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 _____	C 02/08/2019

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 a partial extended survey for Complaint Investigation (CI) MS #15652, from 2/4/19 to 2/8/19. The SA substantiated the complaint for failure to provide adequate supervision and assistance, per care plan, to prevent a fall resulting in major injury and subsequent death of a resident, Resident #4. The facility also failed to report the incident to the SA as required. During the survey it was determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited regulatory deficiencies. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SCQ), that began on 12/11/18, when the facility failed to provide adequate supervision and assistance, per care plan, to prevent an accident/fall with major injury/death, for a resident with a history of balance issues, who required assistance with transfer and mobility. Resident #4 had a diagnosis of Amyotrophic Lateral Sclerosis (ALS) or Lou Gehrig's disease, a nervous system disease that causes progressive muscle weakness. Resident #4 had been assessed and care planned for assistance, due to balance issues. Resident #4 sustained a head injury and skull fracture on 12/11/18, when Registered Nurse #1 ambulated him to the bathroom without assistance, then left him on the opposite side of the bed, unassisted, and out of arm's reach. RN #1 was approximately 43 inches away from Resident #4, with the resident's bed between them, when Resident #4 became unbalanced and fell, hitting his head on the floor. RN #1 was not able to catch the resident or break his fall, due to being on the opposite side of the bed, instead of	F 000		

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

Electronically Signed | 03/08/2019

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.

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 _____	C 02/08/2019

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	Continued From page 1	F 000		

within arms reach of the resident, to assist with any loss of balance.

The facility's failure to provide adequate assistance, as assessed and care planned for Resident #4, resulted in an accident/fall with head injury and Skull Fracture on 12/11/18, and death on 12/18/18, and placed other residents assessed with needed assistance, in a situation that was likely to cause serious injury, harm, impairment, or death.

On 2/5/19 at 12:30 PM, the SA notified the facility's Administrator of the IJ and SQC.

The IJ and SQC existed at:
42 CFR(s) 483.12 (c)(1)(4)-Reporting of Alleged Violations, F609.
42 CFR(s) 483.25 (d)(1)(2)-Free of Accident Hazards/Supervision/Devices, F689.

IJ existed at:
42 CFR(s) 483.21 (b)(1)-Comprehensive Care Plans, F656, and

The facility submitted an acceptable Allegation of Compliance (AOC) on 2/7/19, in which the facility alleged all corrective actions were completed on 2/6/19, and the IJ removed on 2/7/19.

The SA validated the AOC, and determined the IJ was removed, prior to exit. Therefore the scope and severity for 42 CFR(s) 483.25 (d)(1)(2)-Free of Accident Hazards/Supervision/Devices, F689; 42 CFR(s) 483.21 (b)(1)-Comprehensive Care Plans, F656; and 42 CFR(s) 483.12 (c)(1)(4)-Reporting of Alleged Violations, F609, was lowered from a "J" to a scope and severity of a "D", while the facility developed a plan of

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 _____	C 02/08/2019

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	Continued From page 2 correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The facility held a license for 90 beds, with a census of 86.	F 000		
F 609 SS=J	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		3/4/19

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 _____	C 02/08/2019

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 609	Continued From page 3 by: CI MS #15652 Based on observation, interviews, record review and facility policy review, the facility failed to report to the State Agencies (SA), a fall with major injury that resulted in the death of a resident, related to lack of staff assistance, per resident assessment. This affected one (1) of seven (7) residents reviewed, Resident #4. Resident #4 had a diagnosis of Amyotrophic Lateral Sclerosis (ALS) or Lou Gehrig's disease, a nervous system disease, that causes progressive muscle weakness. Resident #1 fell on 12/11/18, and received a Head Injury and Skull Fracture, when Registered Nurse (RN) #1 toileted the resident without assistance and left him standing without assistance at the bedside. RN #1 was approximately 43 inches away from Resident #4, with the resident's bed between them, when Resident #4 became unbalanced and fell, hitting his head on the floor. Resident #4 subsequently died on 12/18/18, as a result of the fall. Resident #4 was assessed for transfer and mobility assistance due to balance issues. The facility did not report the fall with injury and subsequent death to the SA as required. The facility's failure to report Resident #4's fall with major head injury and death to the SA, placed this and other residents assessed for fall risk that required assistance, in a situation that was likely to cause serious harm, injury, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), that began on 12/11/18, when staff failed to provide assistance as needed to prevent Resident #4's	F 609	This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the State and Federal law. 1.On 2/5/19 the Risk Manager notified the State Licensing Agency, Medicaid Fraud Control Unit (Attorney General) and the local Police Department that Resident #4 had a fall with major injury on 12/11/18. 2.The facility will make daily rounds observing for other residents that may be affected by the deficient practice cited. On 2/6/19 at 12:10 PM, the Risk Manager audited all other Exception Reports since 8/1/18, for major injuries, with zero (0) of 142 Exception Reports resulting in major injuries. 3.On 2/5/19 a Quality Assurance (QA) meeting was held with the Medical Director to discuss the events after Resident #4's fall on 12/11/18, and the importance of reporting major injuries to state agencies within two (2) hours of occurrence. The QA Committee also reviewed policies on supervision and prevention of accidents, abuse/neglect, following care plan, and observing for change in condition. There were no changes made to current facility policies.All exception reports will be reviewed by Risk Manager daily beginning	

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 _____	C 02/08/2019

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 609	Continued From page 4 accident/fall, with major head injury and subsequent death; and also failed to report the incident as required. On 2/5/19 at 12:30 PM, the SA notified the facility's Administrator of the IJ and SQC. The facility submitted an acceptable Allegation of Compliance (AOC) on 2/7/19, in which the facility alleged all corrective actions were completed on 2/6/19, and the IJ removed on 2/7/19. The SA validated the AOC, and determined the IJ was removed prior to exit. Therefore the scope and severity for 42 CFR(s) 483.12 (c)-Reporting, F609, was lowered from a "J" to a scope and severity of a "D", while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: The facility's policy, "Prevention of Resident Abuse, Neglect, Mistreatment or Misappropriation of Property", dated December 2017, noted the facility Administrator would report to the State Survey Agency in accordance with State law. This policy noted if the events that cause the allegation involve abuse or result in serious bodily injury, the event must be reported immediately, but not later than two (2) hours after the allegation is made. A review of the facility's "Exception Report", dated 12/12/18, revealed Resident #4 lost his balance on 12/11/18 at 1:50 PM, while standing. Documentation revealed Resident #4 had bleeding from his head and ears after the fall and complained of severe pain. The report was	F 609	2/5/19 and any major injuries will be reported to the state agency. On 2/5/19 through 2/6/19 the Risk Manager and DON completed in-services for all staff members, to include therapy, on supervision and prevention of accidents, reporting requirements for major injuries, and following the care plan and updating plan of care upon a resident's change of condition. All new hires will receive this training during new hire orientation by the Risk Manager. 4.The Administrator will report all results of the established monitoring of random staff interviews on all shifts regarding ADL support and following Kardex/Care Plans to the Quality Assurance Committee meeting monthly for the immediate corrective plan of action of any deficient practice. QA committee will make recommendations as needed. plan of action of any deficient practice.	

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 _____	C 02/08/2019

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 609	Continued From page 5	F 609		

signed by RN #1 on 12/12/18. Documentation included a statement by RN #1, noting she was assisting Resident #4 back to bed when Resident #4 asked her to straighten his bed and when she went around the bed, Resident #4 lost his balance and fell.

Review of an ambulance report, dated 12/11/18, revealed Resident #4 was found in the floor, alert and oriented x 4 (person, place, time, situation). Patient had a blood pool behind his head and bleeding from the left ear. Patient stated the staff stood him up and dropped him. The report documented the resident had a laceration/hematoma to the back of the skull and bleeding from the ear. The resident was placed on a stretcher and taken to the hospital.

Review of Resident #4's Computerized Tomography (CT) scan, dated 12/11/18, revealed, "The study is significant for evidence of a hairline fracture left temporal bone extending into the external auditory canal with fluid possibly blood left external cord canal. Exam also shows what appears to be a very minimal amount of subarachnoid air in the posterior fossa on the left adjacent to the temporal bone."

Review of the Discharge Summary, from the accepting hospital, with a discharge date of 12/18/18, revealed Resident #4 died as a result of a Basilar Skull Fracture, fall at the Nursing Home, and a Cerebral Contusion.

Review of Resident #4's Certificate of Death, dated 12/18/18 at 4:54 AM, revealed the cause of death was Multi-organ Failure, due to Basilar Skull Fracture, as a consequence of a fall to the Floor

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 _____	C 02/08/2019

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 609	Continued From page 6	F 609		

Interview with Resident #4's Responsible Party (RP) on 2/5/19 at 8:31 AM, revealed Resident #4 died as a result of a fall at the facility when a nurse was helping him by herself. She stated she returned to the facility on 12/18/18, the day Resident #4 died, and notified the facility that he had expired.

In an interview on 2/5/19 at 10:17 AM, the facility Administrator at the time of Resident #4's fall on 12/11/18, stated the investigation revealed RN #1 did take Resident #4 to the bathroom alone and when they got back to the bed the resident asked the nurse to straighten his covers. The Administrator stated that Resident #4 was on the left side of the bed from the foot, and the nurse was on the right side of the bed from the foot. The Administrator stated when RN #1 looked up, Resident #4 was falling, she could not catch him, and he fell to the floor, hitting his head. When the Administrator was asked if this incident involving Resident #4's fall with subsequent death should have been reported to the SA, the Administrator responded there was no willful intent on the nurse's part and they knew what happened. The Administrator confirmed the incident was not reported to the SA.

Interview with the Director of Nursing (DON) on 2/5/19 at 9:30 AM, confirmed the facility did not report the incident involving Resident #4 when he fell on 12/11/18, and died on 12/18/18. The DON stated the facility did not think it had to be reported to the State Survey Agencies because it was a witnessed fall and the facility was aware of what happened. When asked if a major injury should be reported, the DON replied, "Yes".

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 _____	C 02/08/2019

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 609	Continued From page 7 The Facility provided an acceptable Allegation of Compliance (AoC), which included: On 2/5/19 at 12:30 PM, the State Agency informed the Administrator, who started in the Administrator role on 1/1/19, of an Immediate Jeopardy with substandard quality of care, due to the facility's lack of supervision and failure to report a major injury of Resident #4. Resident #4 was admitted to the facility on 8/7/18, with diagnoses of Amyotrophic Lateral Sclerosis (ALS), Rhabdomyolysis, Bilateral Artificial Hip Joints, Dry Eye Syndrome of Bilateral Lacrimal Glands, Hypertension, and Gastroesophageal Reflux Disease. Resident #4 was care-planned at risk for falls and required assistance with most aspects of care. Resident #4's care plan dated 11/8/18, included: limited assistance times one (1) staff member for walking in room/corridor, supervision times one (1) staff member for locomotion on unit, extensive assistance times one (1) staff member for dressing, extensive assistance times one (1) staff member for eating, extensive assistance times one (1) staff member for locomotion off unit, extensive assistance times one (1) staff member for personal hygiene, extensive assistance times two (2) staff members for bathing, extensive assistance times two (2) staff members for bed mobility, extensive assistance times two (2) staff members for toilet use, and extensive assistance times two (2) staff members for transfers. Registered Nurse (RN) #1 did not follow the plan of care of Resident #4 who was extensive assistance times two (2) for toileting and transfers. Resident #4 had a Brief Interview for Mental Status (BIMS) of 12 as of 11/6/18, and participated in his plan of care. Resident #4 had a fall due to RN #1 was unable	F 609		

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 _____	C 02/08/2019

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 609	Continued From page 8	F 609		

to catch Resident #4, and Resident #4 sustained a head injury on 12/11/18 at 1:50 PM. Resident #4 was standing to the left side of his bed after being assisted from the bathroom by RN #1. Resident #4 requested that RN #1 straighten his covers on his bed to prepare for bed. RN #1 asked Resident #4 was he good to stand while she proceeded to walk to the opposite side of the bed. Resident #4 confirmed that he was stable with standing unassisted. RN #1 saw Resident #4 falling backwards and called out to him while reaching out towards him. RN #1 was not able to catch Resident #4 as he was falling. RN #1 immediately began to assess Resident #4 who was noted to be bleeding from back of head and ears. RN #1 kept Resident #4's C-spine stable as she alerted Housekeeper #1 and CNA #1 to alert additional nursing staff. LPN #1 called the ambulance at 1:50 PM and the ambulance arrived at the facility at 1:56 PM. LPN #1 notified the Responsible Party on 12/11/18 at 2:00 PM that Resident #4 had a fall with a head injury and was being transported to the local emergency room. The Unit Manager notified the Medical Director on 12/11/18 at 2:06 PM, that Resident #4 had a fall with a head injury and was being transported to the local emergency room. Resident #4 arrived to the local emergency room on 12/11/18 at 2:20 PM . Resident #4 was diagnosed with a Basilar Skull Fracture and Cerebral Contusion and transferred to another hospital which provided a higher level of care. On 12/18/18 at 12:42 PM, the Responsible Party of Resident #4, notified the Assistant Director of Nursing (ADON) that Resident #4 expired on 12/18/18, while in the hospital. Resident #4's Death Certificate dated 12/18/18, states that Resident #4's cause of death was due to Multi-organ Failure, Basilar Skull Fracture, and

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 _____	C 02/08/2019

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 609	Continued From page 9 fall to floor. Corrective Actions: 1. On 12/11/18 at 1:52 PM, the Risk Manager and ADON entered the room and initiated an investigation of Resident #4's fall. 2. On 12/11/18 at 3:00 PM, the Risk Manager completed an in-service with RN #1 regarding not following the care plan of extensive assistance times two (2) for toileting and transfers to prevent falls. 3. On 12/11/18 at 4:30 PM, the Risk Manager and Director of Nursing (DON) initiated a Quality Assurance Performance Improvement (QAPI) and Performance Improvement Project (PIP) to decrease falls with review of interventions to prevent accidents. Interventions included completing fall investigation after each fall, medication review after each fall, in-serviced all caregivers on reporting changes with Activity of Daily Living (ADL) support and following Kardex/Care plans, care plans to be reviewed and updated after each fall, and referrals will be made to therapy as needed. 4. On 1/8/19 at 1:45 PM, the Risk Manager held a scheduled annual in-service on preventing / reporting of abuse and neglect, completing exception reports, and resident rights. The following associates received this training: one (1) of one (1) Activity associates, three (3) of three (3) Maintenance associates, one (1) of one (1) Business Office Associates, 42 of 42 CNAs, 18 of 20 Licensed Practical Nurses (LPN), eight (8) of nine (9) RNs, 11 of 13 Dietary associates, and 12 of 12 Housekeeping/Laundry associates.	F 609		

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 _____	C 02/08/2019

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 609	Continued From page 10	F 609		

5. On 2/5/19 at 5:00 PM, an Emergency Quality Assurance (QA) meeting was held with the Medical Director, Administrator, DON, ADON, Risk Manager, Business Office Manager, Housekeeping Supervisor, Life Enrichment Director, Minimal Data Sets (MDS) Nurse Coordinator, Restorative Coordinator, Unit Manager, Admission/Marketing Nurse, and Social Services Director to discuss the events after Resident #4's fall on 12/11/18, and the importance of reporting major injuries to state agencies within two (2) hours of occurrence. The QA Committee also reviewed policies on supervision and prevention of accidents, abuse/neglect, following care plan, and observing for change in condition. There were no changes made to current facility policies.

