

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/27/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER RIVER CHASE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 5090 GAUTIER VANCELEAVE ROAD GAUTIER, MS 39553		
(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 02/03/2025 through 02/06/2025. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F657, F658, F812, and F851.	F 000			
F 657 SS=D	The facility had a census of 57 and was licensed for 60 beds. Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary	F 657			3/6/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/24/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 657	Continued From page 1 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to revise a comprehensive care plan for Diabetes Mellitus to include interventions related to a continuous glucose monitoring (CGM) device for one (1) of (20) care plans reviewed. Resident #49. Findings included: A review of the facility's policy titled "Comprehensive Care Plans," revised on 02/05/2025, revealed, "... An individual comprehensive care plan that includes measurable objectives and time frames to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident ... Policy Interpretation ...5. The assessment of the resident is ongoing, and care plans are revised as information about the resident and the resident's condition change." A record review of Resident #49's "Comprehensive Care Plan" revealed an individualized care plan titled "Resident has Diabetes Mellitus," initiated on 02/08/2024 with a target date of 02/06/2025. The care plan did not include blood glucose monitoring or the use of a CGM device. During an observation and interview on 02/03/2025 at 11:55 AM, Resident #49 was observed wearing a CGM device on her right upper arm. The resident stated she received the device in March 2024 due to difficulty bending her	F 657	The following plan of correction is not intended to be an admission of guilt or used for any purpose stated herein. 1. The care plan for resident #49 was updated on 2/6/2025 to reflect the use of the Continuous Glucose Monitor and the current plan of care with the use thereof. 2. All other residents may have the potential to be affected by the deficient practice. 3. On 2/4/2025, The Director of Nursing began an in-service training with all nursing staff on the timely revision of resident care plans. Completed by 2/21/2025. 4. The Unit Neighborhood Watch Supervisors will monitor five residents weekly times four weeks then monthly times three months beginning 2/10/2025 to ensure resident care plans are current to their plan of care. Results of the Quality Assessment and Performance Improvement will be taken to Quality Assessment and Assurance Committee on 2/27/2025 and monthly thereafter for review and any systemic changes made as needed. The revisions will be developed and approved by the Quality Assessment and Assurance Committee to ensure the Plan of Correction is achieved and sustained. The Quality Assessment and Assurance Committee includes but not limited to the Medical Director,		

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F 657	Continued From page 2 fingers and experiencing soreness from frequent finger sticks. She reported that her physician approved the device, and she used it to check her blood glucose levels and notify nurses of the results and how much insulin she needed. During an interview on 02/06/2025 at 1:00 PM, Licensed Practical Nurse (LPN) #3 explained that the facility used working care plans that were updated as needed. She stated she was unaware that Resident #49 had a CGM device but explained that the device should have been added to the care plan upon receipt. She stated that the resident's care plan for Diabetes Mellitus should have been revised to reflect the use of the CGM device. LPN #3 explained that the purpose of a care plan was to provide guidance to staff regarding a resident's care and that it should be updated as care needs changed. During an interview on 02/06/2025 at 2:00 PM, with the Administrator and the Director of Nursing (DON) and Administrator stated they expected all staff to follow standard practices regarding resident care. The DON explained that she expected staff to report any changes in a resident's care to her and the interdisciplinary team. She further stated that care plans should be revised any time a change occurs in a resident's condition or care needs. The Administrator stated that the facility did not have a policy specifically addressing the use of CGM devices. A record review of Resident #49's "Admission Record" revealed the facility admitted the resident on 02/01/2024 with current diagnoses including Type 2 Diabetes Mellitus Without Complications.	F 657	Administrator, Director of Nursing, Infection Preventionist, and at least two members of the facility staff.		

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F 657	Continued From page 3 A record review of Resident #49's "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/30/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15.	F 657			
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to follow professional standards for blood glucose monitoring by not ensuring standardized documentation, physician orders for accu-check monitoring, staff training on continuous glucose monitoring (CGM) use and maintenance, and clear protocols on when to use the CGM versus a traditional glucometer for one (1) of twenty (20) sampled residents, Resident #49. Findings included: A record review of a typed statement on facility letterhead provided and signed by the Administrator, dated February 6, 2025, revealed "(Proper name of facility) does not have the following policies ...Free Style Libre (a type of CGM)" A review of the facility's policy titled "Resident Directed Medication Administration Policy," revised 08/2023, revealed, "... Standard: To	F 658	The following plan of correction is not intended to be an admission of guilt or used for any purpose other than the purpose stated herein. 1. Orders were received on 2/4/2025 on resident #49 for use of the Libre Continuous Glucose Monitoring System. Instructions were placed on the medication administration record for use to include placement of sensor, dates for changing of sensor, proper care of sensor, and orders for when to use the Continuous Glucose Monitoring System versus a traditional glucometer finger stick. 2. All other residents may have the potential to be affected by the deficient practice. No other residents currently use the CGM system. 3. On 2/4/2025, the Director of Nursing began an in-service training with all the nursing staff on the proper use and	3/6/25	

