STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A190	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST CHARLESTON, MS 38921

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 12/02/24 through 12/04/24. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F583, F641, F656, F677, and F761. The census at the time of survey was 93 and the facility was licensed for 98 beds.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583		1/8/25

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

Electronically Signed | 12/19/2024

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F 583	Continued From page 1 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to ensure resident information was not accessible to the public during medication administration for one (1) of four (4) residents observed during medication administration. Resident #82. Findings Include: Record review of the facility policy, "Administration of Drugs" with revised date of 09/08 revealed, ".....Medication Administration Records should be kept covered to ensure privacy of information...." An observation on 12/03/24 at 9:00 AM, of a medication cart on the A-Hall, revealed an open computer screen with Resident #82's Electronic Medication Administration Record (EMAR) information visible to anyone passing by the medication cart. The visible information included Resident # 82's name, medications, and room number. An interview on 12/03/24 at 9:10 AM, with Licensed Practical Nurse (LPN) #1 revealed that she was assigned to the medication cart on A-Hall. She confirmed that the EMAR for	F 583	1. Upon notification of deficient practice on 12/03/24, the privacy screen was applied by the Staff Development RN to protect resident #82□s personal health information. 2. The facility has determined that all residents have the potential to be affected by the failure to properly use privacy screens to protect personal health information. 3. An in-service was conducted with Licensed Practical Nurse (LPN) #1 on 12/3/24 by the Staff Development nurse regarding the Residents right to privacy and the proper use of privacy screens. Beginning 12/3/24, LPN□s and Registered Nurses (RN)□s were in-serviced by the Director of Nursing (DON) and Staff Development nurse on the Residents right to privacy and the proper use of privacy screens. 4. Beginning 12/09/24, the Administrator, DON, Medical Records nurse, Minimum Data Set (MDS) nurses and/or Charge Nurses will conduct audits daily times one week then three times weekly times one week then twice weekly times two weeks then weekly times two months to ensure	

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F 583	Continued From page 2 Resident #82 was visible on the computer screen and that she should have clicked the privacy screen on before she walked away from the cart. LPN #1 agreed that this was a privacy issue and that the resident's information in the medical record should be kept confidential. An interview on 12/03/24 at 9:55 AM, with LPN Supervisor revealed that the nurses were supposed to lock the computer screen prior to leaving the medication cart unattended. She revealed that the purpose of the locked screen was to prevent anyone who might be walking by from seeing a resident's personal health information. LPN Supervisor stated, "It's always a given to lock the cart and have the privacy screen on while administering medicine." An interview on 12/03/24 at 10:05 AM, with Director of Nursing (DON) revealed that a resident's personal information should never be left up on the computer screen while the medication cart is unattended. She revealed that there was a privacy button that was supposed to be pushed before the nurse stepped away from the computer. The DON confirmed that this was a privacy issue and that residents information should be kept confidential. Record review of Resident #82's "Admission Record" revealed an admission date of 01/26/23.	F 583	the proper use of computer privacy screens. The Consultant Pharmacist conducted an audit to ensure proper use of privacy screens on 12/18/24. Statement of deficiencies and plan of correction were reviewed by the Quality Assurance Committee (QA) on 12/19/24. All findings from audits will be reported to the QA Committee on 01/2/25 then monthly times three months for evaluation of effectiveness and compliance; the QA Committee will make recommendations and/or changes as needed.	
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	F 641		1/8/25

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F 641	Continued From page 3 by: Based on staff interview, record review, and facility policy review, the facility failed to accurately complete a section of the Minimum Data Set (MDS) for a resident with significant weight loss for one (1) of 22 sampled residents MDS reviewed. Resident #6 Findings Include: Review of the facility policy titled "Resident Assessment Instrument" (RAI) revised September 2010, revealed under, "Policy Interpretation and Implementation:... 3. The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. 4. Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning... 7. All persons who have completed any portion of the MDS Resident Assessment Form must sign such document attesting to the accuracy of such information." Record review of the "Weight Summary" for Resident #6 revealed the following values: 7/2/2024 176.6 Lbs. 7/8/2024 175.2 Lbs. 7/17/2024 173.6 Lbs. 7/24/2024 169.2 Lbs. 8/13/2024 169.2 Lbs. 9/5/2024 158.0 Lbs. 10/2/2024 157.6 Lbs. 10/9/2024 156.4 Lbs Record review of the "Registered Dietician (RD) Assessment Summary" dated 9/13/24 for	F 641	1. A correction of Prior Assessment was completed on 12/16/24, to correctly reflect a significant weight loss for Resident #6. 2. The facility has identified that all residents with a significant weight loss have the potential to be affected. 3. The Dietary Manager was in-serviced by the Director of Nursing (DON) on 12/4/24 regarding the importance of accurately completing section K of the Minimum Data Set (MDS). The MDS Interdisciplinary team (IDT) was in-serviced by the DON on 12/6/24 regarding the importance of accurately completing the MDS. 4. Beginning 12/9/24, MDS Interdisciplinary team (IDT), Charge nurses, Staff Development nurse and/or DON will audit 100 percent of the MDS□s completed times one week then 50 percent times one week then 25 percent times two weeks then 10 percent times two months during the weekly Transmission meeting to ensure the accuracy of Section K. Statement of deficiencies and plan of correction were reviewed by the Quality Assurance Committee (QA) on 12/19/24. All findings from audits will be reported to the QA Committee on 01/02/25 then monthly times three months for evaluation of effectiveness and compliance; the QA Committee will make recommendations and/or changes as needed.	