6. On the evening of 2/5/19, between 5:30 PM-9:00 PM, Nurse Managers including the Social Services Director, Unit Manager, Medicare Nurse, MDS Coordinator, Restorative Coordinator, Admissions/Marketing Nurse, and ADON audited 87 of 87 residents for needs of assistance with ADLs comparing a new fall risk screen to the individual resident's plan of care and Kardex. No discrepancies were noted and no changes were made to the care plan of the 87 residents audited.

7. On 2/5/19 at 5:30 PM through 2/6/19 at 11:45 AM, the Risk Manager and DON completed all in-services for all staff members on supervision and prevention of accidents, reporting requirements for major injuries, and following the care plan and updating plan of care upon a resident's change of condition. Nine (9) of nine (9) RNs, 20 of 20 LPNs, 42 of 42 CNAs, 13 of 13

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 _____	C 02/08/2019

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 609	Continued From page 11 Dietary associates, three (3) of three (3) Maintenance associates, 12 of 12 Housekeeping/Laundry associates, and seven (7) of seven (7) Therapy associates have been in-serviced. All new hires will receive this training during new hire orientation by the Risk Manager. 8. On 2/5/19 at 6:00 PM, the Pharmacy Consultant completed a pharmacy review of nine (9) residents who fell in January 2019, with no concerns noted. 9. On 2/5/19 at 6:03 PM, the Risk Manager notified the State Licensing Agency of the completed investigation of Resident #4's fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture. 10. On 2/5/19 at 6:18 PM, the Risk Manager notified the Medicaid Fraud Control Unit (Attorney General) office that Resident #4 had a fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture. 11. On 2/5/19 at 6:22 PM, the Risk Manager notified the local Police Department that Resident #4 had a fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture. 12. On 2/6/19 at 12:10 PM, the Risk Manager audited all other Exception Reports since 8/1/18, for major injuries, with zero (0) of 142 Exception Reports resulting in major injuries. 13. The Administrator will report all results of the established monitoring to the Quality Assurance	F 609		

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 _____	C 02/08/2019

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 609	Continued From page 12 Committee meeting for the immediate corrective plan of action of any deficient practice. 14. No associate can work until they have received this in-service training. The facility alleges that all corrective actions were completed on 2/6/19, and Immediate Jeopardy removed as of 2/7/19. Validation of the Allegation of Compliance included: The SA validated through record review and interview that Resident #4 was admitted on 8/7/18, with a diagnosis of ALS, and was care planned for two (2) person assistance for transfer and toileting. The SA validated that Resident #4 fell on 12/11/18, after RN #1 assisted him to the toilet without assistance and left him standing, unassisted, as the foot of the bed while she went to the other side of the bed, out of arms reach of the resident. The SA validated Resident #4 was transferred to the hospital and diagnosed with a Basilar Skull fracture and Cerebral Contusion, and subsequently expired on 12/18/18. The SA validated notification to the RP and the Medical Director. The SA validated the facility's Corrective Actions: 1. The SA validated through interviews and record review that on 12/11/18, the Risk Manager and ADON initiated an investigation of Resident #4's fall. 2. The SA validated through interviews and record review that on 12/11/18, the Risk Manager completed an in-service with RN #1 regarding not following the care plan of extensive assistance times two (2) for toileting and transfers to prevent	F 609		

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 _____	C 02/08/2019

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 609	Continued From page 13 falls. 3. The SA validated through interviews and record review that on 12/11/18, the Risk Manager and Director of Nursing (DON) initiated a Quality Assurance Performance Improvement (QAPI) and Performance Improvement Project (PIP) to decrease falls with review of interventions to prevent accidents. Interventions included completing fall investigation after each fall, medication review after each fall, in-serviced all caregivers on reporting changes with Activity of Daily Living (ADL) support and following Kardex/Care plans, care plans to be reviewed and updated after each fall, and referrals will be made to therapy as needed. 4. The SA validated through interviews and record review that on 1/8/19, the Risk Manager held a scheduled annual in-service on preventing/reporting of abuse and neglect, completing exception reports, and resident rights. The following associates received this training: one (1) of one (1) Activity associates, three (3) of three (3) Maintenance associates, one (1)of one (1) Business Office Associates, 42 of 42 CNAs, 18 of 20 Licensed Practical Nurses (LPN), eight (8) of nine (9) RNs, 11 of 13 Dietary associates, and 12 of 12 Housekeeping/Laundry associates. 5. The SA validated through interviews, sign-in sheets, and record review, that on 2/5/19, an Emergency Quality Assurance (QA) meeting was held with the Medical Director, Administrator, DON, ADON, Risk Manager, Business Office Manager, Housekeeping Supervisor, Life Enrichment Director, Minimal Data Sets (MDS) Nurse Coordinator, Restorative Coordinator, Unit Manager, Admission/Marketing Nurse, and Social	F 609		

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 _____	C 02/08/2019

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 609	Continued From page 14 Services Director to discuss the events after Resident #4's fall on 12/11/18, and the importance of reporting major injuries to state agencies within two (2) hours of occurrence. The QA Committee also reviewed policies on supervision and prevention of accidents, abuse/neglect, following care plan, and observing for change in condition. There were no changes made to current facility policies. 6. The SA validated through interviews and record review that on the evening of 2/5/19, Nurse Managers including the Social Services Director, Unit Manager, Medicare Nurse, MDS Coordinator, Restorative Coordinator, Admissions/Marketing Nurse, and ADON audited 87 of 87 residents for needs of assistance with ADLs, comparing a new fall risk screen to the individual resident's plan of care and Kardex. No discrepancies were noted and no changes were made to the care plan of the 87 residents audited. 7. The SA validated through interviews and record review on 2/5/19, through 2/6/19, the Risk Manager and DON completed all in-services for all staff members on supervision and prevention of accidents, reporting requirements for major injuries, and following care plan and updating plan of care upon a resident's change of condition. Nine (9) of (9) RNs, 20 of 20 LPNs, 42 of 42 CNAs, 13 of 13 Dietary associates, three (3) of (3) Maintenance associates, 12 of 12 Housekeeping/Laundry associates, and seven (7) of (7) Therapy associates have been in-serviced. The SA validated that all new hires will receive this training during new hire orientation by the Risk Manager. 8. The SA validated through interviews and	F 609		

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 _____	C 02/08/2019

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 609	Continued From page 15	F 609		

record review that on 2/5/19, the Pharmacy Consultant completed a pharmacy review of nine (9) residents who fell in January 2019, with no concerns noted.

9. The SA validated through interviews and record review on 2/5/19, the Risk Manager notified the State Licensing Agency of the completed investigation of Resident #4's fall on 12/11/18, which resulted in death on 12/18/18 due to Multi-organ Failure and Basilar Skull Fracture.

10. The SA validated through interviews and record review on 2/5/19, the Risk Manager notified the Medicaid Fraud Control Unit (Attorney General) office that Resident #4 had a fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture.

11. The SA validated through interviews and record review on 2/5/19 at 6:22, the Risk Manager notified the local Police Department that Resident #4 had a fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture.

12. The SA validated through interviews and record review on 2/6/19, the Risk Manager audited all other Exception Reports since 8/1/18, for major injuries with zero (0) of 142 Exception Reports resulting in major injuries.

13. The SA validated through interview the Administrator will report all results of the established monitoring to the Quality Assurance Committee meeting for the immediate corrective plan of action of any deficient practice.

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 _____	C 02/08/2019

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 609	Continued From page 16 14. The SA validated through interviews and record review that no associate worked until they had received this in-service training. The SA validated that all corrective actions were completed on 2/6/19, and the Immediate Jeopardy removed as of 2/7/19.	F 609		
F 656 SS=J	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		3/4/19

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 _____	C 02/08/2019

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 656	Continued From page 17 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: CI MS #15652 Based on observation, interviews, record review, and facility policy review, the facility failed to implement the plan of care to provide adequate assistance to prevent accidents and/or major injury, including death, for one (1) of seven (7) residents reviewed, Resident #4. Resident #4 was assessed and care planned for two (2) person assistance with transfer and mobility, related to balance. He fell on 12/11/18, when RN #1 took him to the bathroom unassisted, then left him at the bedside unassisted, while she went to the other side of the bed. The fall resulted in a Head Injury and Skull Fracture when Registered Nurse (RN) #1 was unable to reach the resident to break his fall on 12/11/18. She was approximately 43 inches away from Resident #4, with the resident's bed between them, when Resident #4 fell. Resident #4 died on 12/18/18, as a result of the fall. The facility's failure to follow Resident #4's plan of care to provide supervision and assistance to	F 656	1.On 12/11/18 RN#1 immediately assessed Resident #4 and called out to other staff for additional help. The Risk Manager completed on 12/11/19 an in-service with Registered Nurse (RN) #1 regarding following care plans to decrease falls.On 12/11/18 the Risk Manager and Director of Nursing (DON) initiated a Quality Assurance Performance Improvement (QAPI) and Performance Improvement Project (PIP) to decrease falls. On 12/11/18 all staff was in-serviced by the Risk Manager on reporting changes with Activity of Daily Living (ADL) support and following Kardex/Care plans, care plans to be reviewed and updated after each fall by Risk Manager. 2.The facility will make daily rounds observing for other residents that may be affected by the deficient practice cited. On 2/5/19 Nurse Managers audited 87 of 87 residents for needs of assistance with ADLs comparing a new fall risk screen to the individual resident's plan of care and	

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 _____	C 02/08/2019

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 656	Continued From page 18 prevent accidents, resulted in major injury/death to Resident #4, and placed other residents assessed for assistance needs, in a situation that was likely to cause serious injury, harm, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) that began on 12/11/18, when RN #1 failed to provide the needed assistance, per care plan, to help prevent the accident/fall and major injury, resulting in Resident #4's death. On 2/5/19 at 12:30 PM, the State Agency notified the facility's Administrator of the IJ and Substandard Quality of Care (SCQ). The facility submitted an acceptable Allegation of Compliance (AOC) on 2/7/19, in which the facility alleged all corrective actions were completed on 2/6/19, and the IJ removed on 2/7/19. The SA validated the AOC and determined the IJ was removed, prior to exit. Therefore the scope and severity for 42 CFR(s) 483.21 (b) (1)-Comprehensive Care Plans, F656, was lowered from a "J" to a scope and severity of a "D", while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: The facility's policy, "Care Plan-Comprehensive", dated November 2017, revealed the facility would develop and maintain a Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs of the	F 656	Kardex. No discrepancies were noted and no changes were made to the care plan of the 87 residents audited.On 2/5/19 through 2/6/19 the Risk Manager and DON completed in-services for all staff members, to include therapy, on supervision and prevention of accidents, reporting requirements for major injuries, and following the care plan and updating plan of care upon a resident's change of condition. All new hires will receive this training during new hire orientation by the Risk Manager. 3.On 2/5/19 a Quality Assurance (QA) meeting was held with the Medical Director to discuss the events after Resident #4's fall on 12/11/18. The QA Committee also reviewed policies on supervision and prevention of accidents, abuse/neglect, following care plan, and observing for change in condition. There were no changes made to current facility policies. All residents Care Plans and Kardex's will be audited weekly by Nurse Managers starting on 2/5/19 and will be ongoing to ensure accuracy. Random staff interviews will be completed on all shifts by Nurse Managers weekly to ensure accurate resident ADL support per care plan. 4.The Administrator will report all results of the established monitoring of random staff interviews on all shifts regarding ADL support and following Kardex/Care Plans to the Quality Assurance Committee monthly meeting for the immediate corrective plan of action of any deficient	

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 _____	C 02/08/2019

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 656	Continued From page 19 resident. This policy noted the Care Plans are revised as changes in the resident's condition dictate and are reviewed at least quarterly. Review of the Care Plan (CP) dated 8/7/19, with a target date of 2/6/19, revealed Resident #4 was at risk for falls and was unable to use his upper extremities (hands/arms). The CP did not address interventions for staff assistance when ambulating. The CP noted Resident #4 had an Activities of Daily Living (ADL) deficit and would receive the following assistance: Extensive of two (2) to walk in room/corridor, extensive of one (1) for locomotion off unit, extensive of two (2) for toilet use, extensive of two (2) for transfers, and supervision of one (1) with locomotion on the unit. Extensive assistance is defined as the resident is involved in the activity, but staff provides weight-bearing support (having hands on the resident). Review of another Care Plan, provided by the facility on 2/7/19 at 2:05 PM, with a target date of 11/18/18, noted Resident #4 had an ADL deficit and would receive the following assistance: Limited of one (1) to walk in room/corridor, extensive of one (1) for locomotion off unit, extensive of two (2) for toilet use, extensive of two (2) for transfers and supervision of one (1) with locomotion on the unit. Review of a Care Plan, provided by the facility, dated 8/7/18, with a Target Date of 2/6/19, documented that Resident #4 required extensive assistance by two (2) persons with no resolved date listed, and also listed a resolved intervention of limited assist times one (1) person to walk in room/corridor with the resolved date of 12/11/18, on the day Resident #4 fell.	F 656	practice. QA committee will make recommendations as needed.	