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F 658	Continued From page 4 assure that prescribed medications are administered safely, accurately, and in accordance with good nursing practice while accommodating the resident's routines and request in medication administration ... " A review of the facility's policy titled "Blood Glucose Monitoring," revised 12/04/2024, revealed, "... Policy Explanation and Compliance Guidelines ...2. The nurse will perform the blood glucose test utilizing the facility's glucometer as per manufacturer's instructions ..." On 02/03/2025 at 11:32 AM, during an observation and interview, Resident #49 was observed coming out of her room and telling Licensed Practical Nurse (LPN) #1 that she needed two (2) units of insulin before lunch. LPN #1 stated that the resident frequently advises her insulin dosage, but staff were required to verify her blood glucose levels before administering insulin. On 02/03/2025 at 11:55 AM, during an observation and interview, Resident #49 was observed with a CGM device on her right upper arm. The resident stated she had been using the CGM device since March 2024 because her fingers were too sore from frequent finger sticks, and her physician approved the device. She stated that she checked her blood glucose levels using the CGM and reported the readings to the nurses. On 02/04/2025 at 11:30 AM, during an interview, Resident #49 explained that she regularly visited her endocrinologist and had used the CGM daily. She stated that she changed the CGM device every two (2) weeks with assistance from a	F 658	maintenance of the Libre CGM system. The in-service also included procedures regarding receiving and placement of orders in the electronic medical records. Completed by 2/21/2025 4. The Unit Neighborhood Watch Supervisors will monitor five residents weekly times four weeks then monthly times three months beginning 2/5/2025 to ensure complete orders are obtained for diabetic care on all residents. Results of the Quality Assessment and Performance Improvement will be taken to Quality Assessment and Assurance Committee on 2/27/2025 and monthly thereafter for review and any systemic changes made as needed. The revisions will be developed and approved by the Quality Assessment and Assurance Committee to ensure the Plan of Correction is achieved and sustained. The Quality Assessment and Assurance Committee includes but not limited to the Medical Director, Administrator, Director of Nursing, Infection Preventionist, and at least two members of the facility staff.		

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F 658	Continued From page 5 night-shift nurse, as she was unable to do it herself. She also stated that she had a booklet explaining how the device worked and how to change it. On 02/04/2025 at 1:50 PM, during an interview, the Director of Nursing (DON) stated that she was unaware that Resident #49 used a CGM device for blood glucose monitoring. She reported that facility nurses still used traditional glucometers. When informed that nurses were using the CGM readings unless the device indicated "Hi" or "Low," the DON stated that she was unaware of how the resident obtained the CGM device, as the facility did not supply it. She also stated that she did not know nurses were assisting the resident in changing the device. The DON stated she would investigate further. On 02/04/2025 at 2:30 PM, during an interview, LPN #1 reported that Registered Nurse (RN) #1 had assisted Resident #49 in changing the CGM device earlier that day. LPN #1 stated she had worked at the facility for seven (7) months, and Resident #49 had always had the CGM device. She stated she was never told not to use the CGM readings and that other nurses also used the device for blood glucose readings. She reported that she had never been trained on how to use or change the CGM device. On 02/04/2025 at 2:50 PM, during an interview, RN #1 confirmed she had helped Resident #49 change her CGM device. RN #1 stated she had never received formal training on the device from the facility. She confirmed that there were no physician orders for the CGM or for blood glucose monitoring using the device.	F 658			

