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 _____	03/16/2021

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

(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 A COVID-19 Focused Infection Control Survey, along with complaint investigations (CI), was conducted by the State Agency from 3/8/21 through 3/16/21. CI MS #17499 was substantiated for misappropriation of funds and the facility was cited F602 at a "D" level for Resident #1. The following complaints were investigated and not substantiated: CI MS #17368 related to staffing neglect and weight loss, CI MS #17330 related to pressure ulcers and family notification, CI MS #17244 related to abuse and admit/transfer, CI MS #17141 related to infection control, CI MS #17217 related to services not performed and monitoring, CI MS #16966 related to grooming and rehabilitation, CI MS #16704 related to verbal abuse and CI#17639 related to resident grooming. The facility was found to be in compliance with infection control regulations at CFR 42.483.80. The facility has implemented the Centers for Medicare and Medicaid (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The census at the time of the survey was 42 and the facility has a license for 60 beds.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §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. This REQUIREMENT is not met as evidenced by:	F 602		5/7/21

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

Electronically Signed | 04/21/2021

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 _____	03/16/2021

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

(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 602	Continued From page 1 Based on record review, staff and resident interview, and facility policy and procedure review the facility failed to ensure residents were free from theft of personal property (cash) for one (1) of (15) sampled residents reviewed, Resident #1. Findings include: Review of the facility policy/procedure titled "Employee Corporate Compliance Code of Conduct", last updated 5/18, defined Misappropriation of Resident Property as "The deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident belongings or money without the resident's consent." On 3/9/21, at 10:35 AM, an interview with the Director of Nursing (DON) revealed Resident #1 was upset and reported that she had $60.00 stolen. The facility began an investigation and replaced the $60.00. Resident #1 insisted on keeping the replaced money with her and not keeping it in her trust fund. On 1/24/21, Resident #1 reported that the $60.00 had been stolen again from her room. Resident #1 said Nursing Assistant (NA) #1 took her money. An investigation was begun again, and the resident's money was refunded again. NA #1 was suspended pending the outcome of the investigation. Resident #4 reported to the DON that she saw NA #1 going through Resident #1's things. The facility reported the incidents to the appropriate State Agencies and the Local Police Department. A receipt was made for the money replaced to Resident #1 dated 12/24/2020.	F 602	F602 Director of Nursing immediately suspended NA #1 pending investigation. Incidents were reported to appropriate State Agencies and Local Police Department. NA #1's employment was terminated on 12/28/2020. This deficient practice had the ability to affect (42) of (42) residents. An in-service was conducted on 12/24/2020 by the Director of Nursing and Staff Development Nurse on policies/procedures titled "Resident's Rights" revised 11/17 and "Elder Justice Act" revised 8/13 with staff and was continued until all staff had been in-serviced. Quality Assurance meeting was held on 12/30/2020 with Medical Director, Administrator, Director of Nursing, Nurse Case Manager, Staff Development Nurse, Assessment Nurse, Medical Records Clerk, Social Services Director and Activities Director in attendance and reviewed policies/procedures titled "Resident's Rights" revised 11/17 and "Elder Justice Act" revised 8/13 with no changes recommended. Monitoring started on 12/23/2020 and will occur weekly for four (4) weeks and monthly for two (2) months by Administrator or Director of Nursing or Staff Development Nurse or Assessment Nurse or Nurse Case Manager for adherence to Resident's Rights and Elder Justice Act policy. Monitoring included interviewing five (5) residents on North, East and West Wings. Monitoring will be recorded on Medical Record Audit form. Medical Record Audit forms will be taken	

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 _____	03/16/2021

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

(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 602	Continued From page 2 On 3/10/21 at 2:00 PM, an interview with Resident #4 revealed she saw NA #1 going through Resident #1's things and Resident #1 told her about her money missing. An interview on 3/12/2021, at 12:40 PM, with the Attorney General (AG) investigator, revealed he did get an admission from NA #1 and she admitted to taking $50.00 from Resident #1 on either 12/23/20 or 12/24/20. The AG investigator stated NA #1 would be charged with a misdemeanor. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/29/20 for Resident #1 revealed a Brief Interview for Mental Status (BIMS) score of 4 which indicated severely impaired cognition. Review of the Face Sheet for Resident #1 revealed she was admitted to the facility on 11/10/2009 and readmitted on 10/25/2013. Her diagnoses included History of Urinary Tract Infections (UTI), Alzheimer's, Vitamin deficiency, History of Dehydration, Anemia, Hypokalemia, Osteoporosis, Pacemaker, Cardiovascular Accident with right side Hemiparesis, Hypertension and Expressive Aphasia. Review of NA#1's personnel file revealed she signed the "Employee Corporate Compliance Code of Conduct" on 8/3/2020. She was hired as a temporary nurse aide. Review of the Quarterly MDS with an ARD of 12/10/20 for Resident #4 revealed a BIMS score of 13 indicating she was cognitively intact. Review of the Face Sheet for Resident #4	F 602	to the Quality Assurance committee for review monthly for three (3) months with corrective action taken per Administrator. This will be completed by 3/23/2021.	

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 _____	03/16/2021

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

(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 602	Continued From page 3 revealed she was admitted to the facility on 9/4/2020. Her diagnoses included Bipolar, Anorexia, Herpes viral infection, Diabetes Mellitus, (DM), Edema, Hypertension (HTN), Constipation, Parkinson's disease, Irritable Bowel Syndrome (IBS).	F 602		