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 _____	C 02/08/2019

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 656	Continued From page 20	F 656		

Review of the Kardex/Care Plan, for the Certified Nursing Assistants (CNAs), from the admit date of 8/7/18, and printed on 2/6/19, documented Resident #4 needed extensive assistance of two (2) staff to walk in room/corridor, extensive of two (2) staff for transfers, and extensive of two (2) for toilet use.

The facility admitted Resident #4 on 8/7/18, with the diagnoses of Amyotrophic Lateral Sclerosis (ALS) or Lou Gehrig's disease, High Blood Pressure, Gastro-Esophageal Reflux Disease, and Presence of an Artificial Hip Joint. The Quarterly Minimum Data Set (MDS) with the assessment date of 11/6/18, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) of 12, which indicated he was cognitively intact.

Review of Resident #4's "Fall Risk Screen", dated 11/7/18, revealed Resident #4 scored 11. The Fall Risk Screen assessment noted, "If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls." This assessment was electronically signed by the Restorative Coordinator.

Review of the Physical Therapy (PT) Progress and Discharge Summary, dated 9/25/18, revealed Resident #4 was discharged from PT and the goal was met with standing dynamic balance with documentation: "Improving to Stand by assistance/close supervision (close enough to reach patient if assist needed)."

Review of a Progress Note, dated 12/4/18, revealed an entry by the Nurse Practitioner (NP) for Resident #4 that read: "Reports he is no longer able to go to the bathroom without

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 _____	C 02/08/2019

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 656	Continued From page 21 assistance due to muscle weakness in his legs." Review of a "Fall Scene Investigation Report", dated 12/11/18 at 1:50 PM, unsigned, noted a witnessed fall to the floor while Resident #4 was standing at the bedside. This reported noted Resident #4 requested RN #1 to adjust his covers while he stood at the foot of the bed. A diagram of Resident #4's and RN #1's position was noted with RN #1 on the right side of the bed and Resident #4 on the left side of the bed. This report noted Resident #4 lost his balance while standing at the foot of the bed, with assistance to be increased with ambulation to two (2) persons. Review of the facility's "Exception Report", dated 12/12/18, revealed Resident #4 lost his balance while standing, and fell on 12/11/18 at 1:50 PM. This report noted Resident #4 had bleeding from his head and ears after his fall and was in pain at a level of 10 on a scale from one (1) to 10, with 10 being the most severe. This report was signed by RN #1 on 12/12/18. This report noted a statement by RN #1, that she was assisting Resident #4 back to bed when Resident #4 asked her to straighten his bed, and when she went around the bed, Resident #4 lost his balance and fell. Review of a Computerized Tomography (CT) scan, dated 12/11/18, for Resident #4 revealed: "The study is significant for evidence of a hairline fracture left temporal bone extending into the external auditory canal with fluid possibly blood left external cord canal. Exam also shows what appears to be a very minimal amount of subarachnoid air in the posterior fossa on the left adjacent to the temporal bone."	F 656		

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 _____	C 02/08/2019

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 656	Continued From page 22	F 656		

Review of the hospital Discharge Summary, dated 12/18/18, revealed Resident #4 died as a result of a Basilar Skull Fracture, fall at Nursing Home, and a Cerebral Contusion.

Review of Resident #4's Certificate of Death, dated 12/18/18 at 4:54 AM, revealed the cause of death was Multi-organ Failure, due to Basilar Skull Fracture, as a consequence of a fall to the Floor.

On 2/4/19 at 2:10 PM, in an interview, RN #1 confirmed Resident #4 had been assessed and care planned for (2) person assist for toileting. RN #1 stated that Resident #4 could usually stand alone, but confirmed Resident #4 could not use his arms at all, and when he started to fall, he could not hold his arms out to catch his fall. RN #1 confirmed Resident #4 was standing alone and no one was beside him when he fell. RN #1 confirmed the care plan was not followed. RN #1 was asked if she should have had someone in the room to help and she responded, "Yes. If I could do it all over again I would." RN #1 stated that she was alone in the room at the time of the fall and called for help so they could get Resident #4 to the Emergency Room because he was bleeding out of both ears and head.

During an observation, on 2/6/19 at 12:10 PM, while in the room where Resident #4 fell on 12/11/18, RN #1 demonstrated the distance from where she was standing and where Resident #4 was standing when the fall occurred, and was only able to touch the surveyors sleeve when attempting to reach across the bed to grab her arm. She stated she could not reach Resident #4 because it happened too fast.

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 _____	C 02/08/2019

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 656	Continued From page 23 During an observation on 2/7/19 at 9:12 AM, measurements were obtained related to the distance RN #1 was from Resident #4 when he fell on 12/11/18, according to RN #1. With the Risk Manager present, the distance from the bathroom door to where RN #1 indicated she was standing was measured seven (7) feet. The distance from the bathroom door to where Resident #4 was standing measured six (6) feet. The standard bed measured 35 inches across and in the lowest position 22.5 inches in height. The distance measured, from Resident #4 to RN #1 was approximately 43 inches across. On 2/6/19 at 2:50 PM, Certified Nursing Assistant (CNA) #2, confirmed Resident #4 had problems with balance. She stated, "His arms didn't work, so I had to help him sit up and also had to help him to the bathroom. He had to have two (2) people to help him to be safe because he couldn't help himself any, so I always asked for help. He couldn't grab anything if he started to fall and got off balance." She confirmed Resident #4's Kardex indicated the resident required assistance of staff due to his balance. On 2/6/19 at 2:55 PM, CNA #3 confirmed Resident #4 was unstable and required two (2) peopled to hold on to him to make sure he was stable, because he was unsteady with balance. On 2/6/19 at 3:04 PM, CNA #4 revealed Resident #4 came out of his room for activities and required, "Two (2) people because he was unsteady and it was hard for him to keep his balance." CNA #4 stated Resident #4's Kardex (Care Plan) listed him as two (2) person assist because he was at risk for falls.	F 656		

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 _____	C 02/08/2019

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 656	Continued From page 24 During an interview on 2/5/19 at 11:34 AM, the Physical Therapist (PT) stated Resident #4 needed Contact Guard Assist with one (1) person with their hands on him while walking. He stated if Resident #4 was just standing in the room, he would need stand by assist, which means a person needs to be close enough to catch him in case he was to lose his balance. The PT confirmed Resident #4 did have episodes, during walking and standing, of losing his balance. Further interview with the PT on 2/6/19 at 1:00 PM, revealed Resident #4 was assessed for having someone in arms reach when standing alone, related to his loss of upper body use. The PT stated, "He was flaccid, that put him at risk for not stopping his fall." The PT stated Resident #4 had been assessed and care planned this way during his whole stay at the facility. The PT stated Resident #4 was discharged from PT on 9/25/18, and the plan was for Contact Guard Assist (CGA) (Close enough to assist a resident if they began to fall) to stabilize him should he start to fall. During a phone interview on 2/5/19 at 10:17 AM, the facility Administrator at the time of Resident #4's fall on 12/11/18, stated Resident #4 had the right to stand alone. When asked if the facility had explained to Resident #4 the dangers of standing alone without assistance, as per his assessed plan of care, the Administrator stated she was not sure and would have to go back and look. During an interview on 2/4/19 at 1:50 PM, the Director of Nursing (DON) stated, "Well she broke the rule is all I can say", when asked about RN's procedures during Resident #4's fall. The DON confirmed RN #1 assisted Resident #4 to the bathroom by herself, and confirmed Resident	F 656		

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 _____	C 02/08/2019

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 656	Continued From page 25	F 656		

#4 was care planned for a two (2) person assist when being assisted to the bathroom. Further interview with the DON on 2/4/19 at 2:50 PM, revealed Resident #4's care plan was updated on 12/11/18, from one (1) person limited assistance when ambulating in the room/corridor to two (2) person physical assistance. The DON stated that if staff is not standing beside someone that is limited assist of (1) person physical assist, then they are not following the care plan of the Resident.

On 2/5/19 at 8:31 AM, in an interview, Resident #4's Responsible Party (RP) revealed that during the admission process, the plan was that two (2) people would help Resident #4 at all times. The RP stated on the day Resident #4 fell, the facility told her that he was assisted by only one (1) person, the nurse taking him to the bathroom. The RP stated when she arrived to the Emergency Room on 12/11/18, Resident #4 told her that he kept telling the nurse, "I'm falling, I'm falling", but she didn't try to stop him and he fell and busted his head open. The RP stated Resident #4 died on 12/18/18.

The Facility provided an acceptable Allegation of Compliance (AoC), which included:

On 2/5/19 at 12:30 PM, the State Agency informed the Administrator, who started in the Administrator role on 1/1/19, of an Immediate Jeopardy with substandard quality of care, due to the facility's lack of supervision and failure to report a major injury of Resident #4.

Resident #4 was admitted to the facility on 8/7/18, with diagnoses of Amyotrophic Lateral Sclerosis (ALS), Rhabdomyolysis, Bilateral Artificial Hip

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 _____	C 02/08/2019

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 656	Continued From page 26	F 656		

Joints, Dry Eye Syndrome of Bilateral Lacrimal Glands, Hypertension, and Gastroesophageal Reflux Disease. Resident #4 was care-planned at risk for falls and required assistance with most aspects of care. Resident #4's care plan dated 11/8/18, included: limited assistance times one (1) staff member for walking in room/corridor, supervision times one (1) staff member for locomotion on unit, extensive assistance times one (1) staff member for dressing, extensive assistance times one (1) staff member for eating, extensive assistance times one (1) staff member for locomotion off unit, extensive assistance times one (1) staff member for personal hygiene, extensive assistance times two (2) staff members for bathing, extensive assistance times two (2) staff members for bed mobility, extensive assistance times two (2) staff members for toilet use, and extensive assistance times two (2) staff members for transfers. Registered Nurse (RN) #1 did not follow the plan of care of Resident #4 who was extensive assistance times two (2) for toileting and transfers. Resident #4 had a Brief Interview for Mental Status (BIMS) of 12 as of 11/6/18, and participated in his plan of care. Resident #4 had a fall due to RN #1 was unable to catch Resident #4, and Resident #4 sustained a head injury on 12/11/18 at 1:50pm. Resident #4 was standing to the left side of his bed after being assisted from the bathroom by RN #1. Resident #4 requested that RN #1 straighten his covers on his bed to prepare for bed. RN #1 asked Resident #4 was he good to stand while she proceeded to walk to the opposite side of the bed. Resident #4 confirmed that he was stable with standing unassisted. RN #1 saw Resident #4 falling backwards and called out to him while reaching out towards him. RN #1 was not able to catch Resident #4 as he was falling. RN #1

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 _____	C 02/08/2019

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 656	Continued From page 27	F 656		

immediately began to assess Resident #4 who was noted to be bleeding from back of head and ears. RN #1 kept Resident #4's C-spine stable as she alerted Housekeeper #1 and CNA #1 to alert additional nursing staff. LPN #1 called the ambulance at 1:50 PM and the ambulance arrived at the facility at 1:56 PM. LPN #1 notified the Responsible Party on 12/11/18 at 2:00 PM that Resident #4 had a fall with a head injury and was being transported to the local emergency room. The Unit Manager notified the Medical Director on 12/11/18 at 2:06 PM, that Resident #4 had a fall with a head injury and was being transported to the local emergency room. Resident #4 arrived to the local emergency room on 12/11/18 at 2:20 PM . Resident #4 was diagnosed with a Basilar Skull Fracture and Cerebral Contusion and transferred to another hospital which provided a higher level of care. On 12/18/18 at 12:42 PM, the Responsible Party of Resident #4, notified the Assistant Director of Nursing (ADON) that Resident #4 expired on 12/18/18, while in the hospital. Resident #4's Death Certificate dated 12/18/18, states that Resident #4's cause of death was due to Multi-organ Failure, Basilar Skull Fracture, and fall to floor.

Corrective Actions:

1. On 12/11/18 at 1:52 PM, the Risk Manager and ADON entered the room and initiated an investigation of Resident #4's fall.

2. On 12/11/18 at 3:00 PM, the Risk Manager completed an in-service with RN #1 regarding not following the care plan of extensive assistance times two (2) for toileting and transfers to prevent falls.

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 _____	C 02/08/2019

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 656	Continued From page 28	F 656		

3. On 12/11/18 at 4:30 PM, the Risk Manager and Director of Nursing (DON) initiated a Quality Assurance Performance Improvement (QAPI) and Performance Improvement Project (PIP) to decrease falls with review of interventions to prevent accidents. Interventions included completing fall investigation after each fall, medication review after each fall, in-serviced all caregivers on reporting changes with Activity of Daily Living (ADL) support and following Kardex/Care plans, care plans to be reviewed and updated after each fall, and referrals will be made to therapy as needed.

4. On 1/8/19 at 1:45 PM, the Risk Manager held a scheduled annual in-service on preventing / reporting of abuse and neglect, completing exception reports, and resident rights. The following associates received this training: one (1) of one (1) Activity associates, three (3) of three (3) Maintenance associates, one (1) of one (1) Business Office Associates, 42 of 42 CNAs, 18 of 20 Licensed Practical Nurses (LPN), eight (8) of nine (9) RNs, 11 of 13 Dietary associates, and 12 of 12 Housekeeping/Laundry associates.

