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	09SR	A. BUILDING: _____ B. WING _____	01/20/2022

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SHEARER-RICHARDSON MEMORIAL NURSING HOMI	512 ROCKWELL DRIVE OKOLONA, MS 38860

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification and complaint survey in the facility from 1/18/22 through 1/20/22. The SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm with deficiencies cited at M 500- Resident Rights related to visitation and M 655 Special Needs. The complaint survey for MS #17803 and MS #17688 was not substantiated and no deficiencies were cited. The facility was licensed for 73 beds and had a census of 71 at the time of the survey.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or	M 500		3/10/22

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M 500	Continued From page 1 nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;	M 500		

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M 500	Continued From page 2 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately	M 500		

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M 500	Continued From page 3 with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II	M 500	1/19/22-The Responsible Party for Resident #27 was notified by the Social	

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M 500	Continued From page 4 Based on observation, staff, and responsible party interview, record review, facility policy review, and Centers for Medicare and Medicaid Services (CMS) Quality Safety and Oversight (QSO) Memo review, the facility failed to allow visitation for 44 of 71 residents in the west side of the building during an outbreak of COVID-19. Findings Include: Review of the facility policy titled, "Interim COVID-19 Visitation Policy" with no implementation or revision date revealed (Facility Proper Name) will restrict visitation of all visitors and non-essential health care personnel for the duration of the declared national and public health emergency related to COVID-19. Exceptions will be in accordance with current CMS directives and CDC recommendations, or as directed by state government (whichever is more stringent). Review of the Center for Medicare and Medicaid Services (CMS) Quality Safety and Oversight (QSO) Memo with a reference # of "Ref: QSO-20-39-NH" dated "Revised 11-12-21" revealed under, "Memorandum Summary" " Visitation is now allowed for all residents at all times." An observation on 1/18/22 at 10:00 AM, an observation revealed a notice on the front door of the facility that read, "Visitation starts on Saturday at 12 noon and ends at 6 PM." On 1/18/22 at 10:38 AM, an interview with the Administrator stated that the notice on the front door was old and that she removed it. The Administrator revealed that they have been allowing visitors, but they must dress out with	M 500	Service Director that they could resume visitation immediately. Social services has placed a progress note into Resident #27's chart related to this discussion. 1/19/22-The social service department identified that 42 of 42 resident who resided on the west side of the facility had been or could have been affected by the stated deficient practice. 1/21/22-An Ad Hoc meeting was completed by the Administrator to inform department managers of the need to replace the Interim Covid-19 Visitation Policy with an updated Interim Visitation Policy that only includes a list of precautionary measures to be taken for visitations that require screening/monitoring of visitors for signs/symptoms of Covid-19. 1/25/22-The Ombudsman held a Resident Council meeting with 23 of 70 residents in attendance to discuss the need and requirement for the facility to allow visitation of residents' choosing at all times as outlined per CMS QSO-20-39 NH Memorandum. 1/25/22 thru 2/10/22-Social services and activity personnel completed informing 46 of the current 69 resident census of the need and requirement that the facility is to allow visitation to occur of their choosing. 2/3/22-An in-service was completed by the facility's Nursing Consultant regarding visitation for 31 of 76 staff members. The other 45 staff members will be in-serviced by 2/28/2022 regarding the facility's visitation policy. 2/3/22-The Medical Director was informed	

