

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Amendment 12/07/2021 Upon secondary review with CMS Regional Office staff and State Quality Assurance review, the State Survey Agency (SSA) determined the Immediate Jeopardy to be removed on 7/8/21 for F600 and the scope and severity was lowered to "D", while the facility develops and implements a plan of correction and monitors effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Based on interviews, record reviews and facility policy review the facility failed to ensure a resident was protected from neglect as evidenced by a Temporary Nursing Assistant (TNA) neglected to obtain assistance required from licensed/certified staff when providing incontinent care that resulted in a resident obtaining a bilateral femur fracture for one (1) of three (3)	F 600	1.Immediate action(s) taken for the resident(s) found to have been affected include: On 07/03/2021, the on-call physician was made aware of Resident #31's fall, with the physician requesting x-rays of bilateral legs. On 07/03/2021, X-ray Personnel obtained the x-rays as ordered, revealing bilateral femur fractures. On 07/03/2021, the on-call doctor was made aware of the x-ray results, giving a telephone order to send Resident #31 to the emergency room. Resident #31 was transferred to the local hospital emergency department as ordered. The resident underwent intramedullary nailing surgery to her bilateral femur fractures on 7/8/2021 at an offsite orthopedic surgical center 2. Identification of other residents having	11/4/21	

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

TITLE

(X6) DATE

Electronically Signed

11/04/2021

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.

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600	Continued From page 1 residents reviewed for falls. Resident #31. On 7/3/21, TNA #1 neglected to obtain the assistance required when providing incontinent care for Resident #31. TNA #1 turned the resident to her side without removing the pillows from the resident's feet. This resulted in Resident #31 falling to the floor and sustaining bilateral femur fractures. The resident underwent intramedullary nailing surgery to her bilateral femur fractures on 7/8/21. The facility failed to protect Resident #31 and other residents from potential for further injury during the investigation process by not removing TNA #1 from the facility following the incident on 7/3/2021. The facility continued to allow TNA #1 to work until 7/05/21. The facility's failure to provide protection from abuse and neglect put Resident #31, a vulnerable resident and other residents at risk, and in a situation that caused and is likely to cause serious harm, serious injury, serious impairment, or possible death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 7/3/21 when TNA #1 provided care to Resident #31 without required assistance and the resident sustained a fall with major injury. The facility Administrator was notified of the IJ and SQC on 9/28/21 and presented with the IJ Template. The facility provided an acceptable Removal Plan on 9/30/21, in which the facility alleged that all corrective actions were completed to remove the IJ and SQC on 9/30/21, and the IJ and SQC was removed on 10/1/21. (Amendment 12/2/21 - The SSA determined the IJ and SQC to	F 600	the potential to be affected was accomplished by: After a review of Census and Daily Assignment Sheets, the Administrator concluded that 19 of the 40 residents had the potential of receiving abuse/neglect from TNA #1. 19 out 40 residents were identified as having the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Beginning 10/2/2021, the Director of Nursing (DON) will review Daily Assignment Sheets to ensure that the CNA and TNA staff remain properly paired to perform direct care weekly for a year and a log will be maintained by the DON weekly for four weeks, then monthly for three weeks, and then quarterly for a year. Beginning on 10/2/2021, the Lead CNA began observational rounds to monitor for proper staffing as set forth by the Daily Assignment Sheets, and he will continue to make these observational rounds weekly for a year, and a log will be maintained by the Lead CNA for a year. On 07/04/2021 and 07/05/2021, the Administrator continued in-servicing with staff on the topics of: ADLs and Care Plans and Care Guides, Abuse and Neglect, and Resident's Rights. On 07/05/2021, the Administrator suspended TNA #1 until further notice to complete the investigation. On 07/05/2021, the Administrator conducted and completed the investigation. On 07/12/2021, the Administrator terminated TNA #1 in efforts		

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600	Continued From page 2 be removed on 7/8/21). The State Agency (SA) determined the IJ to be removed 7/8/21 and the scope and severity for CFR 483.12(a)(1)- Freedom from Abuse, Neglect, and Exploitation (F600) was lowered to a "D", while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's policy titled "Abuse Prevention Program", revised September 2013, revealed, "Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion..." Review of the facility policy titled "Abuse and Neglect - Clinical Protocol", revised April 2013, revealed the definition of neglect as, "Failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress". Review of the facility's, "Activities of Daily Living (ADLs), Supporting" policy, revised January 12, 2021, revealed, "Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities pf daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene ...".	F 600	to prevent a reoccurrence of abuse/neglect to Resident #31. The fall of Resident #31 was taken to the QA Committee on 07/08/2021 for review. On 07/04/2021, the Administrator provided in-servicing to the Charge Nurse, Cart Nurse, Temporary Nursing Assistants, and Certified Nursing Assistants. The in-service topics included: following the Activities of Daily Living Care Plans and Care Guides, Abuse and Neglect, and Resident's Rights. On 09/16/2021, the Staff Development Nurse educated all Temporary Nursing Assistants and Certified Nursing Assistants on the subject of Temporary Nursing Assistants can provide resident care only with a Certified Nursing Assistant or Nurse present. On 9/16/2021, a form was created by the Staff Development Nurse for all TNA hire-in packets to ensure that all TNA new hires have proper education, training, and understanding that they must work directly with Certified Nursing Assistant. The Staff Development Nurse and the Administrator from a non-affiliated sister facility presented a directed in-service for all non-contracted staff, the Assistant Director of Maintenance, the Director of Housekeeping, and the Director of Therapy on Freedom From Abuse, Neglect, and Exploitation on 11/10/2021. 4.How the corrective action(s) will be monitored to ensure the practice will not reoccur? Beginning the week of 10/2/2021, the Staff Development Nurse will monitor the Lead CNA's documentation to monitor		

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600	Continued From page 3 Record review of the facility's, "Resident Rights" policy, revised December 2016, revealed, "Policy Statement, Employees shall treat all residents with kindness, respect, and dignity ...Policy Interpretation and Implementation ...c. be free from abuse, neglect, misappropriation of property and exploitation ...". Record review of the Resident Incident Report, dated 7/3/21, revealed "Incident Type: Fall/no head injury ...Date/Time: 7/03/21 02:00 PM ...Type of Injury: Fracture ...Location: Resident room ...Narrative of incident and description of injuries: Nurse entered room after being called by CNA, Resident on her knees on the floor at side of bed holding onto side rail. CNA providing incontinent care to resident, resident turned to right side of bed and she was holding to side rail CNA reports that resident started kicking her legs and fell out of the bed. To ER-X-Ray revealed bilateral femur fractures ..." Review of the local hospital Emergency Room Report dated 7/3/21 revealed Resident #31 was transferred to the local hospital emergency department on 7/3/21 due to a bilateral femur fracture from a fall. Record review of the Operative Report dated 7/8/21 revealed Resident #31 underwent intramedullary nailing surgery to her bilateral femur fractures on 7/8/21. Record review of Resident #31's Face Sheet revealed Resident #31 was admitted to the facility on 3/27/2020, with the diagnoses that included Major Depressive Disorder, Hypertension, Dementia and current diagnoses of Unspecified	F 600	for any problems or concerns and will keep a log of findings weekly x4 weeks, then monthly x 3 months, and then quarterly for one year. The fall of Resident #31 was taken to the QA Committee on 07/08/2021 for review. This incident and a review of Resident's Rights was taken again to the QA team on 10/27/2021, and the QA Committee will continue meeting monthly for three months on these topics. Any new recommendations by the QA Committee will be implemented.		