5. On 2/5/19 at 5:00 PM, an Emergency Quality Assurance (QA) meeting was held with the Medical Director, Administrator, DON, ADON, Risk Manager, Business Office Manager, Housekeeping Supervisor, Life Enrichment Director, Minimal Data Sets (MDS) Nurse Coordinator, Restorative Coordinator, Unit Manager, Admission/Marketing Nurse, and Social Services Director to discuss the events after Resident #4's fall on 12/11/18, and the importance of reporting major injuries to state agencies within two (2) hours of occurrence. The

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 _____	C 02/08/2019

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 656	Continued From page 29 QA Committee also reviewed policies on supervision and prevention of accidents, abuse/neglect, following care plan, and observing for change in condition. There were no changes made to current facility policies. 6. On the evening of 2/5/19, between 5:30 PM-9:00 PM, Nurse Managers including the Social Services Director, Unit Manager, Medicare Nurse, MDS Coordinator, Restorative Coordinator, Admissions/Marketing Nurse, and ADON audited 87 of 87 residents for needs of assistance with ADLs comparing a new fall risk screen to the individual resident's plan of care and Kardex. No discrepancies were noted and no changes were made to the care plan of the 87 residents audited. 7. On 2/5/19 at 5:30 PM through 2/6/19 at 11:45 AM, the Risk Manager and DON completed all in-services for all staff members on supervision and prevention of accidents, reporting requirements for major injuries, and following the care plan and updating plan of care upon a resident's change of condition. Nine (9) of nine (9) RNs, 20 of 20 LPNs, 42 of 42 CNAs, 13 of 13 Dietary associates, three (3) of three (3) Maintenance associates, 12 of 12 Housekeeping/Laundry associates, and seven (7) of seven (7) Therapy associates have been in-serviced. All new hires will receive this training during new hire orientation by the Risk Manager. 8. On 2/5/19 at 6:00 PM, the Pharmacy Consultant completed a pharmacy review of nine (9) residents who fell in January 2019, with no concerns noted. 9. On 2/5/19 at 6:03 PM, the Risk Manager	F 656		

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 _____	C 02/08/2019

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 656	Continued From page 30	F 656		

notified the State Licensing Agency of the completed investigation of Resident #4's fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture.

10. On 2/5/19 at 6:18 PM, the Risk Manager notified the Medicaid Fraud Control Unit (Attorney General) office that Resident #4 had a fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture.

11. On 2/5/19 at 6:22 PM, the Risk Manager notified the local Police Department that Resident #4 had a fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture.

12. On 2/6/19 at 12:10 PM, the Risk Manager audited all other Exception Reports since 8/1/18, for major injuries, with zero (0) of 142 Exception Reports resulting in major injuries.

13. The Administrator will report all results of the established monitoring to the Quality Assurance Committee meeting for the immediate corrective plan of action of any deficient practice.

14. No associate can work until they have received this in-service training.

The facility alleges that all corrective actions were completed on 2/6/19, and Immediate Jeopardy removed as of 2/7/19.

Validation of the Allegation of Compliance included:
The SA validated through record review and

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 _____	C 02/08/2019

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 656	Continued From page 31	F 656		

interview that Resident #4 was admitted on 8/7/18, with a diagnosis of ALS, and was care planned for two (2) person assistance for transfer and toileting. The SA validated that Resident #4 fell on 12/11/18, after RN #1 assisted him to the toilet without assistance and left him standing, unassisted, as the foot of the bed while she went to the other side of the bed, out of arms reach of the resident. The SA validated Resident #4 was transferred to the hospital and diagnosed with a Basilar Skull fracture and Cerebral Contusion, and subsequently expired on 12/18/18. The SA validated notification to the RP and the Medical Director.

The SA validated the facility's Corrective Actions:
1. The SA validated through interviews and record review that on 12/11/18, the Risk Manager and ADON initiated an investigation of Resident #4's fall.

2. The SA validated through interviews and record review that on 12/11/18, the Risk Manager completed an in-service with RN #1 regarding not following the care plan of extensive assistance times two (2) for toileting and transfers to prevent falls.

3. The SA validated through interviews and record review that on 12/11/18, the Risk Manager and Director of Nursing (DON) initiated a Quality Assurance Performance Improvement (QAPI) and Performance Improvement Project (PIP) to decrease falls with review of interventions to prevent accidents. Interventions included completing fall investigation after each fall, medication review after each fall, in-serviced all caregivers on reporting changes with Activity of Daily Living (ADL) support and following

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 _____	C 02/08/2019

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 656	Continued From page 32	F 656		

Kardex/Care plans, care plans to be reviewed and updated after each fall, and referrals will be made to therapy as needed.

4. The SA validated through interviews and record review that on 1/8/19, the Risk Manager held a scheduled annual in-service on preventing/reporting of abuse and neglect, completing exception reports, and resident rights. The following associates received this training: one (1) of one (1) Activity associates, three (3) of three (3) Maintenance associates, one (1)of one (1) Business Office Associates, 42 of 42 CNAs, 18 of 20 Licensed Practical Nurses (LPN), eight (8) of nine (9) RNs, 11 of 13 Dietary associates, and 12 of 12 Housekeeping/Laundry associates.

5. The SA validated through interviews, sign-in sheets, and record review, that on 2/5/19, an Emergency Quality Assurance (QA) meeting was held with the Medical Director, Administrator, DON, ADON, Risk Manager, Business Office Manager, Housekeeping Supervisor, Life Enrichment Director, Minimal Data Sets (MDS) Nurse Coordinator, Restorative Coordinator, Unit Manager, Admission/Marketing Nurse, and Social Services Director to discuss the events after Resident #4's fall on 12/11/18, and the importance of reporting major injuries to state agencies within two (2) hours of occurrence. The QA Committee also reviewed policies on supervision and prevention of accidents, abuse/neglect, following care plan, and observing for change in condition. There were no changes made to current facility policies.

6. The SA validated through interviews and record review that on the evening of 2/5/19, Nurse Managers including the Social Services

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 _____	C 02/08/2019

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 656	Continued From page 33	F 656		

Director, Unit Manager, Medicare Nurse, MDS Coordinator, Restorative Coordinator, Admissions/Marketing Nurse, and ADON audited 87 of 87 residents for needs of assistance with ADLs, comparing a new fall risk screen to the individual resident's plan of care and Kardex. No discrepancies were noted and no changes were made to the care plan of the 87 residents audited.

7. The SA validated through interviews and record review on 2/5/19, through 2/6/19, the Risk Manager and DON completed all in-services for all staff members on supervision and prevention of accidents, reporting requirements for major injuries, and following care plan and updating plan of care upon a resident's change of condition. Nine (9) of (9) RNs, 20 of 20 LPNs, 42 of 42 CNAs, 13 of 13 Dietary associates, three (3) of (3) Maintenance associates, 12 of 12 Housekeeping/Laundry associates, and seven (7) of (7) Therapy associates have been in-serviced. The SA validated that all new hires will receive this training during new hire orientation by the Risk Manager.

8. The SA validated through interviews and record review that on 2/5/19, the Pharmacy Consultant completed a pharmacy review of nine (9) residents who fell in January 2019, with no concerns noted.

9. The SA validated through interviews and record review on 2/5/19, the Risk Manager notified the State Licensing Agency of the completed investigation of Resident #4's fall on 12/11/18, which resulted in death on 12/18/18 due to Multi-organ Failure and Basilar Skull Fracture.

10. The SA validated through interviews and

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 _____	C 02/08/2019

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 656	Continued From page 34 record review on 2/5/19, the Risk Manager notified the Medicaid Fraud Control Unit (Attorney General) office that Resident #4 had a fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture. 11. The SA validated through interviews and record review on 2/5/19 at 6:22, the Risk Manager notified the local Police Department that Resident #4 had a fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture. 12. The SA validated through interviews and record review on 2/6/19, the Risk Manager audited all other Exception Reports since 8/1/18, for major injuries with zero (0) of 142 Exception Reports resulting in major injuries. 13. The SA validated through interview the Administrator will report all results of the established monitoring to the Quality Assurance Committee meeting for the immediate corrective plan of action of any deficient practice. 14. The SA validated through interviews and record review that no associate worked until they had received this in-service training. The SA validated that all corrective actions were completed on 2/6/19, and the Immediate Jeopardy removed as of 2/7/19.	F 656		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		3/4/19

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 _____	C 02/08/2019

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 689	Continued From page 35 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: CI MS #15652 Based on observation, interviews, record review, and facility statement, the facility failed to provide adequate assistance as assessed and care planned, to prevent an accident, which resulted in major injury/death, for one (1) of seven (7) residents reviewed, Resident #4. Resident #4 was assessed and care planned for two (2) person assistance with toileting and transfer, and one (1) person assistance for mobility. Resident #1 fell and received a Head Injury and Skull Fracture when Registered Nurse (RN) #1 was unable to reach him when he became unbalanced, while left unassisted at the bedside. RN #1 assisted Resident #4 to the bathroom by herself on 12/11/18, then left the resident on one (1) side of the bed while she went to the other side to adjust his bed covers. RN #1 was approximately 43 inches away from Resident #4, with the resident's bed between them, when Resident #4, who was left standing alone, fell and hit his head on the floor. Resident #4 sustained a head injury and skull fracture on 12/11/18, and died on 12/18/18. The death certificate listed the cause of death as Multi-organ Failure, Basilar Skull Fracture, and fall to the floor. Resident #4 had a diagnosis of Amyotrophic Lateral Sclerosis (ALS)/Lou Gehrig's disease, a nervous system disease that causes progressive muscle	F 689	1.On 12/11/18 RN#1 immediately assessed Resident #4 and called out to other staff for additional help.On 12/11/18 the Risk Manager completed an in-service with Registered Nurse (RN) #1 regarding following care plans to decrease falls. On 12/11/18 the Risk Manager and Director of Nursing (DON) initiated a Quality Assurance Performance Improvement (QAPI) and Performance Improvement Project (PIP) to decrease falls. On 12/11/18 all staff was in-serviced by the Risk Manager on reporting changes with Activity of Daily Living (ADL) support and following Kardex/Care plans, care plans to be reviewed and updated after each fall by Risk Manager. 2.The facility will make daily rounds observing for other residents that may be affected by the deficient practice cited. On 2/5/19 Nurse Managers audited 87 of 87 residents for needs of assistance with ADLs comparing a new fall risk screen to the individual resident's plan of care and Kardex. No discrepancies were noted and no changes were made to the care plan of the 87 residents audited. All new hires will receive this training during new hire orientation by the Risk Manager.	

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 _____	C 02/08/2019

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 689	Continued From page 36 weakness. The facility's failure to provide supervision/assistance, per assessment and care plan, to prevent accidents and hazards, resulted in the injury and death of Resident #4 , and placed other residents assessed/care planned for transfer/mobility assistance, in a situation that was likely to cause serious injury, harm, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), that began on 12/11/18, when Resident #4 fell, while left standing alone, and RN #1 was not close enough to provide assistance to break and/or prevent his fall. On 2/5/19 at 12:30 PM, the SA notified the facility's Administrator of the IJ and SQC. The facility submitted an acceptable Allegation of Compliance (AOC) on 2/7/19, in which the facility alleged all corrective actions were completed on 2/6/19, and the IJ removed on 2/7/19. The SA validated the AOC, and determined the IJ was removed prior to exit. Therefore the scope and severity for 42 CFR(s) 483.25 (d)(1)(2)-Free of Accidents/Supervision/Devices, F689, was lowered from a "J" to a scope and severity of a "D", while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of a post exit statement on letterhead, from the Director of Nursing (DON) on 2/11/19,	F 689	3.On 2/5/19 a Quality Assurance (QA) meeting was held with the Medical Director to discuss the events after Resident #4's fall on 12/11/18. The QA Committee also reviewed policies on supervision and prevention of accidents, abuse/neglect, following care plan, and observing for change in condition. There were no changes made to current facility policies. All residents Care Plans and Kardex's will be audited weekly by Nurse Managers for ADL's support to ensure accuracy. Random staff interviews will be completed on all shifts by Nurse Managers weekly to ensure accurate resident ADL support.On 2/5/19 through 2/6/19 the Risk Manager and DON completed in-services for all staff members, to include therapy, on supervision and prevention of accidents, reporting requirements for major injuries, and following the care plan and updating plan of care upon a resident's change of condition to prevent falls. 4.The Administrator will report all results of the established monitoring of random staff interviews on all shifts regarding ADL support and following Kardex/Care Plans to the Quality Assurance Committee monthly meeting for the immediate corrective plan of action of any deficient practice. QA committee will make recommendations as needed.	

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 _____	C 02/08/2019

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 689	Continued From page 37	F 689		

revealed the facility did not have a policy in place for assessing residents for preventing accident/hazards with known assistance needs. This statement noted the facility performs "Fall Risk Screens" on admission and quarterly to determine fall risks.

The facility admitted Resident #4 on 8/7/18, with the diagnoses of Amyotrophic Lateral Sclerosis (ALS)/Lou Gehrig's disease, Gastro-Esophageal Reflux Disease, High Blood Pressure and Presence of an Artificial Hip Joint. The Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 11/6/18, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) of 12, and was cognitively intact.

A review of Resident #4's "Fall Risk Screen", dated 11/7/18, revealed Resident #4 scored 11. The Fall Risk Screen assessment noted, "If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls." This assessment was electronically signed by the Restorative Coordinator, Licensed Practical Nurse (LPN).

Review of the Physical Therapy (PT) Progress and Discharge Summary, dated 9/25/18, revealed Resident #4 was discharged from PT and required, "Stand by assistance/close supervision (close enough to reach patient if assist needed)."

Review of the Physician's Progress Notes, for Resident #4, dated 12/4/19, revealed an entry which noted the resident reported he is no longer able to go to the bathroom without assistance due to muscle weakness in his legs. This note was signed by the Nurse Practitioner (NP).

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 _____	C 02/08/2019

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 689	Continued From page 38	F 689		

A review of the Care Plan, dated 8/7/18, with a target date of 2/6/19, revealed Resident #4 was at risk for falls, with no interventions related to staff assistance when ambulating. This Care Plan also noted Resident #4 had an Activities of Daily Living (ADL) Deficit and would receive the following assistance: Extensive assistance of two (2) persons to walk in the room/corridor, extensive assistance of one (1) person for locomotion off the unit, extensive assistance of two (2) persons for toilet use, extensive assistance of two (2) persons for transfers, and supervision of one (1) person with locomotion on the unit. Review of a second Care Plan, dated 8/7/18, with the same Target Date of 2/6/19, listed that Resident #4 required extensive assistance by two (2) persons with no resolved date listed, and also listed a resolved intervention of limited assist of one (1) person to walk in the room/corridor, with the resolved date of 12/11/18, on the day Resident #4 fell. Extensive assistance requires staff holding on to the resident and doing most of the task. Limited assistance requires hands on, but resident doing most of the task. Supervision requires that staff is available and guiding/cueing the resident to do a task.

