STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	58PC	A. BUILDING: _____ B. WING _____	08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NMMC - PONTOTOC NURSING HOME	176 SOUTH MAIN STREET PONTOTOC, MS 38863

(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) COMPLETE DATE
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action;	M 500	**Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** On 08.01.14, 11:45 A.M., the Dietary Manager instructed on-duty Dietary Staff to discontinue use of disposable containers for resident food service. The alternate staff rotation received instruction on 08.02.14. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents were affected by the alleged deficient practice. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** Food & Nutrition guideline #403 "Preparation, Display and Service of Food" was revised to include "...Food should not be served to residents or patients in disposable containers except during power outages or as directed by the Director, Food & Nutrition, or the Administrator...." **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.** Visible observation is conducted X2 weekly by the Director, Food & Nutrition, and by the Nursing Director. Exceptions are addressed and reported to the LTC Performance Improvement Committee.	08.05.14

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M 500	Continued From page 1 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have	M 500		

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M 500	Continued From page 2 policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and	M 500		

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M 500	Continued From page 3 possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure dignity of residents as evidenced by residents were served meals on disposable dishware during two (2) of three (3) meal observations. Findings include: Severity Level 2 - Pattern Observation of Resident #3's dinner meal on 07/31/14 at 5:15 PM, revealed the Dietary Department served greens to the resident in a disposable bowl. The Dietary Department also served four (4) residents on A Hall vegetables in disposable bowls during the dinner meal observation on 07/31/14 at 5:00 PM.	M 500		

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M 500	Continued From page 4 Observation of the Dietary Department on 08/01/14 at 11:15 AM, revealed dietary staff served coleslaw in disposable bowls. Observation, during same date and time, revealed clean empty bowls in clean dish area. Interview with Dietary Staff #1 on 08/01/14 at 11:15 AM, confirmed coleslaw was prepared and placed in individual disposable containers for services to residents. Interview with Dietary Manager (DM) on 08/01/14, at 11:45 AM, confirmed the facility had enough bowls and dishes to serve residents during mealtime, but dietary staff instead utilized disposable dishware. The DM confirmed standard dishes should have been utilized instead of disposable dishware. The facility admitted Resident #3 on 06/18/13. Resident #3's diagnoses included Rheumatoid Arthritis, Hypertrophy, Alzheimer's disease, and Atrial Fibrillation. Review of Resident #3's most recent Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 06/03/14, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 03, indicating impaired cognition. The facility failed to provide a policy regarding dignity during mealtime.	M 500	**Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** For Residents 3 and 5, there were no identifiable adverse outcomes discovered. H&Ps were updated for each resident. **[Continued on Page 6 of 7.]**	09.01.14
M 580	45.20.1 Physical Examination Required Physical Examination Required. Each resident shall be given a complete physical examination	M 580		

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M 580	Continued From page 5 30 days prior to admission and annually thereafter, including a history of tuberculosis exposure and an assessment for signs and symptoms of tuberculosis, by a licensed physician or nurse practitioner/physician assistant. The findings shall be entered as part of the Admission Record. The report of the examination shall include: 1. Medical history (previous illnesses, drug reaction, emotional reactions, etc.). 2. Major physical and mental condition. 3. Current diagnosis. 4. Orders, dated and signed, by a physician or nurse practitioner/physician assistant for the immediate care of the resident to include medication treatment, activities, and diet. This Statute is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure an annual history and physical (H&P) assessment for two (2) of nine (9) resident charts reviewed. [Resident #3 and Resident #5] Findings include: Severity Level 2 - Pattern Review of facility policy entitled, "Physician History and Physical," with no revision date, revealed, "A physical examination shall be done annually on each resident." Resident #3	M 580	**Address how the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents had the potential to be affected by the alleged deficient practice. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** Attending physicians/providers were notified of the results of an H&P audit conducted by the Nursing Director. CMS guidelines were reviewed with each. A Facility log will be utilized to notify medical providers of H&P due dates on new admissions, upcoming annual H&P, and physical updates. Physicians are to review each H&P, make any necessary changes, and sign/date. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.** The Nursing Director or Charge Nurse conducts a monthly review of H&Ps to monitor compliance with State regulations. Medical providers are notified of upcoming needed updates. Findings are acted upon, as warranted, and are reported to the LTC Performance Improvement Committee for review/recommendations.	

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M 580	Continued From page 6 Record review of Resident #3's history and physical revealed a date of 06/19/13. The facility admitted Resident #3 on 06/18/13. Resident #3 had diagnoses which included Rheumatoid Arthritis, Hypertrophy, Alzheimer's Disease, and Atrial Fibrillation. Review of Resident #3's most recent Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 06/03/14, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 03, indicating impaired cognition. Resident #5 Record review of Resident #5's history and physical revealed a date of 06/16/13. The facility admitted Resident #5 on 06/04/12 had diagnosis which included Congestive Heart Failure, Insomnia, and Psychosis. Review of Resident #5's most recent MDS, with an ARD of 05/24/14, revealed Resident #5 had a BIMS score of 15, indicating an intact cognitive status. Interview with the Director of Nursing (DON) on 08/01/14 at 9:05 AM confirmed no history and physical assessment was completed in 2014 for Resident #3 and Resident #5.	M 580		