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600	Continued From page 4 Fracture lower end of right femur and Unspecified Fracture lower end of left femur. Record review of the Admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 06/09/21 revealed Resident#31 had a Brief Interview for Mental Status (BIMS) score of 14 that indicated Resident #31 was cognitively intact. During an interview on 09/16/21 at 09:00 AM, with the Director of Nursing (DON) confirmed Resident #31 fell out of the bed to the floor on 7/3/21. The DON said on 7/6/21 she had TNA #1 come to the facility and re-enact the incident. The DON said TNA #1 was in the room providing incontinent care without CNA #1. TNA #1 turned Resident #31 to the right side and did not remove the pillows from the resident's feet. TNA #1 said when she turned the resident, she slid onto the floor on her knees. Resident #31 was still holding on to the bedrails. TNA #1 said she notified LPN #1. The DON said TNA #1 said she had read Resident #31's plan of care. TNA #1 said she knew Resident #31 was a two (2) person assist with bed mobility, but she thought she could do it without help. The DON said the TNAs and Certified Nursing Assistants (CNA) are trained that TNAs should not provide care without a licensed person being present. The DON confirmed TNA #1 failed to follow Resident #31 Care Plan because the Care Plan reveals the resident should have two (2) people with bed mobility and transfers. During an interview on 09/16/21 at 10:25 AM, with the Administrator revealed TNA #1 had been through the CNA class but she has not taken her test. The Administrator said TNA #1 was paired	F 600			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600	Continued From page 5 with CNA #1. The Administrator said on 7/3/21 LPN #1 called her and said Resident #31 slid to the floor during care. The Administrator said she was told Resident #31's feet got tied up in the sheets. Resident #31 was kicking and fell out of the bed while TNA #1 was providing incontinent care. The Administrator said she came to the facility and started the investigation. The Administrator confirmed TNA #1 was not suspended at that time. The Administrator gave orders to the nurses that TNA #1 should not provide care to any of the residents without supervision. The Administrator said on 7/6/21 TNA #1 was called in to do a re-enactment of the incident. The Administrator said TNA #1 said she raised the bed to her waist. TNA #1 turned the resident over without moving the pillows. TNA #1 said she had just read Resident #31's Care Plan and knew that she was a two (2) person assist with Activities of Daily Living (ADL's). TNA #1 said she thought she could do the care without assistance. The Administrator said it was determined, because TNA #1 did not remove the pillows when she turned Resident #31 this caused the resident to fall out of bed. The Administrator said she started the in-services with the staff on Abuse/Neglect, Resident Rights, Following the Care Plan, ADL supporting and Accidents and Incidents. A Quality Assurance (QA) meeting was held on 7/8/21. The Administrator said she notified the ombudsman, the SA and the Attorney General's Office (AG) on 7/3/21. The Administrator stated that TNA #1 was suspended 7/5 21 and terminated 7/12/21 because she had been identified as having the potential of placing residents' safety at risk, leading the facility to terminate her employment. During an interview on 09/16/21 at 12:51 PM, with	F 600			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600	Continued From page 6 CNA #1 said she was paired with TNA #1 on 7/3/21. CNA #1 stated she went on the other side of the building to stock the linen cart. CNA #1 said TNA #1 was at the nurse's station when she went to stock the cart. CNA #1 also said she did not know TNA #1 was providing incontinent care without assistance until Resident #31 was noted on the floor. CNA #1 revealed Licensed Practical Nurse (LPN) #2 and CNA #2 educates the staff daily that TNAs cannot provide care without assistance from a licensed/certified staff member. CNA #1 said TNA #1 has not had any other instances where she provided care without assistance. During an interview on 09/16/21 at 01:54 PM, with RN #1 said she was the supervisor for the day on 7/3/21. RN #1 said LPN #1 came down the hall extremely upset stating Resident #31 got her feet tied up in the sheets and slid out of the bed. RN #1 said she did not realize LPN #1 was not in the room with TNA #1 while she was providing care. RN #1 said she called the doctor and got an order for an X-ray. During an interview on 09/16/21 at 02:15 PM, with LPN #2/Staff Development, said the staff is trained during orientation and annually on ADL task, skills, and checkoffs. LPN #2 said during her training she tell the TNA's and CNA's that the TNAs cannot provide care without licensed/certified personnel. LPN #2 confirmed she cannot provide an in-service with TNA #1 stating she was trained to only provide care with a licensed person. LPN #2 confirmed TNA #1 failed to follow the care plan because Resident #31 was a two (2) person assist with all ADL's. During an interview on 9/16/21 at 02:30 PM, with	F 600			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600	Continued From page 7 CNA #2, said every day before the staff start working, he does a huddle with the CNA's and TNA's. CNA #2 said he reminds the staff that the TNA's can only provide care to residents with a licensed or certified person. TNAs cannot provide care without a certified CNA or a nurse being present. CNA #2 said he was off the day the incident took place. CNA #2 confirmed TNA #1 failed to follow the facility policy and failed to follow the care plan by providing incontinent care to Resident #31 without having a licensed or certified person present. During an interview on 9/16/21 at 2:45 PM, with TNA #2 confirmed she started working at the facility in August 2021 and was in-serviced that she cannot provide care to residents unless a CNA or Nurse is present. During an interview on 9/16/21 at 3:30 PM, with TNA #1 stated she checked on Resident #31 and noted the resident had an incontinent episode. TNA #1 confirmed she provided incontinent care without a CNA or nurse with her. TNA #1 said she was told by CNA #2 that she only needed another staff member in the room when a lift is used for transfer. TNA #1 said she was not told that she could not provide incontinent care to the residents alone. TNA #1 said she has provided incontinent care alone with multiple residents. TNA #1 said she had looked at Resident #31's Care Plan when she first started working at the facility. TNA #1 said she forgot what the Care Plan said and that Resident #31 should have 2 people with care. TNA #1 confirmed she did not ask any of the other staff for assistance because she has provided incontinent care without help multiple times and the resident was ok.	F 600			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600	Continued From page 8 Review of the facility's fall Risk Evaluation dated 3/10/21 revealed Resident #31 was a high fall risk. Record review of Resident #31's Care Plan with a Problem Onset date of 03/27/2020 revealed "(Formal Name) decline in ability to perform self care activities, (Formal Name) is unable to bear weight, (Formal Name) at risk for soiling clothing ...Approaches: Provide extensive assistance X2 (of two persons) with bed mobility...Provide total assistance X 2 with toileting ..." Record review of the Nurse Aides' Information Sheet, undated, revealed Resident #31 required total assistance X 2 with incontinent care for bowel and bladder and extensive assistance X 2 for turning and repositioning. Record review of the Time Card Report revealed on 7/3/21, TNA#1 clocked into work at 06:50 AM and clocked out at 19:25 (7:25 PM). On 7/4/21, TNA#1 clocked in at 06:49 AM and clocked out at 19:12 (7:12 PM). On 7/5/21, TNA #1 clocked in at 06:49 AM and clocked out at 10:34 AM. Record review of Resident #31's ADL RECORD, for the month of July 2021 revealed that TNA #1 provided personal care to the resident on 7/3/21 and 7/4/21. Record review of the facility's CNA Assignments sheet dated 7/3/21 and 7/4/21 revealed TNA #1 and CNA #1 were assigned to Resident #31. Record review of the facility Counseling Statement dated 7/4/21 revealed TNA #1 was counseled with respect to not following the ADL Plan of Care and the importance of following	F 600			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600	Continued From page 9 proper ADL assistance while providing care. TNA #1 was suspended by the Administrator on 7/5/21 at 10:24 AM while investigation of the fall was completed to ensure safety of all residents. Record review of the facility's Termination Report revealed TNA #1 was terminated on 7/12/21 because the employee has been identified as having the potential of placing residents' safety at risk, leading this facility to terminate her employment. Review of the facility Nurse Assistant Skills Check Off revealed TNA #1 was checked off "PROVIDES PERINEAL CARE FOR FEMALE" on 4/30/21. Review of the facility in-services revealed TNA # 1 was in-serviced on the following: Falls, Safety and Reporting in-service on 6/24/21, Abuse/Neglect on 1/12/21 and 6/24/21, Transfer in-service on 1/12/21, Accident, Incidents and Resident Rights and Vulnerable Adult in-service titled, "History of the Vulnerable Persons Act", on 12/29/20. The facility provided an acceptable Removal Plan on 9/30/21, for the IJ. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: Removal Plan Immediate Jeopardy (IJ) was called on 9/28/2021 at 12:35 PM. The IJ template was provided on 9/28/2021 at 12:35 PM. Beginning 7/3/2021 when Temporary Nursing Assistant (TNA) #1 failed to obtain the necessary assistance to provide incontinent care to resident #31 resulting in a	F 600			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600	Continued From page 10 major injury with fracture of bilateral knees. The State Agency notified the Administrator and the Director of Nursing (DON) that an IJ had been identified. Brief Summary of Events The facility failed to ensure a resident was protected from neglect as evidence by (AEB) an unlicensed TNA neglected to obtain assistance required when providing incontinent care that resulted in Resident #31 obtaining a fracture. ON 7/3/21, immediate action was taken by the cart nurse to notify the doctor and obtain bilateral knee x-rays. The facility failed to follow the comprehensive care plan while providing incontinent care AEB Resident #31 is extensive assist and always needs two people during care. The facility failed to ensure a vulnerable resident was protected from accidents and hazards when a TNA#1 failed to ask for help while providing incontinent care, which caused Resident #31 to fall with a major injury to bilateral knees. The facility failed to protect Resident #31 and other residents from potential for further injury during the investigation process by not removing TNA #1 from the facility following an incident on 7/3/2021. The Facility continued to allow TNA #1 to work until 7/05/21. Corrective Action: 1. On 7/3/2021, the Administrator provided education to the Charge Nurse, two (2) TNAs, 2 Cart Registered Nurses (RN), and three (3) Certified Nursing Assistants (CNA) directly involved in the fall of Resident #31. On 7/3/2021, the in-service topics included following the Activities of Living (ADL) Care Plan and Care Guide, Abuse and Neglect, and Residents'	F 600			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600	Continued From page 11 Rights. On 7/4/2021 and 7/5/2021, the Administrator continued in-servicing with all staff on the above topics. No staff will be allowed to work until in-services are completed. 