A review of the facility's "Fall Scene Investigation Report", dated 12/11/18 at 1:50 PM, unsigned, documented Resident #4 fell to the floor while standing at the bedside. The resident was noted alert and oriented. This report noted Resident #4 requested RN #1 to adjust his covers while he stood at the foot of the bed. A diagram, of Resident #4's and RN #1's position was documented, with RN #1 on the right side of the bed, and Resident #4 on the left side of the bed. This report noted Resident #4 lost his balance while standing at the foot of the bed. The report

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 _____	C 02/08/2019

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 689	Continued From page 39	F 689		

documented assistance was increased to two (2) persons for ambulation.

A review of the facility's "Exception Report", dated 12/12/18, revealed Resident #4 lost his balance, on 12/11/18 at 1:50 PM, while standing. This report noted Resident #4 had bleeding from his head and ears after his fall and was in pain at a level of 10, on a scale from one (1) to 10, with 10 being the most severe. This report was signed by RN #1 on 12/12/18. This report noted a statement by RN #1, which revealed she was assisting Resident #4 back to bed when Resident #4 asked her to straighten his bed and when she went around the bed, Resident #4 lost his balance and fell.

Review of the Ambulance report, dated 12/11/18, revealed Resident #4 was found in the floor, alert and oriented x 4 (person, place, time, situation). The report noted the Patient had a blood pool behind his head and was bleeding from the left ear. The report documented that Resident #4 stated the staff stood him up and dropped him. The report documented the resident had a laceration/hematoma to the back of the skull and bleeding from the ear. The resident was transported to the hospital.

Review of Resident #4's Computerized Tomography (CT) scan, dated 12/11/18, revealed, "The study is significant for evidence of a hairline fracture left temporal bone extending into the external auditory canal with fluid possibly blood left external cord canal. Exam also shows what appears to be a very minimal amount of subarachnoid air in the posterior fossa on the left adjacent to the temporal bone."

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 _____	C 02/08/2019

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 689	Continued From page 40	F 689		

Review of the hospital Discharge Summary, with a discharge date of 12/18/18, revealed Resident #4 expired on 12/18/18, as a result of a Basilar Skull Fracture, fall at the Nursing Home, and a Cerebral Contusion.

A review of Resident #4's Certificate of Death, dated 12/18/18 at 4:54 AM, revealed the cause of death was Multi-organ Failure, due to Basilar Skull Fracture, as a consequence of a fall to the Floor.

In an interview on 2/4/19 at 2:10 PM, RN #1 stated that on 12/11/18, she assisted Resident #4 to the bathroom and he wanted his bed straightened. RN #1 stated that she stood Resident #4 by the bathroom door and asked him if he was okay, and he stated he was. RN #1 stated she was straightening Resident #4's bed and when she looked up, Resident #4 was falling. RN #1 stated that she could not get to Resident #4 in time to catch him and he fell, hitting his head on the floor. RN #1 confirmed that she was alone in the room at the time and called for help, so they could get him to the Emergency Room (ER), because Resident #4 was bleeding out of both ears and head. RN #1 confirmed Resident #4 had been assessed and care planned for (2) person assistance for toileting. RN #1 stated that Resident#4 could usually stand alone, but confirmed Resident #4 could not use his arms at all, and when he started to fall, he could not hold his arms out to catch anything. She stated the resident could not catch himself. RN #1 confirmed Resident #4 was standing alone and no one was beside him when he fell. RN #1 was asked if she should have had someone in the room to help, and responded, "Yes, if I could do it all over again I would."

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 _____	C 02/08/2019

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 689	Continued From page 41 In an interview and observation on 2/6/19 at 12:00 PM-12:10 PM, RN #1 revealed Resident #4 was on the left side of the bed in front of the bathroom door and was approximately two (2) feet from the end of the bed when he fell. RN #1 demonstrated the distance from where she was standing and where Resident #4 was standing when the fall occurred on 12/11/18, in the resident's room. RN #1 was only able to touch the surveyor's sleeve when attempting to reach across the bed, where she indicated Resident #4's position was on the day of the fall. She stated she could not reach Resident #4, because it happened too fast. During an observation on 2/7/19 at 9:12 AM, measurements were obtained with the Risk Manager present, as to the location (identified by RN #1) of Resident #4 and RN #1, when Resident #4 fell on 12/11/18. The distance from the bathroom door to where RN #1 indicated she was standing, was measured at seven (7) feet. The distance from the bathroom door to where Resident #4 was standing measured six (6) feet. The standard bed measured 35 inches across and in the lowest position 22.5 inches in height. The distance measured, from the location RN #1 had indicated both she and the resident was located prior to his fall, was 43 inches across. In an interview, on 2/6/19 at 2:50 PM, Certified Nursing Assistant (CNA) #2 stated Resident #4's arms didn't work, so she had to help him sit up and also had to help him to the bathroom. The CNA stated the resident had to have two (2) people to help him to be safe, because he couldn't help himself any, so she always asked for help. The CNA stated the resident couldn't	F 689		

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 _____	C 02/08/2019

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 689	Continued From page 42	F 689		

grab anything if he started to fall and got off balance. CNA #2 confirmed Resident #4 had concerns with keeping his balance.

In an interview on 2/6/19 at 2:55 PM, CNA #3 revealed Resident #4 required two (2) person assistance to go to the bathroom and she would help the assigned CNA. CNA #3 stated, "Nobody walked him by himself, there was always two (2) of us to hold onto him to make sure he was stable." CNA #3 confirmed Resident #4 was unsteady on his feet.

In an interview on 2/6/19 at 3:04 PM, CNA #4 revealed that Resident #4 came out of his room for activities. The CNA stated Resident #4 required two (2) people for assistance, because he was unsteady and it was hard for him to keep his balance. CNA #4 stated Resident #4 required two (2) person assist, because he was at risk for falls.

In an interview on 2/5/19 at 11:34 AM, the Physical Therapist (PT) revealed Resident #4 was a one (1) person assist with walking and this was mainly because he didn't have much control over his upper extremity, and his balance. The PT stated Resident #4 was Contact Guard Assist with one (1) person with their hands on him while walking, and if Resident #4 was just standing in the room, he would need stand by assist, which means a person needs to be close enough to catch him in case he was to lose his balance. The PT confirmed Resident #4 did have episodes, while walking, of losing his balance. The PT stated when standing, someone always stood by Resident #4, in case he lost his balance. When asked if Resident #4 was safe to stand alone, the PT replied, "Only if you are close enough to catch

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 _____	C 02/08/2019

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 689	Continued From page 43	F 689		

him if he lost his balance." Further interview with the PT on 2/6/19 at 1:00 PM, confirmed Resident #4 was assessed for having someone in arms reach when standing alone, related to his loss of upper body use. The PT stated, "He was flaccid, that put him at risk for not stopping his fall." The PT stated Resident #4 was discharged from PT on 9/25/18, and was on Contact Guard Assist (CGA), which means staff are close enough to assist and stabilize a resident if they began to fall. The PT stated in regards to Resident #4's condition, "With loss of upper body function, balance would always be a problem. I can't say what happened, but balance was a concern."

Interview with Resident #4's Primary Care Physician (PCP)/Medical Director on 2/4/19 at 10:30 AM, reveled he had been notified that Resident #4 had a fall with a brain bleed, skull fracture, and later death. The PCP stated he was notified there was only one (1) nurse in the room when the resident fell. The PCP stated he was not sure if there was supposed to be more assistance in the room, but Resident #4 had no use of his arms, related to his ALS/Lou Gehrig's disease diagnosis, and was declining in status.

During an interview on 2/5/19 at 10:17 AM, the facility Administrator at the time of Resident #4's fall on 12/11/18, stated the investigation revealed the nurse, (RN #1), had helped Resident #4 to the bathroom, walked back to the bed, and Resident #4 requested RN #1 straighten his bed linens. The Administrator stated RN #1 said she asked the resident if he was okay to stand, and RN #1 reported the Resident said that he was. The Administrator stated it was reported that Resident #4 was on the left side of the bed from the foot, and the nurse was on the right side of

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 _____	C 02/08/2019

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 689	Continued From page 44	F 689		

the bed from the foot, and when RN #1 looked up, Resident #4 was falling. The Administrator stated the Nurse could not get to Resident #4 in time to catch him; he fell to the floor, hitting his head. The Administrator stated Resident #4 had the right to stand alone. When asked if the facility had explained to Resident #4 the dangers of standing alone, without assistance, as per his assessed plan of care, the Administrator stated she was not sure and would have to look. When asked if the nurse was on one (1) side of the bed, and the resident on the other, was that considered one (1) person assistance, the Administrator stated, "I don't know." The Administrator stated that Resident #4 was one (1) person assist with ambulation, and two (2) person assist when toileting. The Administrator responded that she did not know if any staff was holding on to the resident, or within arm's length, when he fell.

In an interview on 2/4/19 at 1:50 PM, the Director of Nursing (DON) stated of RN #1, "Well she broke the rule is all I can say". The DON confirmed RN #1 was assisting Resident #4 to the bathroom by herself, and confirmed Resident #4 was assessed and care planned for two (2) person assistance with toileting.

In an interview on 2/4/19 at 2:50 PM, the DON stated Resident #4 was at risk for falls due to the (ALS) diagnosis, and did not have use of his upper extremities. She stated if staff was not standing right beside someone, who required limited assistance of one (1) person, then they were not following the care plan of the Resident. Further interview with the DON on 2/5/19 at 9:30 AM, revealed when Resident #4 fell on 12/11/18, that RN #1 should have been holding on to him.

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 _____	C 02/08/2019

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 689	Continued From page 45	F 689		

Interview with Resident #4's Responsible Party (RP) on 2/5/19 at 8:31 AM, revealed during the admission process it was discussed that two (2) people would help Resident #4 at all times. She stated on the day Resident #4 fell, she was told that only one (1) person, the nurse, assisted him to the bathroom. The RP stated when she arrived at the Emergency Room on 12/11/18, Resident #4 was still awake and told her that he kept telling the nurse, "I'm falling, I'm falling", but that she didn't try to stop him and he fell, busting his head open. The RP stated she returned to the facility on 12/18/18, the day Resident #4 died, and notified the facility that he had expired.

In a post exit interview on 2/11/19 at 10:54 AM, the Nurse Practitioner (NP) stated she alternated visits with the PCP and recalled the progress notes regarding Resident #4. She stated she remembered this resident specifically because of his diagnosis of Lou Gehrig's disease. The NP stated when she first saw Resident #4, he was able to walk some, but reported on the last visit that he had progressive weakness to his legs and was unable to go to the bathroom without assistance. The NP stated, because of the Lou Gehrig's disease, he would have only gotten worse, not better.

The Facility provided an acceptable Allegation of Compliance (AoC), which included:

On 2/5/19 at 12:30 PM, the State Agency informed the Administrator, who started in the Administrator role on 1/1/19, of an Immediate Jeopardy with substandard quality of care, due to the facility's lack of supervision and failure to report a major injury of Resident #4.

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 _____	C 02/08/2019

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 689	Continued From page 46	F 689		

Resident #4 was admitted to the facility on 8/7/18, with diagnoses of Amyotrophic Lateral Sclerosis (ALS), Rhabdomyolysis, Bilateral Artificial Hip Joints, Dry Eye Syndrome of Bilateral Lacrimal Glands, Hypertension, and Gastroesophageal Reflux Disease. Resident #4 was care-planned at risk for falls and required assistance with most aspects of care. Resident #4's care plan dated 11/8/18, included: limited assistance times one (1) staff member for walking in room/corridor, supervision times one (1) staff member for locomotion on unit, extensive assistance times one (1) staff member for dressing, extensive assistance times one (1) staff member for eating, extensive assistance times one (1) staff member for locomotion off unit, extensive assistance times one (1) staff member for personal hygiene, extensive assistance times two (2) staff members for bathing, extensive assistance times two (2) staff members for bed mobility, extensive assistance times two (2) staff members for toilet use, and extensive assistance times two (2) staff members for transfers. Registered Nurse (RN) #1 did not follow the plan of care of Resident #4 who was extensive assistance times two (2) for toileting and transfers. Resident #4 had a Brief Interview for Mental Status (BIMS) of 12 as of 11/6/18, and participated in his plan of care. Resident #4 had a fall due to RN #1 was unable to catch Resident #4, and Resident #4 sustained a head injury on 12/11/18 at 1:50 PM. Resident #4 was standing to the left side of his bed after being assisted from the bathroom by RN #1. Resident #4 requested that RN #1 straighten his covers on his bed to prepare for bed. RN #1 asked Resident #4 was he good to stand while she proceeded to walk to the opposite side of the bed. Resident #4 confirmed that he was stable

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 _____	C 02/08/2019

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 689	Continued From page 47	F 689		

with standing unassisted. RN #1 saw Resident #4 falling backwards and called out to him while reaching out towards him. RN #1 was not able to catch Resident #4 as he was falling. RN #1 immediately began to assess Resident #4 who was noted to be bleeding from back of head and ears. RN #1 kept Resident #4's C-spine stable as she alerted Housekeeper #1 and CNA #1 to alert additional nursing staff. LPN #1 called the ambulance at 1:50 PM and the ambulance arrived at the facility at 1:56 PM. LPN #1 notified the Responsible Party on 12/11/18 at 2:00 PM that Resident #4 had a fall with a head injury and was being transported to the local emergency room. The Unit Manager notified the Medical Director on 12/11/18 at 2:06 PM, that Resident #4 had a fall with a head injury and was being transported to the local emergency room. Resident #4 arrived to the local emergency room on 12/11/18 at 2:20 PM . Resident #4 was diagnosed with a Basilar Skull Fracture and Cerebral Contusion and transferred to another hospital which provided a higher level of care. On 12/18/18 at 12:42 PM, the Responsible Party of Resident #4, notified the Assistant Director of Nursing (ADON) that Resident #4 expired on 12/18/18, while in the hospital. Resident #4's Death Certificate dated 12/18/18, states that Resident #4's cause of death was due to Multi-organ Failure, Basilar Skull Fracture, and fall to floor.

