a gown in an effort to protect their uniform and the possibility of infections being transmitted to residents. The DON confirmed that CNA #1 should have worn a gown while providing catheter care to Resident #18 and that LPN #1 should have worn a gown while performing PEG tube care for Resident #25.	F 880		