MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	69SC	A. BUILDING: _____ B. WING _____	C 03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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 000	Initial Comments The State Agency (SA) conducted Complaint Investigations (CI) MS# 27427, CI MS #27866, CI MS #27934, CI MS #28344, and CI MS #28380 at the facility on 03/25/25 through 03/26/25. During the survey the SA determined that the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. The SA identified non-compliance and cited M610 for CI MS #27427, CI MS #27866 and CI MS#28380 regarding personal hygiene needs. The SA investigated CI MS #27934 and CI MS #28344 with no deficiencies cited. The census at the time of the survey was 84 and they held a license for 106 beds.	M 000		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on staff and resident interviews, record review and facility policy review the facility failed to provide care to maintain personal hygiene for	M 610	This plan of correction constitutes a written allegation of substantial compliance with federal Medicare and Medicaid requirements and State licensure requirements. Preparation and/or execution of this plan does not	5/1/25

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M 610	Continued From page 1 two (2) of six (6) residents reviewed for Activities of Daily Living (ADL) care. Resident #5 and Resident #6. Findings Include: Record review of the undated facility policy, "Activities of Daily Living (ADL's)" revealed under "Policy Explanation and Compliance Guidelines...3. The resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene...." Resident #5 An interview on 03/25/25 at 11:30 AM with Resident #5 revealed that the care at the facility wasn't perfect but was okay. Resident #5 revealed that she did not get her shower on Saturday, 03/22/25, and she hadn't had a shower since last Thursday, 03/20/25. She revealed that she had missed several showers and stated, "I've been averaging about one shower a week this month." Resident #5 revealed that her scheduled shower days were Tuesdays, Thursdays and Saturdays and until the first of the year, she was getting her showers "like clockwork." She also revealed that she kept it in her calendar, and had it written down that she got a shower on 03/04/25 and did not get her next shower until 03/13/25 which was over a week later. She also revealed that on the days of her missed showers, no one offered or mentioned a shower to her. Resident #5 revealed that she had night sweats and when she got to where she could smell herself, she went into the bathroom in her room and washed herself off the best she could. Resident #5 revealed that not getting her scheduled showers made her feel dirty and made her not want to be	M 610	constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law and the State licensure program. 1. Resident #5 received a shower on 3/25/25. Resident #6 received a shower on 3/25/25. Documentation of this was verified by the Administrator on 3/26/25. 2. The Center acknowledges that all residents have the potential to be affected by this deficient practice. A 100% resident shower/bath documentation audit was completed on 3/28/25 by the Administrator to identify other residents who did not have documentation of a shower or bath provided as scheduled and corrective action was taken to ensure appropriate resident hygiene. 3. An education inservice will be completed for Certified Nursing Assistants (CNAs) by 4/30/25 by the Staff Development Coordinator (SDC) on providing assistance with Activities of Daily Living (ADLs), following the care plan for each resident, completion of resident showers and baths to maintain appropriate hygiene, and appropriate documentation of the shower or bath. On 4/14/25, Resident shower/bath	

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around anyone and stated, "Because I didn't want anyone to smell me."

Record review of Resident #5's "Continuous Pressure Ulcer Monitoring" Sheets which they used for keeping track of resident baths/showers revealed that she got her scheduled showers on 03/04/25, 03/13/25, 03/15/25, 03/18/25, and 03/20/25. Resident #5 did not receive her shower on 03/06/25, 03/08/25, 03/11/25, and 03/22/25.

Record review of Resident #5's "Admission Record" revealed an admission date of 11/08/24 with diagnoses that included Chronic Obstructive Pulmonary Disease, Muscle Weakness, and Need for Assistance with Personal Care.

Record review of Resident #5's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 02/11/25 under Section C revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated that she had no cognitive deficits.

Resident #6

An interview on 03/25/25 at 2:55 PM with Resident #6, revealed that his scheduled shower days were Mondays, Wednesdays and Fridays. He revealed that he did not get a shower yesterday, 03/24/25 and he couldn't remember getting a shower at all last week. He revealed that he used to get his showers every Monday, Wednesday and Friday and now it was every once in a while.