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M 500	Continued From page 5 Personal Protective Equipment (PPE), especially in the West building since that is where our COVID-19 positive resident are residing. On 01/18/22 at 11:22 AM, an interview with Registered Nurse (RN) # 2 revealed that the facility had not allowed visitors on the west side for a good two weeks due to two of the residents testing positive for COVID-19. On 1/18/22 at 11:45 AM, an interview with the Director of Nurses (DON) confirmed that the facility had not allowed any visitors on the west side in about 3-4 weeks due to having positive COVID-19 residents. When questioned if the facility had reviewed the most recent QSO memo from CMS regarding allowing visitors during a COVID-19 outbreak, the DON stated that she had told them we were supposed to allow visitors into the building and had always thought that it was a bad thing to not allow families to come into the facility. On 01/18/22 at 03:09 PM, an interview with Resident # 27's Responsible Party (RP) revealed she has not been allowed to come in the west side of the facility to visit her mother for at least two weeks. Resident # 27's RP revealed that the facility called and notified her that the facility was in an outbreak again and had to be shut down for visitors and she could only call her mother on the phone to check on her. Resident # 27's RP stated, "I called to check on Mother this afternoon and the staff that answered the phone told me I could come visit her now. " On 1/19/22 at 2:19 PM, an interview with Registered Nurse-Infection Preventionist (RN-IP) confirmed that visitation was restricted during their current COVID-19 outbreak, but families	M 500	of the receipt of the facility's 2567 deficiency report with findings. 2/7/22-An Ad Hoc Quality Assurance Performance Improvement meeting was held by the Administrator regarding the facility's visitation policy non-Covid related to identify any concerns with residents' right to make choices about aspects of his or her life in the facility that are significant to the resident including visitation, with policy found to be compliant. 2/7/22-A copy of CMS QSO-20-39NH Memorandum with a revision date of 11/12/2021, was given to each departmental manager, which included the Director of Nurses(DON), Quality Assurance Nurse (QA Nurse), MDS Nurse, Social Service Director, Activity Director, Maintenance Director, Dietary Manager, Housekeeping Supervisor, Staff Development, Assistant Administrator and Receptionist to ensure that all parties involved in facility decision making are aware of the requirement to allow visitation to all residents per their choosing. 2/7/22-All staff will be in-serviced on the Interim Visitation Policy no later than 2/28/22 per snfclinic educational program. 2/7/22-Social services will audit all visitation sign-in sheets weekly beginning with the date of 1/19/22 and ending on 3/3/22 to ensure visitation are being exercised for the residents who could have been affected by the stated deficient practice. If on 2/16/22 social services identifies a possible concern with visitation of a resident, they will interview the resident if possible and/or call the	

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M 500	Continued From page 6 could come for compassionate care visits. The RN-IP revealed that the staff called all the resident's families to notify them of the COVID-19 outbreak and that visitation was shut down. The RN-IP revealed that families could come for compassionate care visits only, but the families may not have known they could come for a compassionate care visit, because we did not specifically tell them that. The RN-IP revealed that the Administrator received the CMS-QSO memos, and she denied any knowledge of the most recent update on 11/12/2021 by CMS regarding no restriction on visitation. The RN-IP revealed they would begin calling all families now to inform them they could come to visit. On 1/19/22 at 4:15 PM, an interview with the Administrator revealed that visitation was restricted in the West building where the COVID positive residents were, but not in the East building. The Administrator confirmed she received the CMS QSO memos, reviews them, and keeps a copy. On 1/20/22 at 8:45 AM, an interview with Licensed Practical Nurse (LPN) # 1 revealed that Resident # 27 does not speak. LPN # 1 revealed that all the resident's benefit from visiting with their family and friends; "they just need it." LPN # 1 stated that when the facility is shut down for visitation, then the staff must be their everything and as hard as we try, we are not able to give them the same kind of attention that a family member could. On 1/20/22 at 10:45 AM, an interview with the Administrator revealed that the policy titled, "Interim COVID-19 Visitation Policy" was implemented at the beginning of COVID-19, so it would have been around 2/2020 or 3/2020 and	M 500	responsible party to ensure individual knowledge of the visitation rule. 2/16/22-The Administrator will distribute copies of the facility's updated Interim Visitation Policy for review by the Quality Assurance Committee members including the Medical Director to allow further discussion if needed and to ensure all members are knowledgeable about the requirement rules and regulations pertaining to the residents' ability to have visits of their choosing at all times. 2/16/22-The Quality Assurance Nurse will audit for completion of the visitation tracking log for percentage of residents who have had visitors or not and for validation of responsible party or resident interviews being completed for the individual who has not had a visitor listed since 1/19/22. The results of the stated reviews will be added to the weekly Quality Assurance Performance Improvement Agenda weekly beginning 2/17/22 and ending on 3/10/22 and presented to the Quality Assurance Committee meeting beginning 2/23/22 and ending no later than 3/31/22 till further notice of an outbreak. Ongoing-If the facility incurs a future outbreak of Covid-19 the facility assigned personnel will notify the Responsible Party (RP) of the outbreak and address that visitations may continue if the resident so chooses with notation being placed in the resident's chart. Social Services will be responsible to review resident charts for proper notification of visitation and place calls to at least 10% of the RPs of the affected unit to validate that they are aware of the continuance of visitation as	