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F 641	Continued From page 4	F 641		

Resident #6 revealed under, "Weight changes: (minus) -6.6 % (percent) SWL (significant weight loss) x (times) 30 days ..."

Record review of the "Weight Note" for Resident #6 dated 9/26/24 revealed the resident had an 11.2-pound weight loss in 30 days.

Record review of Resident #6's Quarterly MDS, with an Assessment Reference Date (ARD) of 10/9/24, revealed under section K0300, loss of 5% (percent) or more in the last month or loss of 10% (percent) or more in last 6 months was answered and marked as "No."

An interview with the MDS Nurse on 12/3/24 at 2:25 PM, confirmed that section K was not completed accurately to reflect Resident #6's weight loss. She revealed the Dietary Manager (DM) was responsible for completing that section of the MDS and confirmed that it was missed.

An interview with the DM on 12/3/24 at 3:06 PM revealed, she made a mistake completing Resident #6's section K and explained that she did not go back and look at the weights like she should have. She confirmed if the MDS was not completed accurately, it would not reveal the complete needs of the resident's health status.

An interview with the Director of Nursing (DON) on 12/3/24 at 3:20 PM revealed her expectations were for all sections of the MDS to be completed accurately.

Record review of the "Admission Record" revealed the facility admitted Resident #6 on 7/2/24 with medical diagnoses that included Unspecified Dementia and Heart Failure.

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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 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	F 656		1/8/25

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F 656	Continued From page 6 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 staff interviews, record reviews, and facility policy reviews, the facility failed to develop and implement an Activities of Daily Living (ADL) comprehensive care plan for residents' hygiene, grooming, and nail care for two (2) of 19 sampled residents. Resident #38 and Resident #147 Findings include: Record review of the facility policy titled "Care Plans, Comprehensive Person-Centered" with a revision date of December 2016 revealed under "Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." Resident #38 Record review revealed a care plan revised on 9/26/24 for Resident #38 with a focus on ADL's/Falls/Pain: I have impaired physical functioning and require assistance with ADL's related to chronic pain and (Right) R-sided Hemiplegia. The care plan for the resident with impairments has no personal hygiene, grooming, or nail care interventions.	F 656	1. Upon notification of deficient practice on 12/3/24, the Certified Nurse Aides (CNAs) responsible for Resident # 38 and 147s care immediately provided them with proper hand hygiene and nail care. Resident #38 and 147s care plans were updated to reflect the need for assistance with hygiene and grooming. 2. The facility has determined that all residents have the potential to be affected by this deficient practice. 3. An in-service was conducted with CNA□s, Licensed Practical Nurses (LPN) and Registered Nurses (RN) on 12/5/24 by the Director of Nursing (DON) regarding proper hygiene and grooming and the importance of a comprehensive care plan. Beginning 12/6/24, the Minimum Data Set (MDS) LPN, MDS RN and DON began auditing all Activity of Daily Living (ADL) care plans to ensure they adequately reflected each resident□s need for assistance with hygiene and grooming. 4. Beginning 12/9/24 the MDS Interdisciplinary team (IDT), Charge nurses, Staff Development nurse and/or DON will audit the ADL care plans of 100 percent of the MDS□s completed times one week then 50 percent times one week	