2. On 07/03/21, the Administrator identified that Resident #31 sustained a fall with injury and initiated an investigation. 3. On 07/05/2021 at 10:24 AM, the Administrator suspended TNA #1 until further notice to complete investigation. On 07/05/2021 the Administrator conducted and completed the investigation. On 07/12/21 the Administrator terminated TNA #1. 4. On 7/5/2021 at 10:00 AM, each resident under the care from TNA #1 who was identified as at risk for falls was assessed with no further falls identified. 5. On 07/05/2021 at 10 AM, the Minimum Data Set Nurse (MDS) conducted a 100 percent audit of Resident's Fall Risk Assessments and Care Plans for accuracy with no concerns identified. 6. Each resident has a care guide specific to their needs located in a binder at each nurse's station. These are reviewed by the CNAs prior to the start of each shift and to be followed to provide care to the residents. On 07/05/2021, the MDS Nurse performed a 100 percent audit of the care guides with no concerns identified. On 07/05/2021 The Administrator in-serviced CNAs and TNAs on the following: ADL care guides specific to each resident. On 07/05/2021, the MDS Nurse performed a 100 percent audit on ADLs of residents identified at risk for falls and failure to follow the ADL Plan of Care. All	F 600			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600	Continued From page 12 residents at risk needing two-person assist were identified and reviewed. On 9/16/2021, the Staff Development Nurse educated all TNAs and CNAs on providing resident care only with a CNA or Nurse present, no staff will be allowed to work until in serviced. TNAs and CNAs were instructed to review ADL care plan prior to each shift. 19 of the 40 residents were identified as at risk for falls and failure for the ADL Plan of Care to be followed. A form was developed and created for all TNA new hires to have proper education, training, and understanding that they must work directly with a licensed CNA and to follow and know their ADL plan of care. On 9/21/2021, the Staff Development Nurse educated all staff that all TNA's can only provide resident care with a CNA or Nurse present, no staff will be allowed to work until in-serviced. 7. The Administrator requested an in-person Quality Assurance Performance Improvement (QAPI) meeting to review events leading to this occurrence and corrective action taken. QAPI meeting occurred on July 8, 2021, and included the Administrator, Director of Nursing, Medical Director, MDS Nurse, Wound Care Nurse, Care Plan Nurse, Medical Records Nurse, Infection Preventionist, Physical Therapist, Administrator Assistant, and the Billing Office Manager. The meeting specifically discussed this fall, identified cause of the fall, number of previous falls, fall risk and potential harm, prevention of recurrence, abuse/neglect, following ADL care plan, Resident's Rights, ADL support and serious injury/harm and reporting. On 07/06/21, the Administrator in serviced the DON and Charge Nurse on the topic of removing any staff from the building for alleged violations of abuse, neglect, exploitation, or misappropriation of resident	F 600			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600	Continued From page 13 property until the investigation is completed. No changes to fall policy were required after being reviewed by QAPI. 8. On 9/16/2021, a form was created for all TNA hire in packets to ensure all TNA new hires have proper education, training, and understanding that they must work directly with a licensed CNA. 9. The Administrator and DON conducted a 100 percent audit on all accidents and incidents from 07/04/2021 through 9/30/2021 to ensure that injury or negative outcomes was not identified related to unsupervised TNAs. On 07/05/21, the Administrator in-serviced all staff on fall related policies. Falls are reviewed at stand up meeting every morning and Quarterly Quality Assurance (QA) meeting. On 07/05/21 at 7AM, the Administrator continued on-going in servicing to reiterate with all staff that TNAs must provide care only with CNA assist. 10. The facility alleges that all corrective actions to remove the IJ were completed on 9/30/21, and the IJ was removed on 10/1/21. Validation On 10/2/21, the State Survey Agency (SSA) validated the facility's Removal Plan by staff interviews, record reviews, and review of in-service sign-in sheets. The SSA verified the facility had implemented the following measures to remove IJ: 1. The SSA validated through interview with the Administrator and in-service sign in sheets that on 7/3/2021, the Administrator provided education to the Charge Nurse, two (2) TNAs, 2 Cart	F 600			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600	Continued From page 14 Registered Nurses (RN), and three (3) Certified Nursing Assistants (CNA) directly involved in the fall of Resident #31. On 7/3/2021, the in-service topics included following the Activities of Living (ADL) Care Plan and Care Guide, Abuse and Neglect, and Residents' Rights. On 7/4/2021 and 7/5/2021, the Administrator continued in-servicing with all staff on the above topics. No staff will be allowed to work until in-services are completed. 2. The SSA validated through interview on 10/1/21 that on 07/03/21, the Administrator identified Resident #31 sustained a fall with injury and initiated an investigation. 3. The SSA validated through interview and record review that on 07/05/2021 at 10:24 AM, the Administrator suspended TNA #1 until further notice to complete investigation and on 07/05/2021 the Administrator conducted and completed the investigation. On 07/12/21 the Administrator terminated TNA #1. 4. The SSA validated through interview with DON and record review that on 7/5/2021 at 10:00 AM, each resident under the care from TNA #1 who was identified as at risk for falls was assessed with no further falls identified. 5. The SSA validated through interview with the Minimum Data Set Nurse (MDS) nurse and record review on 07/05/2021 at 10 AM, the MDS nurse conducted a 100 percent audit of Resident's Fall Risk Assessments and Care Plans for accuracy with no concerns identified. 6. The SSA validated through staff interviews, record reviews and signed in-services that each resident has a care guide specific to their needs	F 600			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600	Continued From page 15 located in a binder at each nurse's station. These are reviewed by the CNAs prior to the start of each shift and to be followed to provide care to the residents. On 07/05/2021, the MDS Nurse performed a 100 percent audit of the care guides with no concerns identified. On 07/05/2021 The Administrator in-serviced CNAs and TNAs on the following: ADL care guides specific to each resident. On 07/05/2021, the MDS Nurse performed a 100 percent audit on ADLs of residents identified at risk for falls and failure to follow the ADL Plan of Care. All residents at risk needing two-person assist were identified and reviewed. On 9/16/2021, the Staff Development Nurse educated all TNAs and CNAs on providing resident care only with a CNA or Nurse present, no staff will be allowed to work until in serviced. TNAs and CNAs were instructed to review ADL care plan prior to each shift. 19 of the 40 residents were identified as at risk for falls and failure for the ADL Plan of Care to be followed. A form was developed and created for all TNA new hires to have proper education, training, and understanding that they must work directly with a licensed CNA and to follow and know their ADL plan of care. On 9/21/2021, the Staff Development Nurse educated all staff that all TNA's can only provide resident care with a CNA or Nurse present, no staff will be allowed to work until in-serviced. 7. The SSA validated through staff interviews, record review and signed in-service sheets that the Administrator requested an in-person Quality Assurance Performance Improvement (QAPI) meeting to review events leading to this occurrence and corrective action taken. The QAPI meeting occurred on July 8, 2021, and included the Administrator, Director of Nursing,	F 600			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600	Continued From page 16 Medical Director, MDS Nurse, Wound Care Nurse, Care Plan Nurse, Medical Records Nurse, Infection Preventionist, Physical Therapist, Administrator Assistant, and the Billing Office Manager. The meeting specifically discussed this fall, identified cause of the fall, number of previous falls, fall risk and potential harm, prevention of recurrence, abuse/neglect, following ADL care plan, Resident's Rights, ADL support and serious injury/harm and reporting. On 07/06/21, the Administrator in serviced the DON and Charge Nurse on the topic of removing any staff from the building for alleged violations of abuse, neglect, exploitation, or misappropriation of resident property until the investigation is completed. No changes to fall policy were required after being reviewed by QAPI. 8. The SSA validated through an interview with the Administrator and record review that on 9/16/2021, a form was created for all TNA's hire in packets to ensure all TNA new hires have proper education, training, and understanding that they must work directly with a licensed CNA. 9. The SSA validated through record review, signed in-services and interview with the Administrator and DON that a 100 percent audit was conducted on all accidents and incidents from 07/04/2021 through 9/30/2021 to ensure that injury or negative outcomes was not identified related to unsupervised TNAs. On 07/05/21, the Administrator in-serviced all staff on fall related policies. Falls are reviewed at stand up meeting every morning and Quarterly Quality Assurance (QA) meeting. On 07/05/21 at 7AM, the Administrator continued on-going in servicing to reiterate with all staff that TNAs must provide care only with CNA assist.	F 600			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 600	Continued From page 17	F 600			
F 610 SS=J	10. Amendment 12/2/21 - The SSA validated that all corrective actions to remove the IJ had been completed as of 7/8/21, and the IJ removed on 7/8/21. Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 by: Amendment 12/07/2021 Upon secondary review with CMS Regional Office staff and State Quality Assurance review, the State Survey Agency (SSA) determined the Immediate Jeopardy to be removed on 7/8/21 for F610 and the scope and severity was lowered to "D", while the facility develops and implements a plan of correction and monitors effectiveness of systemic changes to ensure the facility sustains	F 610	1.Immediate action(s) taken for the resident(s) found to have been affected include: On 07/03/2021, the Administrator started an investigation immediately after being notified of fall of Resident #31 that resulted in a major injury. Resident #31's X-Rays revealed that Resident #31 was noted with bilateral femur fractures on 7/3/2021. Resident #31 was transported	11/4/21	