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M 500	Continued From page 7 confirmed that she believes allowing visitors to visit the residents is important. Record review of the Resident #27's Face Sheet revealed an admission date of 12/12/19 with medical diagnoses that included: Cerebral Infarction, Hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side and Memory Deficit following Cerebral Infarction. Record review of the Resident #27's nurse's note dated 1/3/2022 revealed the nurse documented that she spoke with the RP (RP's name). Notified that we have new COVID positive cases at facility, and there will be no visitation for 2 weeks. Also notified that if resident has a decline in her condition, they will be allowed to visit. Record review of the resident's Minimum Data Set with an Assessment Reference Date of 8/24/21 revealed Resident #27 had Brief Interview of Mental Status Score (BIMS) of 2, indicating that the resident has a severe cognitive deficit.	M 500	evidenced by the COVID-19 Visitation Tracking Log. The Social Services Director will report any negative findings to the Administrator or QA Nurse immediately for evaluation of deficient practice with follow up discussion with QA Committee and governing board for other corrective measures to be taken.	
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II	M 655	On 01/19/2022 the Director of Nursing replaced Resident #15's oxygen humidifier	3/10/22

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M 655	Continued From page 8 Based on observations, staff and resident interviews, record review and facility policy review, the facility failed to change oxygen (O2) tubing for, failed to date humidifier bottles for humified O2, failed to date the storage bags and failed to provide storage bags for O2 tubing, nebulizer masks and C-PAP masks for three (3) of eight (8) residents reviewed that are using the respiratory equipment and oxygen therapy for Resident #15, Resident #20, and Resident #24. Findings include: Review of facility policy titled, "Oxygen Administration," with a policy number of NP.VI-28, revealed, " ...12. Cannulas and masks should be changed and dated every other week. *Humidifier container with distilled water is NOT required unless Oxygen (O2) is ordered at four (4) liters (L)/ (per) Minute or higher." The facility policy did not contain information addressing the storage of the O2 tubing, when it was not in use, and did not contain information addressing that a date was needed on the humidifier bottle. There was not an effective date on the policy. Review of facility policy titled, "Nebulizer Policy and Procedure," revealed it did not contain information addressing the storage of a nebulizer mask, when not in use. The policy was not dated. Review of facility policy titled, "CPAP/BiPAP (Continuous Positive Airway Pressure/Bi-level Positive Airway Pressure) Cleaning," revealed, " ...6. Cover with plastic bag or completely enclosed in machine storage when not in use." The policy was not dated. Resident #15	M 655	bottle and tubing and placed a storage bag onto the oxygen concentrator and provided a storage bag for the nebulizer mask with all supplies being dated 01/19/2022. On 01/19/2022 the Director of Nursing provided Resident #20 with a storage bag for her Continuous Positive Airway Pressure mask with a new date of 01/19/2022. On 01/19/2022 the Director of Nursing replaced Resident #24's oxygen tubing and placed a storage bag onto the oxygen concentrator with a new date of 01/19/2022, which will be checked after every 14 day interval scheduled for respiratory equipment changes. On 01/24/2022 with Minimum Data Set Coordinator identified 13 of 70 residents who required the need for respiratory devices that could have been affected by the deficient practice. On 02/03/2022 the Compliance Nurse in-serviced 12 of 20 licensed nurses on proper dating and storage of respiratory equipment. The remaining 8 licensed nurses will be in-serviced on proper dating and storage of respiratory equipment no later than 02/28/2022. On 02/07/2022 the Administrator and Compliance Nurse reviewed and revised the Continuous Positive Airway Pressure and Bilevel Positive Airway Pressure, Nebulizer and Oxygen policies to include storage procedures, labeling of equipment, listed dates of review and/or revision to policy, with a 2/7/22 review/revised date. The Quality Assurance Nurse developed a Quality Assurance Performance Improvement Focus Plan on 02/07/2022,	