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F 656	Continued From page 7 On 12/02/24 at 2:10 PM, an observation of Resident #38's nails revealed bilateral fingernails were approximately one-half (1/2) inch long and jagged with a brown substance under the nails. On 12/03/24 at 10:45 AM, an observation and interview with Certified Nurse Aide (CNA) #1 revealed the CNAs were responsible for doing Resident #38's nail care. CNA #1 confirmed that Resident #38's fingernails were long and had a brown substance under them, revealing they needed to be cleaned and trimmed. During an interview on 12/04/24 at 11:35 AM, the Director of Nurses (DON) revealed that the purpose of the care plan is to indicate the resident's individualized care that is needed for that resident, so the staff will know the resident's needs. She confirmed that the care plan was not developed to reflect Resident #38's hygiene or grooming needs, which included nail care. Record review of Resident #38's "Admission Record" revealed the resident was admitted to the facility on 06/01/2021 with medical diagnoses that included Vascular Dementia, Depressive disorders, and Hemiplegia and Hemiparesis following Cerebral infarction. Resident #147 Record review of the care plan for Resident #147 date initiated 11/25/24 revealed, "Focus: ADLs ...I have impaired physical functioning and require assistance with ADLs ..." This care plan did not address bathing, hygiene, grooming, or nail care. On 12/02/24 at 10:25 AM, during an observation and interview, Resident #147 revealed she would	F 656	then 25 percent times two weeks then 10 percent times two months during the weekly Transmission meeting. Statement of deficiencies and plan of correction were reviewed by the Quality Assurance Committee (QA) on 12/19/24. All findings from audits will be reported to the QA Committee on 01/02/25 and monthly times three months for evaluation of effectiveness and compliance; the QA Committee will make recommendations and/or changes as needed.	

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F 656	Continued From page 8 like her nails to be trimmed. She stated she had never had long nails, and she preferred her nails to be kept short. Observation of her nails revealed seven (7) of her 10 nails were long with the thumb nails approximately 3/4 inch long and some of her nails were jagged and rough. During an interview on 12/3/24 at 11:20 AM, the DON stated the purpose of the care plan was to drive the resident's individualized plan of care and to inform staff of the care that was needed. She confirmed the facility failed to develop an ADL care plan for this resident's nail care. During an interview on 12/3/24 at 3:30 PM, the Minimum Data Set (MDS) Coordinator Registered Nurse revealed she was responsible for the development of the care plans and the purpose of the care plan was to give the staff information on the needed care and preferences for each resident. She confirmed the facility failed to develop the care plan for ADL nail care for Resident #147. Record review of Resident #147's "Admission Record" revealed the facility admitted the resident on 11/12/24 with diagnoses of Stress Fracture to right ankle and Hypertension. Record review of Resident #147's MDS with Assessment Reference Date (ARD) of 11/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had a moderate cognitive impairment.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		1/8/25

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F 677	Continued From page 9 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, record review, and facility policy review, the facility failed to provide care to maintain personal hygiene, as evidenced by the failure to provide nail care for two (2) of nineteen sampled residents. Resident #38 and Resident #147 Findings include: A review of the facility policy titled "Fingernails/Toenails, Care Of" revised 09/08 revealed "Purpose: ... To clean the nail bed, to keep nails trimmed, and to prevent infections...Nail care cleaning should be done daily." Resident #38 An observation on 12/02/24 at 2:10 PM of Resident #38's nails revealed bilateral fingernails were approximately one-half (1/2) inch long and jagged with a brown substance under the nails. An observation on 12/03/24 at 9:03 AM and again at 10:30 AM revealed Resident #38's fingernails on bilateral hands remained long and jagged with a brown substance under the nails. An observation and interview on 12/03/24 at 10:45 AM, Certified Nurse Aide (CNA) #1 revealed the CNAs are responsible for doing Resident #38's nail care. She revealed we do the nail care when we see that it needs to be done	F 677	1. Upon notification of deficient practice on 12/3/24, the Certified Nurse Aides (CNAs) responsible for Resident # 38 and 147s care immediately provided them with proper hand hygiene and nail care. 2. The facility has determined that all residents who require assistance with hygiene and/or grooming have the potential to be affected. 3. An in-service was conducted with CNA□s, Licensed Practical Nurses (LPN) and Registered Nurses (RN) on 12/5/24 by the Director of Nursing regarding proper hygiene and grooming. All residents requiring assistance with grooming/hygiene were assessed on 12/3/24 and 12/4/24 for proper nail care by the Director of Nursing, Charge nurses, floor nurses and Staff Development nurse. 4. Beginning 12/6/24, at least five different residents will be checked per day by the Director of Nurses, Staff Development Nurse, Charge Nurses, Medical Records Nurse and/or Minimum Data Set (MDS) nurse□s daily times one week then three times weekly times one week then twice weekly times two weeks then weekly times two months to ensure proper hygiene and grooming has been provided to residents. Statement of deficiencies and plan of correction were reviewed by the Quality Assurance Committee (QA) on 12/19/24. All findings from audits will be reported to the QA	