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 610	Continued From page 18 compliance with regulatory requirements. Based on staff interviews, record review and facility policy review, the facility failed to prevent the potential for further injury during the investigation process by not removing Temporary Nursing Assistant (TNA) #1 from the facility following an incident on 7/3/21 which resulted in a major injury to Resident #31, for one (3) of three (3) investigations reviewed. On 7/3/21, TNA #1 neglected to obtain the assistance required when providing incontinent care for Resident #31. TNA #1 turned the resident to her side without removing the pillows from the resident's feet. This resulted in Resident #31 falling to the floor and sustaining bilateral femur fractures. The resident underwent intramedullary nailing surgery to her bilateral femur fractures on 7/8/21. The facility failed to protect Resident #31 and other residents from the potential for further injury during the investigation process by not removing TNA #1 from the facility following the incident on 7/3/2021. The facility continued to allow TNA #1 to work until 7/05/21. The facility's failure to remove TNA #1 from the facility immediately placed Resident #31, a vulnerable resident, and other residents at risk. These actions had the likelihood to cause all residents residing in the facility serious harm, serious injury, serious impairment, or possible death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 7/3/21 when TNA #1 failed to obtain assistance to provide incontinent care and Resident #31 fell from the bed and received	F 610	by ambulance to an offsite surgical center for repair of bilateral knees. Resident #31's Responsible Party (RP) was notified on 07/03/2021 of the incident with injury, and he was kept updated during the treatment process. On 07/03/2021, the Administrator gave verbal orders to the Cart Nurse that TNA #1 should not provide care to any of the residents without assistance from Certified Nursing Assistants (CNA) or Nurses. The Administrator notified the Ombudsman, the State Survey Agency (SSA), and the Attorney General's Office (AG) on 7/3/2021. On 9/15/2021, while reviewing the Investigation Policy, the Administrator was made aware that any employee alleged of abuse/neglect, misappropriation of funds, or exploitation must be suspended immediately until an investigation is completed. 2. Identification of other residents having the potential to be affected was accomplished by: After review of Census and Daily Assignment Sheets, the Administrator concluded that 19 of the 40 residents had the potential of receiving care from TNA #1. 19 of 40 residents were identified as having the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Temporary Nursing Assistant (TNA) #1 was suspended on 07/05/2021 pending further investigation. TNA #1 was terminated on 7/12/2021. On 09/16/2021,		

