STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255286	A. BUILDING _____ B. WING _____	09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CENTER	1304 WALNUT ST WAYNESBORO, MS 39367

(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 re-certification survey along with a complaint survey for CI MS #16020. The complaint was related to an allegation of residents having to wait several hours for the facility van to transfer them from dialysis back to the facility. The facility only has one van for transports. The complainant said the facility needed two vans. The SA did not substantiate the complaint during the survey. The SA determined the complaint was unsubstantiated by staff and resident interviews, and record reviews. The SA did not cite any deficiencies related to the complaint. During the survey, the SA did determine the facility was not in compliance with the requirements of participation for Medicare and Medicaid, and cited F644. At the time of survey, the census was 87, and the facility held a license for 90 beds.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.	F 644		10/3/19

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

Electronically Signed | 10/03/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 644	Continued From page 1 §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on facility statement review, record review and staff interview, the facility failed to refer Resident #2 for a Level II Pre-Admission Screening and Resident Review (PASRR) when the resident's status changed from being a Short Term Care (STC) resident to a Long Term Care (LTC) resident. This concern was identified for one (1) of 30 sampled residents reviewed. Findings include: Review of the untitled document on the facility's letterhead, dated 9/12/2019, provided and signed by the facility's Administrator, the facility does not have a Pre-Admission Screening and Resident Review (PASRR) policy. The facility follows State guidelines. The document was provided when asked for a policy on the PASRR process. Review of Resident #2's medical record document titled, "PAS Summary and Physician Certification (Electronic PAS)," dated 7/31/2017, revealed the section of the PASRR review for the Level II Referral Criteria was noted to be blank. The document revealed a mark to indicate that a Level II evaluation was not indicated at this time. The document was signed and dated, on 8/1/2017, by Resident #2's physician. Review of the facility's document titled, "Progress Notes," dated 10/17/2017 at 11:10 AM, and	F 644	Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged in the statement of deficiencies. This Plan of Correction is prepared solely as a matter of compliance with the Federal and State law. F644 Pre-Admission Screening And Resident Review (PASARR) for Resident #2 was completed and submitted to PASSAR Ascend MS Team on 09/12/2019 by the Social Services Director. PASARR is still in progress per Ascend as of 10/09/2019. 100% audit of all current residents to identify residents with diagnoses of a Major Mental Illness and Antipsychotic Medication use was completed on 9/12/2019 by the Social Services Director with no discrepancies identified. A plan was developed by the Administrator, Director of Nursing and Social Services Director on 9/12/2019 for monthly audits to begin 10/2019. Social Services Director will audit monthly for residents with new Major Mental Illness diagnoses, new orders for Antipsychotic	

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F 644	Continued From page 2 electronically signed by the Social Services Staff (SSS), revealed Resident #2 decided to become a Long Term Care (LTC) resident at the facility. The note revealed Resident #2 no longer felt safe at home, and that Resident #2 wanted to stay at the facility, because his brother would no longer be living with him. The note revealed Resident #2 stated, "I don't want to fall and no one help me either." Review of the facility's document titled, "Diagnosis Report," dated 9/12/2019, revealed all of Resident #2's diagnoses, the onset dates for each diagnosis, and each diagnosis' rank. The document revealed the Schizoaffective Disorder diagnosis had an onset date of 7/31/2017, and was Resident #2's primary diagnosis at admission. The diagnosis Unspecified Dementia with Behavioral Disturbance had an onset date of 7/31/2017, and was ranked as diagnosis #4. The 12th diagnosis was Generalized Anxiety with an onset dated of 7/31/2017. During an interview, on 9/11/2019 at 11:18 AM, with the Director of Nursing (DON), it was determined that the current PASRR located on Resident #2's chart, did not reflect Resident #2's current status. The DON stated Resident #2 was first admitted, on 7/31/2017, as a short term resident for therapy services. The DON stated Resident #2 later changed his mind and wanted to stay. The DON confirmed a new PASRR should have been done when Resident #2 changed from a Short Term Care (STC) resident to a Long Term Care (LTC) resident. During an interview, on 9/11/2019 at 2:02 PM, with the facility's Admissions Coordinator (AC), it was confirmed that the current PASRR did not	F 644	medications, and residents with changes from short stay to long stay to determine the need for a new PASARR. Results of the audit plan will be reviewed monthly by the Interdisciplinary Team at the monthly Quality Assurance (QA) meeting with recommendations and/or changes as needed to ensure continued compliance.	

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PINEVIEW HEALTH AND REHABILITATION CENTER	1304 WALNUT ST WAYNESBORO, MS 39367

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F 644	Continued From page 3 reflect the resident's current Long Term Care (LTC) status. The AC stated that at the time of admission, on 7/31/2017, Resident #2's intention was only to stay at the facility for short term skilled therapy care. The AC stated it was decided at a later date, that Resident #2 would remain in the facility as a Long Term Care resident. The AC stated that because of the resident's mental diagnosis with the use of antipsychotic medications, a new Level II PASRR should have been sent for review. Review of the Face Sheet revealed Resident #2 was admitted by the facility, on 7/31/2017, with diagnoses to include Schizoaffective Disorder, Parkinson's Disease, and Unspecified Dementia with Behavioral Disturbances.	F 644		

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	255286	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/13/2019**

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K 000	INITIAL COMMENTS The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 09/27/2019

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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E 000	Initial Comments ********** Survey conducted on 09/13/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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