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F 658	Continued From page 6 On 02/06/2025 at 1:00 PM, during an interview, LPN #2 reported she had worked at the facility for six (6) months and that Resident #49 had always had the CGM device. She stated that she had always used the device for blood glucose readings and that a facility glucometer was only used if the CGM device displayed "Hi" or "Low." She confirmed that she had never been formally trained on the use of the CGM device by the facility. On 02/06/2025 at 1:15 PM, during an interview, the Nurse Practitioner (NP) stated she was unaware that Resident #49 had been using a CGM device. She stated that the facility had discussed using the device last year but that she had advised that policies and procedures needed to be in place before implementing CGM use. She stated she never received any follow-up from the facility regarding the issue and assumed staff were using facility glucometers for blood glucose monitoring. On 02/06/2025 at 2:00 PM, during an interview, the DON and Administrator stated they expected all staff to follow professional standards of care regarding resident management. The DON stated she expected staff to report all changes in a resident's care to her and the interdisciplinary team. The Administrator stated that the facility did not have a policy regarding the use of CGM devices. A record review of Resident #49's "Admission Record" revealed the facility admitted the resident on 02/01/2024 with current diagnoses including Type 2 Diabetes Mellitus Without Complications. A record review of Resident #49's "Order	F 658			

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F 658	Continued From page 7 Summary Report," with active orders as of 02/03/2025, revealed a Physician's Order, dated 6/25/2024 for sliding scale insulin,. The order did not indicate how blood glucose result should be obtained, such as through accucheck or CGM. A record review of Resident #49's "Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/30/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Section N of the MDS indicated that the resident had received insulin injections during the seven (7) day look-back period. A record review of the "Medication Administration Records (MARs)" for January and February 2025 revealed Resident #49's blood sugar results were documented but did not indicate how the results were obtained.	F 658			
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		3/6/25	

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F 812	Continued From page 8 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and ServSafe Coursebook review, the facility failed to label and date food stored in the refrigerator and freezer and failed to dispose of spoiled foods for one (1) of four (4) days of kitchen observations. Findings included: A review of the "ServSafe Coursebook, 8th Edition", 2022, revealed, " ...Labeling Food for Use On-Site: Any item not stored in its original container must be labeled... The label must include the common name of the food ..." On 02/03/2025 at 10:17 AM, during an observation of the kitchen and interview with the Dietary Manager (DM), the following observations were made in Refrigerator #1: a clear plastic bag containing three (3) cucumbers, one (1) of which had a black colored biological growth resembling mold and two (2) showing breakdown and a bag of discolored brown shredded lettuce. In the freezer, an opened bag of chicken tenders and an opened bag of pepperoni were observed without labels or opened dates. In the dry goods area, an opened bag of Oreo pieces in a clear ziplock bag was observed undated, along with a one-gallon ziplock bag of graham cracker crumbs that was not dated or labeled, and an opened bag of vanilla wafers in a ziplock bag that was also not dated or labeled. The DM confirmed these observations and stated his expectations for staff	F 812	The following plan of correction is not intended to be an admission of guilt or used for any purpose other than the purpose stated herein. 1. All foods identified not properly dated and labeled were removed by the Dietary Manager on 2/3/2025 from the refrigerator, freezer, and dry goods area. 2. All residents may have the potential to be affected by this deficient practice. 3. On 2/3/2025, the Dietary Manager began an in-service training with all the dietary staff on the proper dating and labeling of foods. Completed by 2/14/2025. 4. The Dietary Manager will monitor the refrigerator, freezer, and dry goods area weekly times four weeks then every two weeks times three months beginning 2/10/2025 to ensure all foods are properly dated and labeled. Results of the Quality Assessment and Performance Improvement will be taken to Quality Assessment and Assurance Committee on 2/27/2025 and monthly thereafter for review and any systemic changes made as needed. The revisions will be developed and approved by the Quality Assessment and Assurance Committee to ensure the Plan of Correction is achieved and sustained. The Quality Assessment and Assurance Committee includes but		

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F 812	Continued From page 9 were to follow guidelines and properly store food for residents. He further stated that the facility received a produce truck delivery every Thursday. On 02/04/2025 at 11:04 AM, during an interview, the Registered Dietitian (RD) stated that staff were expected to follow guidelines for food preparation and storage. She stated that she supported the DM and confirmed that kitchen staff followed ServSafe standards and policies regarding dating, labeling, and food storage. The RD confirmed that she was aware of the findings observed during kitchen observation. A review of the facility's staff in-service training titled "Dating and Labeling, Food Storage," completed on 09/23/2024, revealed the staff received training regarding ServSafe standards related to food dating and labeling.	F 812	not limited to the Medical Director, Administrator, Director of Nursing, Infection Preventionist, and at least two members of the facility staff.		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) Mandatory submission of staffing 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	F 851		3/6/25	