Corrective Actions:

1. On 12/11/18 at 1:52 PM, the Risk Manager and ADON entered the room and initiated an investigation of Resident #4's fall.

2. On 12/11/18 at 3:00 PM, the Risk Manager

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 _____	C 02/08/2019

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 689	Continued From page 48 completed an in-service with RN #1 regarding not following the care plan of extensive assistance times two (2) for toileting and transfers to prevent falls. 3. On 12/11/18 at 4:30 PM, the Risk Manager and Director of Nursing (DON) initiated a Quality Assurance Performance Improvement (QAPI) and Performance Improvement Project (PIP) to decrease falls with review of interventions to prevent accidents. Interventions included completing fall investigation after each fall, medication review after each fall, in-serviced all caregivers on reporting changes with Activity of Daily Living (ADL) support and following Kardex/Care plans, care plans to be reviewed and updated after each fall, and referrals will be made to therapy as needed. 4. On 1/8/19 at 1:45 PM, the Risk Manager held a scheduled annual in-service on preventing / reporting of abuse and neglect, completing exception reports, and resident rights. The following associates received this training: one (1) of one (1) Activity associates, three (3) of three (3) Maintenance associates, one (1) of one (1) Business Office Associates, 42 of 42 CNAs, 18 of 20 Licensed Practical Nurses (LPN), eight (8) of nine (9) RNs, 11 of 13 Dietary associates, and 12 of 12 Housekeeping/Laundry associates. 5. On 2/5/19 at 5:00 PM, an Emergency Quality Assurance (QA) meeting was held with the Medical Director, Administrator, DON, ADON, Risk Manager, Business Office Manager, Housekeeping Supervisor, Life Enrichment Director, Minimal Data Sets (MDS) Nurse Coordinator, Restorative Coordinator, Unit Manager, Admission/Marketing Nurse, and Social	F 689		

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 _____	C 02/08/2019

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 689	Continued From page 49 Services Director to discuss the events after Resident #4's fall on 12/11/18, and the importance of reporting major injuries to state agencies within two (2) hours of occurrence. The QA Committee also reviewed policies on supervision and prevention of accidents, abuse/neglect, following care plan, and observing for change in condition. There were no changes made to current facility policies. 6. On the evening of 2/5/19, between 5:30 PM-9:00 PM, Nurse Managers including the Social Services Director, Unit Manager, Medicare Nurse, MDS Coordinator, Restorative Coordinator, Admissions/Marketing Nurse, and ADON audited 87 of 87 residents for needs of assistance with ADLs comparing a new fall risk screen to the individual resident's plan of care and Kardex. No discrepancies were noted and no changes were made to the care plan of the 87 residents audited. 7. On 2/5/19 at 5:30 PM through 2/6/19 at 11:45 AM, the Risk Manager and DON completed all in-services for all staff members on supervision and prevention of accidents, reporting requirements for major injuries, and following the care plan and updating plan of care upon a resident's change of condition. Nine (9) of nine (9) RNs, 20 of 20 LPNs, 42 of 42 CNAs, 13 of 13 Dietary associates, three (3) of three (3) Maintenance associates, 12 of 12 Housekeeping/Laundry associates, and seven (7) of seven (7) Therapy associates have been in-serviced. All new hires will receive this training during new hire orientation by the Risk Manager. 8. On 2/5/19 at 6:00 PM, the Pharmacy Consultant completed a pharmacy review of nine	F 689		

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 _____	C 02/08/2019

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 689	Continued From page 50 (9) residents who fell in January 2019, with no concerns noted. 9. On 2/5/19 at 6:03 PM, the Risk Manager notified the State Licensing Agency of the completed investigation of Resident #4's fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture. 10. On 2/5/19 at 6:18 PM, the Risk Manager notified the Medicaid Fraud Control Unit (Attorney General) office that Resident #4 had a fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture. 11. On 2/5/19 at 6:22 PM, the Risk Manager notified the local Police Department that Resident #4 had a fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture. 12. On 2/6/19 at 12:10 PM, the Risk Manager audited all other Exception Reports since 8/1/18, for major injuries, with zero (0) of 142 Exception Reports resulting in major injuries. 13. The Administrator will report all results of the established monitoring to the Quality Assurance Committee meeting for the immediate corrective plan of action of any deficient practice. 14. No associate can work until they have received this in-service training. The facility alleges that all corrective actions were completed on 2/6/19, and Immediate Jeopardy removed as of 2/7/19.	F 689		

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 _____	C 02/08/2019

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 689	Continued From page 51 Validation of the Allegation of Compliance included: The SA validated through record review and interview that Resident #4 was admitted on 8/7/18, with a diagnosis of ALS, and was care planned for two (2) person assistance for transfer and toileting. The SA validated that Resident #4 fell on 12/11/18, after RN #1 assisted him to the toilet without assistance and left him standing, unassisted, as the foot of the bed while she went to the other side of the bed, out of arms reach of the resident. The SA validated Resident #4 was transferred to the hospital and diagnosed with a Basilar Skull fracture and Cerebral Contusion, and subsequently expired on 12/18/18. The SA validated notification to the RP and the Medical Director. The SA validated the facility's Corrective Actions: 1. The SA validated through interviews and record review that on 12/11/18, the Risk Manager and ADON initiated an investigation of Resident #4's fall. 2. The SA validated through interviews and record review that on 12/11/18, the Risk Manager completed an in-service with RN #1 regarding not following the care plan of extensive assistance times two (2) for toileting and transfers to prevent falls. 3. The SA validated through interviews and record review that on 12/11/18, the Risk Manager and Director of Nursing (DON) initiated a Quality Assurance Performance Improvement (QAPI) and Performance Improvement Project (PIP) to decrease falls with review of interventions to prevent accidents. Interventions included	F 689		

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 _____	C 02/08/2019

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 689	Continued From page 52 completing fall investigation after each fall, medication review after each fall, in-serviced all caregivers on reporting changes with Activity of Daily Living (ADL) support and following Kardex/Care plans, care plans to be reviewed and updated after each fall, and referrals will be made to therapy as needed. 4. The SA validated through interviews and record review that on 1/8/19, the Risk Manager held a scheduled annual in-service on preventing/reporting of abuse and neglect, completing exception reports, and resident rights. The following associates received this training: one (1) of one (1) Activity associates, three (3) of three (3) Maintenance associates, one (1)of one (1) Business Office Associates, 42 of 42 CNAs, 18 of 20 Licensed Practical Nurses (LPN), eight (8) of nine (9) RNs, 11 of 13 Dietary associates, and 12 of 12 Housekeeping/Laundry associates. 5. The SA validated through interviews, sign-in sheets, and record review, that on 2/5/19, an Emergency Quality Assurance (QA) meeting was held with the Medical Director, Administrator, DON, ADON, Risk Manager, Business Office Manager, Housekeeping Supervisor, Life Enrichment Director, Minimal Data Sets (MDS) Nurse Coordinator, Restorative Coordinator, Unit Manager, Admission/Marketing Nurse, and Social Services Director to discuss the events after Resident #4's fall on 12/11/18, and the importance of reporting major injuries to state agencies within two (2) hours of occurrence. The QA Committee also reviewed policies on supervision and prevention of accidents, abuse/neglect, following care plan, and observing for change in condition. There were no changes made to current facility policies.	F 689		

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 _____	C 02/08/2019

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 689	Continued From page 53 6. The SA validated through interviews and record review that on the evening of 2/5/19, Nurse Managers including the Social Services Director, Unit Manager, Medicare Nurse, MDS Coordinator, Restorative Coordinator, Admissions/Marketing Nurse, and ADON audited 87 of 87 residents for needs of assistance with ADLs, comparing a new fall risk screen to the individual resident's plan of care and Kardex. No discrepancies were noted and no changes were made to the care plan of the 87 residents audited. 7. The SA validated through interviews and record review on 2/5/19, through 2/6/19, the Risk Manager and DON completed all in-services for all staff members on supervision and prevention of accidents, reporting requirements for major injuries, and following care plan and updating plan of care upon a resident's change of condition. Nine (9) of (9) RNs, 20 of 20 LPNs, 42 of 42 CNAs, 13 of 13 Dietary associates, three (3) of (3) Maintenance associates, 12 of 12 Housekeeping/Laundry associates, and seven (7) of (7) Therapy associates have been in-serviced. The SA validated that all new hires will receive this training during new hire orientation by the Risk Manager. 8. The SA validated through interviews and record review that on 2/5/19, the Pharmacy Consultant completed a pharmacy review of nine (9) residents who fell in January 2019, with no concerns noted. 9. The SA validated through interviews and record review on 2/5/19, the Risk Manager notified the State Licensing Agency of the completed investigation of Resident #4's fall on	F 689		

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 _____	C 02/08/2019

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 689	Continued From page 54 12/11/18, which resulted in death on 12/18/18 due to Multi-organ Failure and Basilar Skull Fracture. 10. The SA validated through interviews and record review on 2/5/19, the Risk Manager notified the Medicaid Fraud Control Unit (Attorney General) office that Resident #4 had a fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture. 11. The SA validated through interviews and record review on 2/5/19 at 6:22, the Risk Manager notified the local Police Department that Resident #4 had a fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture. 12. The SA validated through interviews and record review on 2/6/19, the Risk Manager audited all other Exception Reports since 8/1/18, for major injuries with zero (0) of 142 Exception Reports resulting in major injuries. 13. The SA validated through interview the Administrator will report all results of the established monitoring to the Quality Assurance Committee meeting for the immediate corrective plan of action of any deficient practice. 14. The SA validated through interviews and record review that no associate worked until they had received this in-service training. The SA validated that all corrective actions were completed on 2/6/19, and the Immediate Jeopardy removed as of 2/7/19.	F 689		

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
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 000	Initial Comments CI MS #15652 The State Agency (SA) conducted a partial extended survey for Complaint Investigation (CI) MS #15652, from 2/4/19 to 2/8/19. The SA substantiated the complaint for failure to implement the care plan and provide adequate supervision and assistance to prevent a fall resulting in major injury and subsequent death of a resident, Resident #4. During the survey, the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M640. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SCQ), that began on 12/11/18, when the facility failed to follow the care plan and provide adequate supervision and assistance to prevent an accident/fall with major injury and subsequent death, for a resident with a history of balance issues, who required assistance with transfer and mobility. Resident #4 sustained a head injury and skull fracture on 12/11/18, when Registered Nurse #1 ambulated him to the bathroom without assistance, then left him on the opposite side of the bed, unassisted, and not in arm's reach. RN #1 was approximately 43 inches away from Resident #4, with the resident's bed between them, when Resident #4 became unbalanced and fell, hitting his head on the floor. RN #1 was not able to catch the resident or break his fall, due to being on the opposite side of the bed, instead of within arms reach of the resident, to assist with any loss of balance. Resident #4 had a diagnosis of Amyotrophic Lateral Sclerosis (ALS) or Lou Gehrig's disease that is a nervous system disease that causes progressive muscle	M 000		

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

Electronically Signed | 03/08/19

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
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 000	Continued From page 1 weakness. Resident #4 had been assessed and care planned for assistance, due to balance issues. The facility's failure to provide adequate assistance, as assessed and care planned for Resident #4, resulted in an accident/fall with head injury and Skull Fracture on 12/11/18, and death on 12/18/18, and placed other residents assessed with needed assistance, in a situation that was likely to cause serious injury, harm, impairment, or death. On 2/5/19 at 12:30 PM, the SA notified the facility's Administrator of the IJ and SQC. The IJ and SQC existed at: M640-Accidents The facility submitted an acceptable Allegation of Compliance (AOC) on 2/7/19, in which the facility alleged all corrective actions were completed on 2/6/19, and the IJ removed on 2/7/19. The SA validated the AOC, and determined the IJ was removed, prior to exit. Therefore the scope and severity for M640- Accident was lowered from a "Level IV" to a "Level II", while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. The facility held a license for 90 beds, with a census of 86.	M 000		
M 640	45.21.8 Accidents Accidents. The facility shall ensure that the	M 640		3/4/19