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F 677	Continued From page 10 and confirmed that the resident's fingernails were long and had a brown substance under them, revealing they needed to be cleaned and trimmed. An observation and interview on 12/03/24 at 11:05 AM, the Director of Nurses (DON) confirmed that Resident #38's fingernails needed cleaning and trimming and revealed that this could cause skin concerns for the resident. Record review of Resident #38's "Admission Record" revealed the resident was admitted to the facility on 06/01/2021 with medical diagnoses that included Vascular Dementia, Depressive disorders, and Hemiplegia and Hemiparesis following Cerebral infarction affecting right dominant side. Resident #147 During an observation and interview on 12/02/24 at 10:25 AM, Resident #147 revealed she would like her nails to be trimmed. She stated she had never had long nails and she preferred her nails to be kept short. Observation of her nails revealed seven (7) of her 10 nails were long with thumb nails approximately 3/4 inch long and some of her nails were jagged and rough. An interview with Registered Nurse (RN) #1 with an observation of Resident #147's nails on 12/3/24 at 10:25 AM, revealed the resident's long and rough nails. The resident informed RN #1 that she preferred to have short nails.	F 677	Committee on 01/2/25 then monthly times three months for evaluation of effectiveness and compliance; the QA Committee will make recommendations and/or changes as needed.	

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F 677	Continued From page 11 During an interview on 12/3/24 at 11:20 AM, the DON revealed each resident's nails should be maintained as the resident preferred and since this resident preferred short nails, the staff should ensure they are kept clean and short. Record review of Resident #147's "Admission Record" revealed the facility admitted the resident on 11/12/24 with a diagnosis of Stress Fracture to right ankle. Record review of Resident #147's "Minimum Data Set" (MDS) with Assessment Reference Date (ARD) of 11/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had a moderate cognitive impairment.	F 677		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		1/8/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A190	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLAHATCHIE GENERAL HOSP ECF	201 SOUTH MARKET ST CHARLESTON, MS 38921

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F 761	Continued From page 12 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to properly secure medications as evidenced by leaving a medication cart unlocked for one (1) of four (4) medication administration observations. Findings include: Record review of the facility policy, "Storage of Medications" with revision date of 09/08 revealed, "Purpose: Is to ensure that medications are stored in a safe, secure, and orderly manner...Compartments containing medications are locked when not in use. Carts used to transport such items are not left unattended. (Compartments include...drawers, cabinets, rooms, refrigerators, carts..." An observation on 12/03/24 at 9:45 AM, with Licensed Practical Nurse (LPN) #1 revealed an unlocked medication cart left unattended on A-Hall during administration of a resident's medications. At 9:48 AM, LPN #1 revealed that she was assigned to the medication cart on A-Hall and confirmed that she did not lock the medication cart and stated, "I don't usually lock it." LPN #1 confirmed that she should have locked the medication cart prior to walking away to prevent others from taking medications out of the cart.	F 761	1. Upon notification of deficient practice on 12/03/24, the medication cart was locked by the Staff Development nurse. 2. The facility has determined that all residents have the potential to be affected by this deficient practice. 3. Licensed Practice Nurses and Registered Nurses were in-serviced on the importance of never leaving an unattended medication cart unlocked beginning 12/3/24 by Staff Development Nurse. 4. Beginning 12/09/24, the Administrator, DON and/or Charge Nurses will conduct audits daily times one week then three times weekly times one week then twice weekly times two weeks then weekly times two months to ensure the medication carts are locked properly. The Consultant Pharmacist conducted an audit to ensure medication carts were properly secured on 12/18/24. Statement of deficiencies and plan of correction were reviewed by the Quality Assurance Committee (QA) on 12/19/24. All findings from audits will be reported to the QA Committee on 01/2/25 then monthly times three months for evaluation of effectiveness and compliance; the QA Committee will make recommendations	

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F 761	Continued From page 13 An interview on 12/03/24 at 9:53 AM, with LPN Supervisor, revealed that the medication carts should always be locked when unattended to prevent others from opening the drawers and taking the medications. She stated, "It's always a given to lock the carts...and they all know this." An interview on 12/03/24 at 10:03 AM, with Director of Nursing (DON), revealed that the medication carts should always be locked when unattended to keep the medications secure and for safety reasons. She revealed that LPN #1 should have locked the medication cart before she walked away from it to keep the medications secure.	F 761	and/or changes as needed.	