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 610	Continued From page 19 a major injury. The facility Administrator was notified of the IJ and SQC on 9/28/21 at 12:35 PM, and the IJ templates were provided to the Administrator. The State Survey Agency (SSA) received an acceptable Removal Plan on 9/30/21, in which the facility alleged that all corrective actions were completed as of 9/30/21, and the Immediate Jeopardy was removed on 10/1/21. (Amendment 12/2/21 - The SSA determined the IJ and SQC to be removed on 7/8/21). The SSA validated the Removal Plan and determined the IJ to be removed on 7/8/2021. Therefore, the scope and severity for CFR 483.12(c)(2)(3)-Investigation (F610) was lowered to a "D", while the facility develops and implements a plan of correction and monitors effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's policy, "Abuse Investigations", revised September 2013, revealed "Policy Statement, All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management." Review of the facility's policy "Abuse Prevention Program", revised September 2013, revealed "Policy Statement: Our residents have the right to be free from abuse, neglect...Policy Interpretation and Implementation:...3....Our abuse prevention program provides policies and procedures that govern, as a minimum:...d. The protection of	F 610	the Staff Development Nurse created a form and placed into all new hire-in packets, educating new hires that in the event of alleged abuse/neglect, misappropriation of funds, or exploitation, any employee will be suspended until an investigation is complete. The Administrator began in-servicing direct care staff on suspension of any employee alleged of abuse/neglect, misappropriation of funds, or exploitation, and then beginning on 09/21/2021, the Staff Development Nurse will in-service quarterly on the same topic for a year. Beginning 10/2/2021, the Staff Development Nurse will review hire-in packets weekly x 4 weeks, monthly x 3 months, and quarterly x one year to ensure the hire-in packets include data mentioned above. Review findings will be documented by the Staff Development Nurse. The Administrator began in-servicing on 07/05/2021 with the staff on Abuse/Neglect, Residents' Rights, following the Care Plan, Activities of Daily Living (ADL) Supporting, and Accidents and Incidents. A Quality Assurance (QA) meeting was held on 7/8/2021. The current Director of Nursing was in-serviced on 09/25/2021 on suspending any employee suspected of abuse/neglect, misappropriation of funds, or exploitation of any resident. The Administrator in-serviced the Administration Staff in regards to suspensions in our morning standup meetings the week of 09/20/2021-09/24/2021. The Staff Development Nurse and the Administrator from a non-affiliated		

