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
	55PI	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CEN	1620 READ ROAD PICAYUNE, MS 39466

(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 an annual recertification survey, along with two (2) Complaint Investigations (CIs), MS #27720 and CI MS #27954 at the facility from 3/11/25 through 3/13/25. During the survey, the SA determined the facility was in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. M500, M815 and M1570 were cited as a result of the annual recertification survey. CI MS #27720 was investigated for the facility being cold, not clean, and quality of care/life and M500 was cited. CI MS #27954 was a facility reported incident (FRI) investigated regarding verbal abuse and resident not treated with respect and dignity. The facility failed to protect a resident's right to be free from verbal abuse and M500 was cited. The facility's failure to protect Resident #17 when Certified Nursing Aide (CNA) #1 engaged in an argument with the resident on 2/8/25, using profanity and picked up a spray bottle of chemicals, pointed toward the resident, in response to the resident's agitation. Resident #17 reported feeling "nervous and afraid" at the time of the incident and the facility did not immediately remove the abuser from the facility. Licensed Practical Nurse (LPN) #1 witnessed the abuse and failed to intervene or report the abuse within the required timeframe and the facility did not report the event until 2/12/25. CNA #1 continued to work, delaying the facility's ability to protect this resident from further harm and placing other residents at risk of similar mistreatment. During the investigation of the FRI, the SA identified Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) which began	M 000		

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M 000	Continued From page 1 on 2/8/25 and existed at Rule 45.17.2 Residents' Rights (M500) - Level IV The abuser was not immediately removed from the facility which left Resident #17 and other residents in a situation that was likely to result in ongoing serious injury, serious harm, serious impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 3/12/25 at 2:15 PM. Based on the facility's implementation of corrective actions on 2/12/25, the SA determined the IJ and SQC to be Past Non-Compliance (PNC) and the IJ was removed on 2/13/25, prior to the SA's entrance on 3/11/25.	M 000		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on observation, staff interview, and facility policy review, the facility failed to ensure food items in the cooler and freezer were wrapped, covered, and dated and ensure serving bowls were cleaned appropriately for one (1) of three (3) days of survey. Findings included: A review of the facility's policy titled "Food	M 815	M 815- Food Procurement, Store/Prepare/Serve- Sanitary 1. On 3/11/2025 Dietary Staff #4 was immediately in-serviced by the Dietary Manager on infection control, sanitation, and food borne illness. Based on tracking and trending conducted by the Infection Control Preventionist observations, no resident has become ill. 2. All residents have the potential to be affected.	4/10/25

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M 815	Continued From page 2 Storage: Cold Foods" dated 02/2023 revealed, " ...All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored ... Procedures ... 5. All foods will be stored wrapped or covered in containers, labeled and dated..." A review of the facility's policy titled "Ware Washing," dated 02/2023 revealed, " ...All dishware, serviceware, and utensils will be cleaned and sanitized after each use..." On 03/11/2025 at 8:43 AM, during an observation of the kitchen and interview with Dietary Manager (DM) #1 revealed: Walk-In Cooler #1, there was an opened cheesecake box, which did not indicate the date opened, and the cheesecake was not fully wrapped or covered in the container. In Freezer #1, an opened frozen mixed vegetables container and an opened box of beef patties were not fully wrapped or covered in the containers and were exposed. Dried and stuck-on food residue was observed on serving bowls that were considered washed. The DM stated that these dishes were washed and stacked by the night shift. On 03/12/2025 at 12:35 PM, during an interview, Dietary Aide (DA) #4 confirmed the importance of ensuring plates and dishes are cleaned and sanitized to prevent residents from becoming sick. On 03/13/2025 at 2:40 PM, during an interview, the Administrator stated that her expectation is that kitchen staff prepare, store, label, and date foods according to facility policy.	M 815	3. On 03/25/2025 An in-service was conducted by the Dietary Manager with Healthcare Services Group on food preparation and servicing in relation to infection control and sanitation with all dietary staff. 4. Beginning on 03/14/25 the dietary manager will conduct rounds to monitor the sanitation and storage including labeling within dietary department three times a week for four (4) weeks, then monthly for three (3) months then and quarterly thereafter. A report will be submitted to the Quality Assurance Performance Improvement on 04/01/2025 for review and recommendations then and monthly for three (3) months. The Dietary Manager is responsible for monitoring and compliance.	