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
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 2 residents ' environment remains as free of accident hazards as possible, and adequate supervision shall be provided to prevent accidents. If an unexplained accident occurs, this injury must be investigated and reported to appropriate state agencies. This Statute is not met as evidenced by: Level IV CI MS #15652 Based on observation, interviews, record review, and facility statement, the facility failed to provide adequate assistance as assessed and care planned, to prevent an accident, which resulted in major injury/death, for one (1) of seven (7) residents reviewed, Resident #4. Resident #4 was assessed and care planned for two (2) person assistance with toileting and transfer, and one (1) person assistance for mobility. Resident #1 fell and received a Head Injury and Skull Fracture when Registered Nurse (RN) #1 was unable to reach him when he became unbalanced, while left unassisted at the bedside. RN #1 assisted Resident #4 to the bathroom by herself on 12/11/18, then left the resident on one (1) side of the bed while she went to the other side to adjust his bed covers. RN #1 was approximately 43 inches away from Resident #4, with the resident's bed between them, when Resident #4, who was left standing alone, fell and hit his head on the floor. Resident #4 sustained a head injury and skull fracture on 12/11/18, and died on 12/18/18. The death certificate listed the cause of death as Multi-organ Failure, Basilar Skull Fracture, and fall to the floor. Resident #4 had a diagnosis of Amyotrophic Lateral Sclerosis (ALS)/Lou Gehrig's disease, a nervous system	M 640	1.On 12/11/18 RN#1 immediately assessed Resident #4 and called out to other staff for additional help.On 12/11/18 the Risk Manager completed an in-service with Registered Nurse (RN) #1 regarding following care plans to decrease falls. On 12/11/18 the Risk Manager and Director of Nursing (DON) initiated a Quality Assurance Performance Improvement (QAPI) and Performance Improvement Project (PIP) to decrease falls. On 12/11/18 all staff was in-serviced by the Risk Manager on reporting changes with Activity of Daily Living (ADL) support and following Kardex/Care plans, care plans to be reviewed and updated after each fall by Risk Manager. 2.The facility will make daily rounds observing for other residents that may be affected by the deficient practice cited. On 2/5/19 Nurse Managers audited 87 of 87 residents for needs of assistance with ADLs comparing a new fall risk screen to the individual resident's plan of care and Kardex. No discrepancies were noted and no changes were made to the care plan of the 87 residents audited. All new hires will receive this training during new hire orientation by the Risk Manager. 3.On 2/5/19 a Quality Assurance (QA)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 3 disease that causes progressive muscle weakness. The facility's failure to provide supervision/assistance, per assessment and care plan, to prevent accidents and hazards, resulted in the injury and death of Resident #4 , and placed other residents assessed/care planned for transfer/mobility assistance, in a situation that was likely to cause serious injury, harm, impairment, or death. This situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC), that began on 12/11/18, when Resident #4 fell, while left standing alone, and RN #1 was not close enough to provide assistance to break and/or prevent his fall. On 2/5/19 at 12:30 PM, the SA notified the facility's Administrator of the IJ and SQC. The facility submitted an acceptable Allegation of Compliance (AOC) on 2/7/19, in which the facility alleged all corrective actions were completed on 2/6/19, and the IJ removed on 2/7/19. The SA validated the AOC, and determined the IJ was removed prior to exit. Therefore the scope and severity for 42 CFR(s) 483.25 (d)(1)(2)-Free of Accidents/Supervision/Devices, F689, was lowered from a "J" to a scope and severity of a "D", while the facility developed a plan of correction to monitor the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of a post exit statement on letterhead, from the Director of Nursing (DON) on 2/11/19,	M 640	meeting was held with the Medical Director to discuss the events after Resident #4's fall on 12/11/18. The QA Committee also reviewed policies on supervision and prevention of accidents, abuse/neglect, following care plan, and observing for change in condition. There were no changes made to current facility policies. All residents Care Plans and Kardex's will be audited weekly by Nurse Managers for ne ADL's support to ensure accuracy. Random staff interviews will be completed on all shifts by Nurse Managers weekly to ensure accurate resident ADL support.On 2/5/19 through 2/6/19 the Risk Manager and DON completed in-services for all staff members, to include therapy, on supervision and prevention of accidents, reporting requirements for major injuries, and following the care plan and updating plan of care upon a resident's change of condition. 4.The Administrator will report all results of the established monitoring of random staff interviews on all shifts regarding ADL support and following Kardex/Care Plans to the Quality Assurance Committee meeting for the immediate corrective plan of action of any deficient practice. QA committee will make recommendations as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 4 revealed the facility did not have a policy in place for assessing residents for preventing accident/hazards with known assistance needs. This statement noted the facility performs "Fall Risk Screens" on admission and quarterly to determine fall risks. The facility admitted Resident #4 on 8/7/18, with the diagnoses of Amyotrophic Lateral Sclerosis (ALS)/Lou Gehrig's disease, Gastro-Esophageal Reflux Disease, High Blood Pressure and Presence of an Artificial Hip Joint. The Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 11/6/18, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) of 12, and was cognitively intact. A review of Resident #4's "Fall Risk Screen", dated 11/7/18, revealed Resident #4 scored 11. The Fall Risk Screen assessment noted, "If the total score is 10 or greater, the resident should be considered at HIGH RISK for potential falls." This assessment was electronically signed by the Restorative Coordinator, Licensed Practical Nurse (LPN). Review of the Physical Therapy (PT) Progress and Discharge Summary, dated 9/25/18, revealed Resident #4 was discharged from PT and required, "Stand by assistance/close supervision (close enough to reach patient if assist needed)." Review of the Physician's Progress Notes, for Resident #4, dated 12/4/19, revealed an entry which noted the resident reported he is no longer able to go to the bathroom without assistance due to muscle weakness in his legs. This note was signed by the Nurse Practitioner (NP). A review of the Care Plan, dated 8/7/18, with a	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 5 target date of 2/6/19, revealed Resident #4 was at risk for falls, with no interventions related to staff assistance when ambulating. This Care Plan also noted Resident #4 had an Activities of Daily Living (ADL) Deficit and would receive the following assistance: Extensive assistance of two (2) persons to walk in the room/corridor, extensive assistance of one (1) person for locomotion off the unit, extensive assistance of two (2) persons for toilet use, extensive assistance of two (2) persons for transfers, and supervision of one (1) person with locomotion on the unit. Review of a second Care Plan, dated 8/7/18, with the same Target Date of 2/6/19, listed that Resident #4 required extensive assistance by two (2) persons with no resolved date listed, and also listed a resolved intervention of limited assist of one (1) person to walk in the room/corridor, with the resolved date of 12/11/18, on the day Resident #4 fell. Extensive assistance requires staff holding on to the resident and doing most of the task. Limited assistance requires hands on, but resident doing most of the task. Supervision requires that staff is available and guiding/cueing the resident to do a task. A review of the facility's "Fall Scene Investigation Report", dated 12/11/18 at 1:50 PM, unsigned, documented Resident #4 fell to the floor while standing at the bedside. The resident was noted alert and oriented. This report noted Resident #4 requested RN #1 to adjust his covers while he stood at the foot of the bed. A diagram, of Resident #4's and RN #1's position was documented, with RN #1 on the right side of the bed, and Resident #4 on the left side of the bed. This report noted Resident #4 lost his balance while standing at the foot of the bed. The report documented assistance was increased to two (2) persons for ambulation.	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 6 A review of the facility's "Exception Report", dated 12/12/18, revealed Resident #4 lost his balance, on 12/11/18 at 1:50 PM, while standing. This report noted Resident #4 had bleeding from his head and ears after his fall and was in pain at a level of 10, on a scale from one (1) to 10, with 10 being the most severe. This report was signed by RN #1 on 12/12/18. This report noted a statement by RN #1, which revealed she was assisting Resident #4 back to bed when Resident #4 asked her to straighten his bed and when she went around the bed, Resident #4 lost his balance and fell. Review of the Ambulance report, dated 12/11/18, revealed Resident #4 was found in the floor, alert and oriented x 4 (person, place, time, situation). The report noted the Patient had a blood pool behind his head and was bleeding from the left ear. The report documented that Resident #4 stated the staff stood him up and dropped him. The report documented the resident had a laceration/hematoma to the back of the skull and bleeding from the ear. The resident was transported to the hospital. Review of Resident #4's Computerized Tomography (CT) scan, dated 12/11/18, revealed, "The study is significant for evidence of a hairline fracture left temporal bone extending into the external auditory canal with fluid possibly blood left external cord canal. Exam also shows what appears to be a very minimal amount of subarachnoid air in the posterior fossa on the left adjacent to the temporal bone." Review of the hospital Discharge Summary, with a discharge date of 12/18/18, revealed Resident #4 expired on 12/18/18, as a result of a Basilar	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 7 Skull Fracture, fall at the Nursing Home, and a Cerebral Contusion. A review of Resident #4's Certificate of Death, dated 12/18/18 at 4:54 AM, revealed the cause of death was Multi-organ Failure, due to Basilar Skull Fracture, as a consequence of a fall to the Floor. In an interview on 2/4/19 at 2:10 PM, RN #1 stated that on 12/11/18, she assisted Resident #4 to the bathroom and he wanted his bed straightened. RN #1 stated that she stood Resident #4 by the bathroom door and asked him if he was okay, and he stated he was. RN #1 stated she was straightening Resident #4's bed and when she looked up, Resident #4 was falling. RN #1 stated that she could not get to Resident #4 in time to catch him and he fell, hitting his head on the floor. RN #1 confirmed that she was alone in the room at the time and called for help, so they could get him to the Emergency Room (ER), because Resident #4 was bleeding out of both ears and head. RN #1 confirmed Resident #4 had been assessed and care planned for (2) person assistance for toileting. RN #1 stated that Resident#4 could usually stand alone, but confirmed Resident #4 could not use his arms at all, and when he started to fall, he could not hold his arms out to catch anything. She stated the resident could not catch himself. RN #1 confirmed Resident #4 was standing alone and no one was beside him when he fell. RN #1 was asked if she should have had someone in the room to help, and responded, "Yes, if I could do it all over again I would." In an interview and observation on 2/6/19 at 12:00 PM-12:10 PM, RN #1 revealed Resident #4 was on the left side of the bed in front of the	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 8 bathroom door and was approximately two (2) feet from the end of the bed when he fell. RN #1 demonstrated the distance from where she was standing and where Resident #4 was standing when the fall occurred on 12/11/18, in the resident's room. RN #1 was only able to touch the surveyor's sleeve when attempting to reach across the bed, where she indicated Resident #4's position was on the day of the fall. She stated she could not reach Resident #4, because it happened too fast. During an observation on 2/7/19 at 9:12 AM, measurements were obtained with the Risk Manager present, as to the location (identified by RN #1) of Resident #4 and RN #1, when Resident #4 fell on 12/11/18. The distance from the bathroom door to where RN #1 indicated she was standing, was measured at seven (7) feet. The distance from the bathroom door to where Resident #4 was standing measured six (6) feet. The standard bed measured 35 inches across and in the lowest position 22.5 inches in height. The distance measured, from the location RN #1 had indicated both she and the resident was located prior to his fall, was 43 inches across. In an interview, on 2/6/19 at 2:50 PM, Certified Nursing Assistant (CNA) #2 stated Resident #4's arms didn't work, so she had to help him sit up and also had to help him to the bathroom. The CNA stated the resident had to have two (2) people to help him to be safe, because he couldn't help himself any, so she always asked for help. The CNA stated the resident couldn't grab anything if he started to fall and got off balance. CNA #2 confirmed Resident #4 had concerns with keeping his balance. In an interview on 2/6/19 at 2:55 PM, CNA #3	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 9	M 640		

revealed Resident #4 required two (2) person assistance to go to the bathroom and she would help the assigned CNA. CNA #3 stated, "Nobody walked him by himself, there was always two (2) of us to hold onto him to make sure he was stable." CNA #3 confirmed Resident #4 was unsteady on his feet.

In an interview on 2/6/19 at 3:04 PM, CNA #4 revealed that Resident #4 came out of his room for activities. The CNA stated Resident #4 required two (2) people for assistance, because he was unsteady and it was hard for him to keep his balance. CNA #4 stated Resident #4 required two (2) person assist, because he was at risk for falls.