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 610	Continued From page 20 residents during abuse investigations;...f. Timely and thorough investigations of all reports and allegations of abuse..." Review of the facility's investigation revealed the facility started the investigation immediately on 7/3/21 by the Administrator. Resident #31's X-rays revealed the resident was noted with bilateral femur fractures on 7/3/21. TNA #1 was suspended on 7/5/21 pending further investigation. TNA #1 was terminated 7/12/21. Quality Assurance (QA) meeting was held to discuss in-services to be completed due to the fall, ways to prevent re-occurrences and fall prevention, identify all residents at risk, with potential to be harmed by this incident, how many falls Resident #31 has had, harm caused by the fall and the residents outcome, serious injury/harm and reporting, Abuse-Neglect, Following Activities of Daily Living (ADL) care plan, ADL supporting. During an interview on 09/16/21 at 10:25 AM, with the Administrator she confirmed the facility notified her of Resident #31's fall on 7/3/21 and she came to the facility and immediately started the investigation. The Administrator confirmed TNA #1 was not suspended at that time. The Administrator gave orders to the nurses that TNA #1 should not provide care to any of the residents without assistance. The Administrator said she started the inservices with the staff on Abuse/Neglect, Resident Rights, Following the Care Plan, ADL Supporting and Accidents and Incidents. A QA meeting was held on 7/8/21. The Administrator said she notified the Ombudsman, the SSA and the Attorney General's Office (AG) on 7/3/21. The Administrator stated that TNA #1 was suspended on 7/5/21 and terminated on	F 610	sister facility in-serviced all non-contracted staff, the Maintenance Director, the Assistant Maintenance Director, the Director of Housekeeping, and the Director of Therapy on the topic of Investigation on 11/10/2021. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur? Beginning 10/2/2021, the Administrative Assistant will complete an audit of quarterly in-services to ensure that all staff is aware that suspension will occur to any employee alleged of resident abuse/ neglect, misappropriation of funds, or exploitation, quarterly for a year. Beginning 10/2/2021, the Administrative Assistant will audit logs kept by the Staff Development Nurse to ensure a reoccurrence of failure to suspend in a timely manner does not reoccur weekly for four weeks, monthly for three months, and then quarterly for a year. On 10/27/2021, a QA meeting was held to discuss in-services to be completed due to the fall, ways to prevent re-occurrences and fall prevention. We will hold QA meetings monthly for three months to discuss Investigation. Any recommendations from the QA meeting will be implemented.		