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F 851	Continued From page 10 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). §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.	F 851			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER RIVER CHASE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 5090 GAUTIER VANCELEAVE ROAD GAUTIER, MS 39553		
(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 851	Continued From page 11 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 interview and record review, the facility failed to accurately report to the Centers for Medicare and Medicaid Services (CMS) the direct care hours based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS for the fourth quarter of fiscal year 2024 (07/01/2024 - 10/31/2024) for one (1) of (1) quarters reviewed. Findings included: A record review of a typed statement on facility letterhead provided and signed by the Administrator, dated February 6, 2025, revealed "(Proper name of facility) does not have the following policies: Staffing ..." A record review of the facility's "Payroll Based Journal (PBJ) Staffing Data Report" for the fourth quarter of fiscal year 2024 (July 1-September 30) revealed, "... Excessively Low Weekend Staffing ...Triggered ... Submitted Weekend Staffing data is excessively low ... " On 02/04/2025 at 8:25 AM, during an interview, the Director of Nursing (DON) stated that she was unaware the facility had triggered low weekend staffing in the fourth quarter. She reported that she was responsible for nursing staff scheduling, while the Admissions department handled scheduling for Certified Nurse Aides (CNAs). The DON explained that the Administrator was responsible for ensuring staffing was accurate before the corporate office	F 851	The following plan of correction is not intended to be an admission of guilt or used for any purpose other than the purpose stated herein. 1. Attempts were made by the business office to re-submit without success. Contact was made to the Centers for Medicare and Medicaid Services Payroll Based Journal technical support and confirmed that the facility is unable to re-submit due to the deadline had passed. The Administrator notified the Internet Quality Improvement and Evaluation requesting additional email addresses added to the verification process. 2. All residents may have the potential to be affected by the deficient practice. 3. On 2/5/2025, the Quality Assurance Committee developed a Payroll Based Journal Policy on accurately reporting of direct care staffing information including agency and contract staff. The business office was in-serviced on the new policy and ensuring data is submitted correctly. 4. The Administrator, Administrative Assistant, and Director of Nursing will verify the accuracy of the staffing data monthly times three months beginning 2/10/2025 then quarterly thereafter. The Accounts Receivable Manager will be responsible for verifying the accuracy of census data, submitting data, and		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 851	Continued From page 12 submitted the data to CMS. She further reported that the Administrator that was at the facility during the time period of the fourth quarter was no longer employed at the facility. On 02/05/2025 at 1:50 PM, during an interview, the Administrator stated that the corporate office first calculated direct care hours before sending the data to the facility for verification. He explained that the Administrator was responsible for reviewing and verifying the staffing data before sending it back to corporate for submission. He reported that he was unsure who at the facility would have received notification indicating the facility had excessively low weekend staffing data. The Administrator confirmed that the facility had used a significant number of agency staff during that period. On 02/06/2025 at 1:40 PM, during an interview, the Admissions Coordinator confirmed that she was responsible for scheduling CNAs. She explained that during the fourth quarter, the facility used only one staffing agency, but agency CNAs were used frequently and daily. She reported that at that time, the staffing agency transitioned from paper time logs to a web-based time log system. She stated that the agency required its employees to use a mobile application on their personal phones to sign in and out of work. However, she explained that the application relied on GPS tracking and required the employee's phone to remain powered on throughout the shift. If the phone battery died, the system did not record the employee's worked hours. The Admissions Coordinator reported that during this transition, she frequently received phone calls from agency CNAs stating their phone battery had died and that their work hours	F 851	obtaining validation reports. The Administrator will be responsible for reviewing the validation reports and ensuring that any corrections are made before the quarterly deadline. Results of the Quality Assessment and Performance Improvement will be taken to Quality Assessment and Assurance Committee on 2/27/2025 and monthly thereafter for review and any systemic changes made as needed. The revisions will be developed and approved by the Quality Assessment and Assurance Committee to ensure the Plan of Correction is achieved and sustained. The Quality Assessment and Assurance Committee includes but not limited to the Medical Director, Administrator, Director of Nursing, Infection Preventionist, and at least two members of the facility staff.		

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F 851	Continued From page 13 needed to be manually adjusted. She stated that this issue could have caused discrepancies in the facility's PBJ staffing data for that reporting period, but she was unsure. She further confirmed that the previous Administrator who was in charge of the facility during the fourth quarter never confirmed the actual hours worked by agency CNAs before submitting the PBJ report. On 02/06/2025 at 2:30 PM, during an interview, the Administrator stated that he did not know exactly what had happened regarding PBJ reporting for the fourth quarter but expected that staffing should always be reported accurately.	F 851			