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M 655	Continued From page 9 An observation, on 1/18/22 at 10:55 AM, for Resident #15, revealed there was no date on the O2 humidifier bottle and there was not a storage bag, on the O2 concentrator, for the O2 tubing. An observation and interview, on 01/19/21 at 09:15 AM, with Resident #15, revealed there was a nebulizer machine, and mask being stored between Resident #15's mattress and the wall. The mask was not in a storage bag. Resident #15 stated this was where she always kept the nebulizer, used it 2-3 times a day, and had never put her nebulizer mask in a bag. An observation and interview, on 1/19/22 at 03:13 PM, with the Director of Nursing (DON), confirmed Resident #15 did not have a date on the humidification bottle, did not have an O2 tubing storage bag, and did not have a storage bag for the nebulizer mask. The DON confirmed that resident is at risk of infection because there was no date on the humidifier bottle to indicate how long it had been on the concentrator and there was no storage bag available to cover the O2 tubing and nebulizer mask, when it was not in use. Record review of the Order Summary Report revealed Resident #15 had a physician's order for Oxygen @ (at) two (2) - (to) four (4) liters (L) continuous, dated 7/20/18. Record review, of the Order Summary Report, for Resident #15, revealed physician's orders for medications to be given with a nebulizer: Albuterol Sulfate 2.5 milligrams (MG)/3 milliliters (ML) every 4 hours as needed (PRN), dated 3/25/21, and for Albuterol 2.5 MG/3ML 4 times a day, dated 3/25/21.	M 655	to include that the Staff Development Nurse will ensure professional standards are known while completing competency check offs within 10 days of hire, 6 months from hire date and annually thereafter with each nurse beginning 3/1/2022 and will be reviewed by the Administrator upon receipt of annual employee evaluation. On 02/07/2022 the Quality Assurance Nurse developed a Focus Review Plan through the facility's Quality Assurance Performance Improvement Program to include audits to be completed by the Quality Assurance Nurse and/or the Director of Nursing bi-weekly beginning 2/7/22 times 3 months with an end date no later than 5/31/22 to ensure proper equipment storage, tubing changes, humidifier bottles are changed labeled/dated. The updated policies will be presented at the next Quality Assurance Committee meeting scheduled for February 23,2022 with the Medical Director for review and approval. The Quality Assurance Nurse will report any negative findings of audits to the Administrator immediately for further review and possible corrective actions to be taken.	

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M 655	Continued From page 10 Record review of a Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/20/21, for Resident #15, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #15 is cognitively intact. Resident #20 An observation, on 1/18/21 at 02:00 PM, for Resident #20, revealed she had a C-PAP on her bedside table, with no storage bag for the mask. An observation, on 1/19/21 at 4:15 PM, revealed Resident #20's C-PAP mask was on the floor and not in a storage bag. An interview, on 1/19/21 at 04:15 PM, with Resident #20, revealed she ordered all her supplies for her personal C-PAP and changed her own tubing. Resident #20 revealed she did not allow the facility nursing staff to clean her C-PAP often and she prefers to clean her own C-PAP. Resident revealed the nursing staff had not offered her a storage bag for her C-PAP mask. Resident stated she knew it was not good for her C-PAP mask to be on the floor. Resident stated she used her C-PAP every night. An interview, on 1/19/21 at 04:25 PM, with the Director of Nursing, (DON), revealed Resident #20 cared for her personal C-PAP, preferred to order her own C-PAP supplies, and did not allow staff to touch her C-PAP. The DON stated the resident had not been offered a storage bag, by the facility, for the C-PAP mask. Record review of the Order Summary Report for Resident #20 revealed a physician's order to apply C-PAP at bedtime, dated 2/8/21.	M 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09SR	A. BUILDING: _____ B. WING _____	01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEARER-RICHARDSON MEMORIAL NURSING HOMI	512 ROCKWELL DRIVE OKOLONA, MS 38860

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M 655	Continued From page 11 Record review of a Quarterly Minimum Data Set (MDS), with an ARD of 11/10/21, for Resident #20, revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating Resident #20 is cognitively intact. Resident #24 An observation and interview, on 01/18/22 at 10:50 AM, with Resident #24, revealed O2 tubing dated 12/2/21 and a zip lock bag, for tubing storage, that was not dated. Resident #24 stated he used the O2 every night as ordered by his doctor. Resident revealed he could not recall the last day the O2 tubing had been changed. An observation and interview, on 1/19/22 at 04:20 PM, with the DON, confirmed Resident #24 had an O2 tubing on his concentrator dated for 12/2/21. The DON confirmed the tubing should have been changed since that date, should be changed every 14 days, and could cause Resident #24 to be at risk of infection for not being changed according to policy. Record review, of the Order Summary Report revealed Resident #24 has a physician's order for Oxygen at (@) 2 liters (L) at night (PM), dated 6/5/2018. Record review of an Annual Minimum Data Set (MDS), with an ARD of 11/16/21, for Resident #24, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #24 is cognitively intact.	M 655		