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 610	Continued From page 21 7/12/21 because she had been identified as having the potential of placing residents' safety at risk, leading the facility to terminate her employment. Record review of the Time-Card Report revealed on 7/3/21, TNA#1 clocked into work at 06:50 AM and clocked out at 19:25 (7:25 PM). On 7/4/21, TNA#1 clocked in at 06:49 AM and clocked out at 19:12 (7:12 PM). On 7/5/21, TNA #1 clocked in at 06:49 AM and clocked out at 10:34 AM. Record review of Resident #31's ADL RECORD, for the month of July 2021 revealed that TNA #1 provided personal care to the resident on 7/3/21 and 7/4/21. Record review of the facility's CNA Assignments sheet dated 7/3/21 and 7/4/21 revealed TNA #1 and CNA #1 were assigned to Resident #31. Record review of Resident #31's Face Sheet revealed Resident #31 was admitted to the facility on 3/27/2020, with the diagnoses that included Major Depressive Disorder, Hypertension, Dementia and current diagnoses of Unspecified Fracture lower end of right femur and Unspecified Fracture lower end of left femur. Record review of Resident #31's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/09/2021, Section C, revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #31 is cognitively intact. The facility provided an acceptable Removal Plan on 9/30/21, for the IJ. Review of the facility's Removal Plan revealed the facility took the	F 610			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 610	Continued From page 22 following actions to remove the IJ: Removal Plan Immediate Jeopardy (IJ) was called on 9/28/2021 at 12:35 PM. The IJ template was provided on 9/28/2021 at 12:35 PM. Beginning 7/3/2021 when Temporary Nursing Assistant (TNA) #1 failed to obtain the necessary assistance to provide incontinent care to resident #31 resulting in a major injury with fracture of bilateral knees. The State Agency notified the Administrator and the Director of Nursing (DON) that an IJ had been identified. Brief Summary of Events The facility failed to ensure a resident was protected from neglect as evidence by (AEB) an unlicensed TNA neglected to obtain assistance required when providing incontinent care that resulted in Resident #31 obtaining a fracture. ON 7/3/21, immediate action was taken by the cart nurse to notify the doctor and obtain bilateral knee x-rays. The facility failed to follow the comprehensive care plan while providing incontinent care AEB Resident #31 is extensive assist and always needs two people during care. The facility failed to ensure a vulnerable resident was protected from accidents and hazards when a TNA#1 failed to ask for help while providing incontinent care, which caused Resident #31 to fall with a major injury to bilateral knees. The facility failed to protect Resident #31 and other residents from potential for further injury during the investigation process by not removing TNA #1 from the facility following an incident on 7/3/2021. The Facility continued to allow TNA #1 to work until 7/05/21.	F 610			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 610	Continued From page 23 Corrective Actions: - On 7/3/2021, the Administrator provided education to the Charge Nurse, two (2) TNAs, 2 Cart Registered Nurses (RN), and three (3) Certified Nursing Assistants (CNA) directly involved in the fall of Resident #31. On 7/3/2021, the in-service topics included following the Activities of Living (ADL) Care Plan and Care Guide, Abuse and Neglect, and Residents' Rights. On 7/4/2021 and 7/5/2021, the Administrator continued in-servicing with all staff on the above topics. No staff will be allowed to work until in-services are completed. - On 07/03/21, the Administrator identified that Resident #31 sustained a fall with injury and initiated an investigation. - On 07/05/2021 at 10:24 AM, the Administrator suspended TNA #1 until further notice to complete investigation. On 07/05/2021 the Administrator conducted and completed the investigation. On 07/12/21 the Administrator terminated TNA #1. - On 7/5/2021 at 10:00 AM, each resident under the care from TNA #1 who was identified as at risk for falls was assessed with no further falls identified. - On 07/05/2021 at 10 AM, the Minimum Data Set Nurse (MDS) conducted a 100 percent audit of Resident's Fall Risk Assessments and Care Plans for accuracy with no concerns identified. - Each resident has a care guide specific to their needs located in a binder at each nurse's station. These are reviewed by the CNAs prior to	F 610			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 610	Continued From page 24 the start of each shift and to be followed to provide care to the residents. On 07/05/2021, the MDS Nurse performed a 100 percent audit of the care guides with no concerns identified. On 07/05/2021 The Administrator in-serviced CNAs and TNAs on the following: ADL care guides specific to each resident. On 07/05/2021, the MDS Nurse performed a 100 percent audit on ADLs of residents identified at risk for falls and failure to follow the ADL Plan of Care. All residents at risk needing two-person assist were identified and reviewed. On 9/16/2021, the Staff Development Nurse educated all TNAs and CNAs on providing resident care only with a CNA or Nurse present, no staff will be allowed to work until in serviced. TNAs and CNAs were instructed to review ADL care plan prior to each shift. 19 of the 40 residents were identified as at risk for falls and failure for the ADL Plan of Care to be followed. A form was developed and created for all TNA new hires to have proper education, training, and understanding that they must work directly with a licensed CNA and to follow and know their ADL plan of care. On 9/21/2021, the Staff Development Nurse educated all staff that all TNA's can only provide resident care with a CNA or Nurse present, no staff will be allowed to work until in-serviced. 7. The Administrator requested an in-person Quality Assurance Performance Improvement (QAPI) meeting to review events leading to this occurrence and corrective action taken. QAPI meeting occurred on July 8, 2021, and included the Administrator, Director of Nursing, Medical Director, MDS Nurse, Wound Care Nurse, Care Plan Nurse, Medical Records Nurse, Infection Preventionist, Physical Therapist, Administrator Assistant, and the Billing Office Manager. The	F 610			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 610	Continued From page 25 meeting specifically discussed this fall, identified cause of the fall, number of previous falls, fall risk and potential harm, prevention of recurrence, abuse/neglect, following ADL care plan, Resident's Rights, ADL support and serious injury/harm and reporting. On 07/06/21, the Administrator in serviced the DON and Charge Nurse on the topic of removing any staff from the building for alleged violations of abuse, neglect, exploitation, or misappropriation of resident property until the investigation is completed. No changes to fall policy were required after being reviewed by QAPI. 8. On 9/16/2021, a form was created for all TNA hire in packets to ensure all TNA new hires have proper education, training, and understanding that they must work directly with a licensed CNA. 9. The Administrator and DON conducted a 100 percent audit on all accidents and incidents from 07/04/2021 through 9/30/2021 to ensure that injury or negative outcomes was not identified related to unsupervised TNAs. On 07/05/21, the Administrator in-serviced all staff on fall related policies. Falls are reviewed at stand up meeting every morning and Quarterly Quality Assurance (QA) meeting. On 07/05/21 at 7AM, the Administrator continued on-going in servicing to reiterate with all staff that TNAs must provide care only with CNA assist. 10. The facility alleges that all corrective actions to remove the IJ were completed on 9/30/21, and the IJ was removed on 10/1/21. On 10/2/21, the State Survey Agency (SSA) validated the facility's AOC Removal Plan by staff interviews, record reviews, and review of	F 610			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 610	Continued From page 26 in-service sign-in sheets. The SSA verified the facility had implemented the following measures to remove IJ: Validation: 1. The SSA validated through interview with the Administrator and in-service sign in sheets that on 7/3/2021, the Administrator provided education to the Charge Nurse, two (2) TNAs, 2 Cart Registered Nurses (RN), and three (3) Certified Nursing Assistants (CNA) directly involved in the fall of Resident #31. On 7/3/2021, the in-service topics included following the Activities of Living (ADL) Care Plan and Care Guide, Abuse and Neglect, and Residents' Rights. On 7/4/2021 and 7/5/2021, the Administrator continued in-servicing with all staff on the above topics. No staff will be allowed to work until in-services are completed. 2. The SSA validated through interview on 10/1/21 that on 07/03/21, the Administrator identified Resident #31 sustained a fall with injury and initiated an investigation. 3. The SSA validated through interview and record review that on 07/05/2021 at 10:24 AM, the Administrator suspended TNA #1 until further notice to complete investigation and on 07/05/2021 the Administrator conducted and completed the investigation. On 07/12/21 the Administrator terminated TNA #1. 4. The SSA validated through interview with DON and record review that on 7/5/2021 at 10:00 AM, each resident under the care from TNA #1 who was identified as at risk for falls was assessed with no further falls identified.	F 610			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 610	Continued From page 27 5. The SSA validated through interview with the Minimum Data Set Nurse (MDS) nurse and record review on 07/05/2021 at 10 AM, the MDS nurse conducted a 100 percent audit of Residents Fall Risk Assessments and Care Plans for accuracy with no concerns identified. 6. The SSA validated through staff interviews, record reviews and signed in-services that each resident has a care guide specific to their needs located in a binder at each nurse's station. These are reviewed by the CNAs prior to the start of each shift and to be followed to provide care to the residents. On 07/05/2021, the MDS Nurse performed a 100 percent audit of the care guides with no concerns identified. On 07/05/2021 The Administrator in-serviced CNAs and TNAs on the following: ADL care guides specific to each resident. On 07/05/2021, the MDS Nurse performed a 100 percent audit on ADLs of residents identified at risk for falls and failure to follow the ADL Plan of Care. All residents at risk needing two-person assist were identified and reviewed. On 9/16/2021, the Staff Development Nurse educated all TNAs and CNAs on providing resident care only with a CNA or Nurse present, no staff will be allowed to work until in serviced. TNAs and CNAs were instructed to review ADL care plan prior to each shift. 19 of the 40 residents were identified as at risk for falls and failure for the ADL Plan of Care to be followed. A form was developed and created for all TNA new hires to have proper education, training, and understanding that they must work directly with a licensed CNA and to follow and know their ADL plan of care. On 9/21/2021, the Staff Development Nurse educated all staff that all TNA's can only provide resident care with a CNA or Nurse present, no staff will be allowed to work	F 610			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 610	Continued From page 28 until in-serviced. 7. The SSA validated through staff interviews, record review and signed in-service sheets that the Administrator requested an in-person Quality Assurance Performance Improvement (QAPI) meeting to review events leading to this occurrence and corrective action taken. The QAPI meeting occurred on July 8, 2021, and included the Administrator, Director of Nursing, Medical Director, MDS Nurse, Wound Care Nurse, Care Plan Nurse, Medical Records Nurse, Infection Preventionist, Physical Therapist, Administrator Assistant, and the Billing Office Manager. The meeting specifically discussed this fall, identified cause of the fall, number of previous falls, fall risk and potential harm, prevention of recurrence, abuse/neglect, following ADL care plan, Resident's Rights, ADL support and serious injury/harm and reporting. On 07/06/21, the Administrator in serviced the DON and Charge Nurse on the topic of removing any staff from the building for alleged violations of abuse, neglect, exploitation, or misappropriation of resident property until the investigation is completed. No changes to fall policy were required after being reviewed by QAPI. 8. The SSA validated through an interview with the Administrator and record review that on 9/16/2021, a form was created for all TNA's hire in packets to ensure all TNA new hires have proper education, training, and understanding that they must work directly with a licensed CNA. 9. The SSA validated through record review, signed in-services and interview with the Administrator and DON that a 100 percent audit was conducted on all accidents and incidents	F 610			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 610	Continued From page 29 from 07/04/2021 through 9/30/2021 to ensure that injury or negative outcomes was not identified related to unsupervised TNAs. On 07/05/21, the Administrator in-serviced all staff on fall related policies. Falls are reviewed at stand up meeting every morning and Quarterly Quality Assurance (QA) meeting. On 07/05/21 at 7AM, the Administrator continued on-going in servicing to reiterate with all staff that TNAs must provide care only with CNA assist.	F 610			
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).	F 656		11/4/21	