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M1570	Continued From page 3	M1570		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observation, interviews, record review, and facility policy review, the facility failed to maintain proper infection control practices by failing to prevent cross-contamination of perineal wipes during perineal care for one (1) of four (4) residents observed. Resident #58. Findings included:	M1570	M1570 Infection Prevention Control 1. On 3/13/2025 Resident #58 was reviewed and assessed by the Director of Nursing for any adverse reactions due to failure to prevent the possibility of infections by failing to maintain proper infection control practices during a direct care observation on 3/13/2025 by state surveyor. No adverse reactions were	4/10/25

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M1570	Continued From page 4 A review of the facility's policy titled "Perineal Care," revised 04/16/2024, revealed, " ...The purposes of this procedure are to provide cleanliness and comfort to the resident... to prevent infections and skin irritation ..." On 03/13/2025 at 9:18 AM, during an observation of perineal care of Resident #58, Certified Nursing Assistant (CNA)#3, assisted by CNA #5, gathered supplies, sanitized her hands, and donned gloves. CNA #3 removed six (6) premoistened wipes from the pack and used the wipes to clean the front area of the resident. The resident was assisted to her left side and then CNA #3 pulled six (6) additional wipes from the pack, touching the package with contaminated gloves, and then continued perineal care in the buttocks area. Resident #58 had a bowel movement during care and CNA #3's gloves were visibly soiled with feces. CNA #3 pulled six (6) more wipes from the pack, touching the package with visibly soiled gloves. CNA #3 then removed her soiled gloves, sanitized hands, applied clean gloves, and then pulled more wipes from the pack to continue cleaning the resident. On 03/13/2025 at 9:33 AM, during an interview, CNA #3 stated she improperly removed wipes during care. She confirmed she contaminated the wipes container by pulling more wipes from the pack with soiled gloves. On 03/13/2025 at 11:36 AM, during an interview, the Risk Manager (RM)/Infection Preventionist (IP) stated that CNA #3 contaminated the wipes each time she pulled them from the pack with dirty gloves on. On 03/13/2025 at 1:57 PM, during an interview,	M1570	found. On 03/13/2025 Certified Nursing Assistant (CNA) #3 was educated by the Director of Nursing on Infection Control policies and procedures and completed a peri care check off. No issues were found. On 03/13/2025 CNA# 3 provided proper peri care following infection control policies and procedures on Resident #58 under observation of the Director of Nursing. No issues were found. 2. All residents have the potential to be affected. 3. On 04/1/2025 and ongoing the Director of Nurses in-serviced nursing staff on following the infection control policy with all direct resident care including peri care practices. 4. On 3/14/2025 the Infection Preventionist will make observation rounds on three (3) resident peri care observations to ensure that accurate infection control practices were followed during direct care. These observations will occur weekly times four (4) weeks and then monthly for three (3) months and quarterly thereafter. A report will be submitted to the Quality Assurance Performance Improvement on 04/01/2025 for review and recommendations then and monthly for three (3) months. The Director of Nursing is responsible for monitoring and compliance.	

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M1570	Continued From page 5 the Director of Nursing (DON) stated CNA #3 should have pulled enough wipes from the container before beginning care. The DON confirmed there was potential for contamination and possible infection. A record review of the "Admission Record" revealed the facility admitted Resident #58 on 11/02/2021 with diagnoses including Unspecified Dementia. A record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/28/2025 revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Section GG revealed the resident requires partial to moderate assistance with toileting. A record review of the facility's "Perineal Care Check List", dated 8/22/24, revealed CNA #3 received training and performed a return demonstration regarding perineal care.	M1570		