Record review of Resident #6's "Continuous Pressure Ulcer Monitoring" sheets which were used as bath and shower sheets revealed that he received showers on 03/03/25, 03/06/25,

schedules were entered by the Administrator into the electronic medical record (EMR), PointClickCare (PCC), as a custom care task requiring responses and allowing for electronic monitoring. The Director of Nursing, beginning 4/15/25, will review the completion of the shower tasks as part of the daily clinical start-up meeting to identify any residents without documentation of a shower or bath being offered.

4. Beginning 4/1/25, a resident shower/bath documentation audit will be completed by the Administrator 5 x (times) per week x 4 weeks, then 3 x week x 3 weeks to ensure that residents are receiving activities of daily living (ADL) assistance as necessary and that resident comprehensive care plans are implemented for residents to maintain appropriate hygiene.

Beginning 4/9/25, Registered Nurse Unit Managers will complete interviews with 12 residents 2 x per week x 7 weeks to ensure appropriate resident hygiene is maintained. If a resident has a BIMS score (Brief Interview for Mental Status) of less than 8 or is unable to be interviewed, a body audit will be conducted by the Registered Nurse Unit Manager to ensure appropriate hygiene.

The results of these audits will be brought to the Quality Assessment Performance Improvement (QAPI) Committee meeting x 2 months beginning April 30, 2025, for review and further corrective action as

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M 610	Continued From page 3 03/11/25, 03/12/25, and 03/13/25 in the month of March. There were no other showers documented as completed for Resident #6. Record review of Resident #6's "Admission Record" revealed an admission date of 09/12/22 with diagnoses that included Cerebral Infarction, Hemiplegia and Hemiparesis following Cerebral Infarction, and Need for Assistance with Personal Care. Record review of Resident #6's MDS with ARD of 02/11/25 under Section C revealed a BIMS score of 15 which indicated that he had no cognitive deficits. An interview on 03/25/25 at 10:55 AM with Licensed Practical Nurse (LPN) #1, revealed that the Certified Nursing Assistants (CNAs) had to fill out a sheet on each resident and turn it in to the nurses to sign off on when a shower or bath was completed. She revealed that the shower "sheets" that they used were titled, "Continuous Pressure Ulcer Monitoring." She also revealed that if a resident refused a bath or shower, the staff had to document "refused" and turn a sheet in for that day. LPN #1 revealed that once the bath sheets were turned in and the skin assessment part was looked at, the nurse signed off on it and the shower sheets were turned in to Certified Nursing Assistant (CNA) Supervisor to be filed. An interview on 03/25/25 at 3:35 PM with the Certified Nursing Assistant (CNA) Supervisor, revealed that the shower sheets they used were the "Continuous Monitoring Pressure Ulcer Monitoring" sheets. She revealed that the CNAs filled them out on each resident when they gave showers or baths, and they documented any new	M 610	necessary to maintain sustained compliance.	

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skin breakdown. CNA Supervisor revealed that the CNAs turned the sheets in to the nurses and the nurses had to sign off that the showers were completed and then turn them in to her for filing. She revealed that she had not received any complaints about residents not getting their showers. CNA Supervisor confirmed that there were missing shower sheets on Resident #5 and Resident #6 for the month of March 2025 and the lack of documentation would indicate that they didn't get showers on those days. CNA Supervisor confirmed that Resident #5 and Resident #6 were both cognitively intact and since they reported not getting some of their showers and with the missing shower documentation sheets, they probably did not get their showers as scheduled. She also agreed that they needed a better system for tracking to ensure that baths, showers, and personal care were being completed and documented.

An interview on 03/26/25 at 9:10 AM with Administrator (ADM), revealed that he was not aware of any residents missing their baths or showers and said it could be from the lack of stabilization in staffing and stated, "We can get that back under control and get this issue fixed."

An interview on 03/26/25 at 11:10 AM with Registered Nurse (RN) Supervisor, revealed that the CNAs had to fill out a shower sheet on each resident when they complete it and turn the sheet in to the nurse and the nurse had to sign off on it. She revealed that the sheets had to be filled out and signed by the CNA and the nurse even if a resident refused the service. RN Supervisor revealed that she was not aware that showers were being missed until now, and it was very concerning to her. She revealed that she would find out where the breakdown was and would be

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M 610	Continued From page 5 working on putting something in place to rectify the situation, so it didn't happen again. RN Supervisor revealed that going forward, she would make sure that she as well as the nurses collected the shower sheets on all residents and make sure everyone received their baths or showers as scheduled.	M 610		