In an interview on 2/5/19 at 11:34 AM, the Physical Therapist (PT) revealed Resident #4 was a one (1) person assist with walking and this was mainly because he didn't have much control over his upper extremity, and his balance. The PT stated Resident #4 was Contact Guard Assist with one (1) person with their hands on him while walking, and if Resident #4 was just standing in the room, he would need stand by assist, which means a person needs to be close enough to catch him in case he was to lose his balance. The PT confirmed Resident #4 did have episodes, while walking, of losing his balance. The PT stated when standing, someone always stood by Resident #4, in case he lost his balance. When asked if Resident #4 was safe to stand alone, the PT replied, "Only if you are close enough to catch him if he lost his balance." Further interview with the PT on 2/6/19 at 1:00 PM, confirmed Resident #4 was assessed for having someone in arms reach when standing alone, related to his loss of upper body use. The PT stated, "He was flaccid, that put him at risk for not stopping his fall." The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 10 PT stated Resident #4 was discharged from PT on 9/25/18, and was on Contact Guard Assist (CGA), which means staff are close enough to assist and stabilize a resident if they began to fall. The PT stated in regards to Resident #4's condition, "With loss of upper body function, balance would always be a problem. I can't say what happened, but balance was a concern." Interview with Resident #4's Primary Care Physician (PCP)/Medical Director on 2/4/19 at 10:30 AM, reveled he had been notified that Resident #4 had a fall with a brain bleed, skull fracture, and later death. The PCP stated he was notified there was only one (1) nurse in the room when the resident fell. The PCP stated he was not sure if there was supposed to be more assistance in the room, but Resident #4 had no use of his arms, related to his ALS/Lou Gehrig's disease diagnosis, and was declining in status. During an interview on 2/5/19 at 10:17 AM, the facility Administrator at the time of Resident #4's fall on 12/11/18, stated the investigation revealed the nurse, (RN #1), had helped Resident #4 to the bathroom, walked back to the bed, and Resident #4 requested RN #1 straighten his bed linens. The Administrator stated RN #1 said she asked the resident if he was okay to stand, and RN #1 reported the Resident said that he was. The Administrator stated it was reported that Resident #4 was on the left side of the bed from the foot, and the nurse was on the right side of the bed from the foot, and when RN #1 looked up, Resident #4 was falling. The Administrator stated the Nurse could not get to Resident #4 in time to catch him; he fell to the floor, hitting his head. The Administrator stated Resident #4 had the right to stand alone. When asked if the facility had explained to Resident #4 the dangers of	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 11 standing alone, without assistance, as per his assessed plan of care, the Administrator stated she was not sure and would have to look. When asked if the nurse was on one (1) side of the bed, and the resident on the other, was that considered one (1) person assistance, the Administrator stated, "I don't know." The Administrator stated that Resident #4 was one (1) person assist with ambulation, and two (2) person assist when toileting. The Administrator responded that she did not know if any staff was holding on to the resident, or within arm's length, when he fell. In an interview on 2/4/19 at 1:50 PM, the Director of Nursing (DON) stated of RN #1, "Well she broke the rule is all I can say". The DON confirmed RN #1 was assisting Resident #4 to the bathroom by herself, and confirmed Resident #4 was assessed and care planned for two (2) person assistance with toileting. In an interview on 2/4/19 at 2:50 PM, the DON stated Resident #4 was at risk for falls due to the (ALS) diagnosis, and did not have use of his upper extremities. She stated if staff was not standing right beside someone, who required limited assistance of one (1) person, then they were not following the care plan of the Resident. Further interview with the DON on 2/5/19 at 9:30 AM, revealed when Resident #4 fell on 12/11/18, that RN #1 should have been holding on to him. Interview with Resident #4's Responsible Party (RP) on 2/5/19 at 8:31 AM, revealed during the admission process it was discussed that two (2) people would help Resident #4 at all times. She stated on the day Resident #4 fell, she was told that only one (1) person, the nurse, assisted him to the bathroom. The RP stated when she arrived	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 12 at the Emergency Room on 12/11/18, Resident #4 was still awake and told her that he kept telling the nurse, "I'm falling, I'm falling", but that she didn't try to stop him and he fell, busting his head open. The RP stated she returned to the facility on 12/18/18, the day Resident #4 died, and notified the facility that he had expired. In a post exit interview on 2/11/19 at 10:54 AM, the Nurse Practitioner (NP) stated she alternated visits with the PCP and recalled the progress notes regarding Resident #4. She stated she remembered this resident specifically because of his diagnosis of Lou Gehrig's disease. The NP stated when she first saw Resident #4, he was able to walk some, but reported on the last visit that he had progressive weakness to his legs and was unable to go to the bathroom without assistance. The NP stated, because of the Lou Gehrig's disease, he would have only gotten worse, not better. The Facility provided an acceptable Allegation of Compliance (AoC), which included: On 2/5/19 at 12:30 PM, the State Agency informed the Administrator, who started in the Administrator role on 1/1/19, of an Immediate Jeopardy with substandard quality of care, due to the facility's lack of supervision and failure to report a major injury of Resident #4. Resident #4 was admitted to the facility on 8/7/18, with diagnoses of Amyotrophic Lateral Sclerosis (ALS), Rhabdomyolysis, Bilateral Artificial Hip Joints, Dry Eye Syndrome of Bilateral Lacrimal Glands, Hypertension, and Gastroesophageal Reflux Disease. Resident #4 was care-planned at risk for falls and required assistance with most aspects of care. Resident #4's care plan dated	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 13 11/8/18, included: limited assistance times one (1) staff member for walking in room/corridor, supervision times one (1) staff member for locomotion on unit, extensive assistance times one (1) staff member for dressing, extensive assistance times one (1) staff member for eating, extensive assistance times one (1) staff member for locomotion off unit, extensive assistance times one (1) staff member for personal hygiene, extensive assistance times two (2) staff members for bathing, extensive assistance times two (2) staff members for bed mobility, extensive assistance times two (2) staff members for toilet use, and extensive assistance times two (2) staff members for transfers. Registered Nurse (RN) #1 did not follow the plan of care of Resident #4 who was extensive assistance times two (2) for toileting and transfers. Resident #4 had a Brief Interview for Mental Status (BIMS) of 12 as of 11/6/18, and participated in his plan of care. Resident #4 had a fall due to RN #1 was unable to catch Resident #4, and Resident #4 sustained a head injury on 12/11/18 at 1:50 PM. Resident #4 was standing to the left side of his bed after being assisted from the bathroom by RN #1. Resident #4 requested that RN #1 straighten his covers on his bed to prepare for bed. RN #1 asked Resident #4 was he good to stand while she proceeded to walk to the opposite side of the bed. Resident #4 confirmed that he was stable with standing unassisted. RN #1 saw Resident #4 falling backwards and called out to him while reaching out towards him. RN #1 was not able to catch Resident #4 as he was falling. RN #1 immediately began to assess Resident #4 who was noted to be bleeding from back of head and ears. RN #1 kept Resident #4's C-spine stable as she alerted Housekeeper #1 and CNA #1 to alert additional nursing staff. LPN #1 called the ambulance at 1:50 PM and the ambulance	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 14 arrived at the facility at 1:56 PM. LPN #1 notified the Responsible Party on 12/11/18 at 2:00 PM that Resident #4 had a fall with a head injury and was being transported to the local emergency room. The Unit Manager notified the Medical Director on 12/11/18 at 2:06 PM, that Resident #4 had a fall with a head injury and was being transported to the local emergency room. Resident #4 arrived to the local emergency room on 12/11/18 at 2:20 PM . Resident #4 was diagnosed with a Basilar Skull Fracture and Cerebral Contusion and transferred to another hospital which provided a higher level of care. On 12/18/18 at 12:42 PM, the Responsible Party of Resident #4, notified the Assistant Director of Nursing (ADON) that Resident #4 expired on 12/18/18, while in the hospital. Resident #4's Death Certificate dated 12/18/18, states that Resident #4's cause of death was due to Multi-organ Failure, Basilar Skull Fracture, and fall to floor. Corrective Actions: 1. On 12/11/18 at 1:52 PM, the Risk Manager and ADON entered the room and initiated an investigation of Resident #4's fall. 2. On 12/11/18 at 3:00 PM, the Risk Manager completed an in-service with RN #1 regarding not following the care plan of extensive assistance times two (2) for toileting and transfers to prevent falls. 3. On 12/11/18 at 4:30 PM, the Risk Manager and Director of Nursing (DON) initiated a Quality Assurance Performance Improvement (QAPI) and Performance Improvement Project (PIP) to decrease falls with review of interventions to prevent accidents. Interventions included	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 15 completing fall investigation after each fall, medication review after each fall, in-serviced all caregivers on reporting changes with Activity of Daily Living (ADL) support and following Kardex/Care plans, care plans to be reviewed and updated after each fall, and referrals will be made to therapy as needed. 4. On 1/8/19 at 1:45 PM, the Risk Manager held a scheduled annual in-service on preventing / reporting of abuse and neglect, completing exception reports, and resident rights. The following associates received this training: one (1) of one (1) Activity associates, three (3) of three (3) Maintenance associates, one (1) of one (1) Business Office Associates, 42 of 42 CNAs, 18 of 20 Licensed Practical Nurses (LPN), eight (8) of nine (9) RNs, 11 of 13 Dietary associates, and 12 of 12 Housekeeping/Laundry associates. 5. On 2/5/19 at 5:00 PM, an Emergency Quality Assurance (QA) meeting was held with the Medical Director, Administrator, DON, ADON, Risk Manager, Business Office Manager, Housekeeping Supervisor, Life Enrichment Director, Minimal Data Sets (MDS) Nurse Coordinator, Restorative Coordinator, Unit Manager, Admission/Marketing Nurse, and Social Services Director to discuss the events after Resident #4's fall on 12/11/18, and the importance of reporting major injuries to state agencies within two (2) hours of occurrence. The QA Committee also reviewed policies on supervision and prevention of accidents, abuse/neglect, following care plan, and observing for change in condition. There were no changes made to current facility policies. 6. On the evening of 2/5/19, between 5:30 PM-9:00 PM, Nurse Managers including the	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 16 Social Services Director, Unit Manager, Medicare Nurse, MDS Coordinator, Restorative Coordinator, Admissions/Marketing Nurse, and ADON audited 87 of 87 residents for needs of assistance with ADLs comparing a new fall risk screen to the individual resident's plan of care and Kardex. No discrepancies were noted and no changes were made to the care plan of the 87 residents audited. 7. On 2/5/19 at 5:30 PM through 2/6/19 at 11:45 AM, the Risk Manager and DON completed all in-services for all staff members on supervision and prevention of accidents, reporting requirements for major injuries, and following the care plan and updating plan of care upon a resident's change of condition. Nine (9) of nine (9) RNs, 20 of 20 LPNs, 42 of 42 CNAs, 13 of 13 Dietary associates, three (3) of three (3) Maintenance associates, 12 of 12 Housekeeping/Laundry associates, and seven (7) of seven (7) Therapy associates have been in-serviced. All new hires will receive this training during new hire orientation by the Risk Manager. 8. On 2/5/19 at 6:00 PM, the Pharmacy Consultant completed a pharmacy review of nine (9) residents who fell in January 2019, with no concerns noted. 9. On 2/5/19 at 6:03 PM, the Risk Manager notified the State Licensing Agency of the completed investigation of Resident #4's fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture. 10. On 2/5/19 at 6:18 PM, the Risk Manager notified the Medicaid Fraud Control Unit (Attorney General) office that Resident #4 had a fall on	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 17 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture. 11. On 2/5/19 at 6:22 PM, the Risk Manager notified the local Police Department that Resident #4 had a fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture. 12. On 2/6/19 at 12:10 PM, the Risk Manager audited all other Exception Reports since 8/1/18, for major injuries, with zero (0) of 142 Exception Reports resulting in major injuries. 13. The Administrator will report all results of the established monitoring to the Quality Assurance Committee meeting for the immediate corrective plan of action of any deficient practice. 14. No associate can work until they have received this in-service training. The facility alleges that all corrective actions were completed on 2/6/19, and Immediate Jeopardy removed as of 2/7/19. Validation of the Allegation of Compliance included: The SA validated through record review and interview that Resident #4 was admitted on 8/7/18, with a diagnosis of ALS, and was care planned for two (2) person assistance for transfer and toileting. The SA validated that Resident #4 fell on 12/11/18, after RN #1 assisted him to the toilet without assistance and left him standing, unassisted, as the foot of the bed while she went to the other side of the bed, out of arms reach of the resident. The SA validated Resident #4 was transferred to the hospital and diagnosed with a	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 18 Basilar Skull fracture and Cerebral Contusion, and subsequently expired on 12/18/18. The SA validated notification to the RP and the Medical Director. The SA validated the facility's Corrective Actions: 1. The SA validated through interviews and record review that on 12/11/18, the Risk Manager and ADON initiated an investigation of Resident #4's fall. 2. The SA validated through interviews and record review that on 12/11/18, the Risk Manager completed an in-service with RN #1 regarding not following the care plan of extensive assistance times two (2) for toileting and transfers to prevent falls. 3. The SA validated through interviews and record review that on 12/11/18, the Risk Manager and Director of Nursing (DON) initiated a Quality Assurance Performance Improvement (QAPI) and Performance Improvement Project (PIP) to decrease falls with review of interventions to prevent accidents. Interventions included completing fall investigation after each fall, medication review after each fall, in-serviced all caregivers on reporting changes with Activity of Daily Living (ADL) support and following Kardex/Care plans, care plans to be reviewed and updated after each fall, and referrals will be made to therapy as needed. 4. The SA validated through interviews and record review that on 1/8/19, the Risk Manager held a scheduled annual in-service on preventing/reporting of abuse and neglect, completing exception reports, and resident rights. The following associates received this training: one (1) of one (1) Activity associates, three (3) of	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 19 three (3) Maintenance associates, one (1)of one (1) Business Office Associates, 42 of 42 CNAs, 18 of 20 Licensed Practical Nurses (LPN), eight (8) of nine (9) RNs, 11 of 13 Dietary associates, and 12 of 12 Housekeeping/Laundry associates. 5. The SA validated through interviews, sign-in sheets, and record review, that on 2/5/19, an Emergency Quality Assurance (QA) meeting was held with the Medical Director, Administrator, DON, ADON, Risk Manager, Business Office Manager, Housekeeping Supervisor, Life Enrichment Director, Minimal Data Sets (MDS) Nurse Coordinator, Restorative Coordinator, Unit Manager, Admission/Marketing Nurse, and Social Services Director to discuss the events after Resident #4's fall on 12/11/18, and the importance of reporting major injuries to state agencies within two (2) hours of occurrence. The QA Committee also reviewed policies on supervision and prevention of accidents, abuse/neglect, following care plan, and observing for change in condition. There were no changes made to current facility policies. 6. The SA validated through interviews and record review that on the evening of 2/5/19, Nurse Managers including the Social Services Director, Unit Manager, Medicare Nurse, MDS Coordinator, Restorative Coordinator, Admissions/Marketing Nurse, and ADON audited 87 of 87 residents for needs of assistance with ADLs, comparing a new fall risk screen to the individual resident's plan of care and Kardex. No discrepancies were noted and no changes were made to the care plan of the 87 residents audited. 7. The SA validated through interviews and record review on 2/5/19, through 2/6/19, the Risk Manager and DON completed all in-services for	M 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 20 all staff members on supervision and prevention of accidents, reporting requirements for major injuries, and following care plan and updating plan of care upon a resident's change of condition. Nine (9) of (9) RNs, 20 of 20 LPNs, 42 of 42 CNAs, 13 of 13 Dietary associates, three (3) of (3) Maintenance associates, 12 of 12 Housekeeping/Laundry associates, and seven (7) of (7) Therapy associates have been in-serviced. The SA validated that all new hires will receive this training during new hire orientation by the Risk Manager. 8. The SA validated through interviews and record review that on 2/5/19, the Pharmacy Consultant completed a pharmacy review of nine (9) residents who fell in January 2019, with no concerns noted. 9. The SA validated through interviews and record review on 2/5/19, the Risk Manager notified the State Licensing Agency of the completed investigation of Resident #4's fall on 12/11/18, which resulted in death on 12/18/18 due to Multi-organ Failure and Basilar Skull Fracture. 10. The SA validated through interviews and record review on 2/5/19, the Risk Manager notified the Medicaid Fraud Control Unit (Attorney General) office that Resident #4 had a fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture. 11. The SA validated through interviews and record review on 2/5/19 at 6:22, the Risk Manager notified the local Police Department that Resident #4 had a fall on 12/11/18, which resulted in death on 12/18/18, due to Multi-organ Failure and Basilar Skull Fracture.	M 640		

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
	77RA	A. BUILDING: _____ B. WING _____	C 02/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEVIEW HEALTH AND REHABILITATION CEI	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) COMPLETE DATE
M 640	Continued From page 21 12. The SA validated through interviews and record review on 2/6/19, the Risk Manager audited all other Exception Reports since 8/1/18, for major injuries with zero (0) of 142 Exception Reports resulting in major injuries. 13. The SA validated through interview the Administrator will report all results of the established monitoring to the Quality Assurance Committee meeting for the immediate corrective plan of action of any deficient practice. 14. The SA validated through interviews and record review that no associate worked until they had received this in-service training. The SA validated that all corrective actions were completed on 2/6/19, and the Immediate Jeopardy removed as of 2/7/19.	M 640		