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 (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)- (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: Amendment 12/07/2021 Upon secondary review with CMS Regional Office staff and State Quality Assurance, the State Survey Agency (SSA) determined the Immediate Jeopardy to be removed on July 8, 2021 for F600, F610, F656 and F689 and the scope and severity was lowered to "D", while the facility develops and implements a plan of correction and monitors effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Based on observation, staff interviews, record review and facility policy review the facility failed to follow the comprehensive care plan for providing Activities of Daily Living (ADL's) for one	F 656	1. Immediate action(s) taken for the resident(s) found to have been affected include: On 7/3/2021, the Administrator provided education to the Charge Nurse, two (2) TNAs (Temporary Nursing Assistants), 2 Cart Registered Nurses (RN), and three (3) Certified Nursing Assistants (CNA) directly involved in the care of Resident #31. On 07/05/2021, Resident #31's Activity for Daily Living Care Plan and Care Guide was reviewed by the Minimum Data Set (MDS) Nurse with no concerns. 2. Identification of other residents having the potential to be affected was accomplished by:		

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 (1) of sixteen care plans reviewed. Resident #31. The facility failed to follow the comprehensive care plan when Temporal Nurse Assistant (TNA) #1 provided incontinent care without the required two (2) person assistance licensed/certified staff needed which resulted in Resident #31 falling from the bed and sustaining a major injury. The facility's failure to follow the care plan caused Resident #31 to fall to the floor resulting in bilateral femur fractures. These actions had the likelihood to cause all residents residing in the facility serious harm, serious injury, serious impairment, or possible death. The situation was determined to be an Immediate Jeopardy (IJ) that began on 7/3/21, when TNA #1 failed to follow the care plan and did not have the required assistance needed to provide care for Resident #31 that resulted in a fall with a major injury. The facility Administrator was notified of the IJ on 9/28/21 and the IJ templates were provided to the Administrator. The State Survey Agency (SSA) received an acceptable Removal Plan on 9/30/21, in which the facility alleged that all corrective actions were completed as of 9/30/21, and the IJ was removed on 10/1/21. (Amendment 12/2/21 - The SSA determined that the IJ was removed on 7/8/21). The SSA validated the Removal Plan and determined the IJ to be removed 7/8/21. Therefore, the scope and severity for IJ at CFR 483.21(b)(1)-Comprehensive Care Plans (F656) was lowered to "D", while the facility develops and implements a plan of correction and monitors effectiveness of systemic changes to ensure the	F 656	After review of Census and Daily Assignment Sheets, the Administrator concluded that 19 of the 40 residents had the potential of receiving harm from the care plan not being followed by TNA #1. 3. Actions taken/systems put into place to reduce the risk of future occurrence include On 07/04/2021 and 07/05/2021, the Administrator in serviced TNA and CNA staff on the subject of following the ADL and Care Guides to ensure all resident obtain the assistance stated in the Residents' Care Plan and Care Guides. On 07/05/2021, a one hundred percent review of all residents' Activities of Daily Living Care Plan and Care Guides were done by the Minimum Data Set (MDS) Nurse with no concerns identified. On 11/10/2021, the Staff Development Nurse and Administrator from a non-affiliated sister facility, performed in-servicing with all non-contracted staff, the Maintenance Director, the Assistant Maintenance Director, and the Director of Housekeeping on the topic of Comprehensive Care Plans. On 10/02/2021, the Lead CNA began making weekly rounds for a year to monitor Resident Care to ensure that Care Plans are being followed. Beginning on 07/08/2021, the MDS Nurse started performing weekly rounds on Resident #31's ADL and Care Guides to ensure that Resident #31 is obtaining the assistance stated in that Resident's Comprehensive Care Plan. The MDS Nurse will maintain a log of the findings		

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 facility sustains compliance with regulatory requirements. Findings Include: Review of the facility policy, "Care Plan, Comprehensive Person-Centered", revised December 2016, revealed, "Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." Record review of Resident #31's Care Plan with a Problem Onset date of 03/27/2020 revealed "(Formal Name) decline in ability to perform self care activities, (Formal Name) is unable to bear weight, (Formal Name) at risk for soiling clothing ...Approaches: Provide extensive assistance X2 (of two persons) with bed mobility...Provide total assistance X2 with toileting ..." Record review of the Nurse Aides' Information Sheet, undated, revealed Resident #31 required total assistance X2 with incontinent care for bowel and bladder and extensive assistance X2 for turning and repositioning. Record review of Resident #31's Fall Risk Evaluation revealed the assessments were completed on 06/09/21, 07/06/21, and 07/21/21. All assessments revealed Resident #31 scored a total of 24 which indicated the resident was high risk for falls. During an interview on 09/16/21at 09:00 AM, with the Director of Nursing (DON) confirmed Resident #31 fell out of the bed to the floor on	F 656	weekly for four weeks, monthly for three months, and then quarterly for a year. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur? Beginning 10/02/2021, the Director of Nursing will perform an audit of the Lead CNA's findings to monitor for problems and to help prevent a reoccurrence, weekly for a year. Beginning on 07/08/2021, the DON will monitor the MDS Nurse's logs on Resident #31's ADL and Care Guides weekly for a year. The incident of Resident #31 and Resident #31's ADLs and Comprehensive Care Plan were brought before the QA Committee on 07/08/2021, and also the topic of following all Residents' ADL Plan of Care and ADL supporting documentation was discussed with the QA Committee on 07/08/2021. This topic was brought before the QA Committee again on 10/27/2021, and it will continue being discussed with the QA Committee monthly for three months.		

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 7/3/21. The DON said on 7/6/21 she had TNA #1 come to the facility and re-enact the incident. The DON revealed TNA #1 provided incontinent care without a Certified Nursing Assistant (CNA) or Nurse assisting her. TNA #1 turned Resident #31 to the right side and did not remove the pillows from the resident's feet. TNA #1 said she forgot to remove Resident #31's pillows before turning her. Resident #31 slid to the floor on her knees. Resident #31 was still holding on to the bedrails. TNA #1 said she notified Licensed Practical Nurse (LPN) #1. The DON said TNA #1 said she had read Resident #31's plan of care. TNA #1 said she knew Resident #31 was a two (2) person assist with bed mobility, but she thought she could do it without help. The DON said TNA #1 and CNAs are trained that TNAs should not provide care without a licensed/certified person being present. The DON confirmed TNA #1 failed to follow Resident #31's Care Plan because the Care Plan says Resident #31 should have two (2) people with bed mobility and transfers. During an interview on 09/16/21 at 2:15 PM, LPN #2, said the staff is trained during orientation and annually on ADL task, skills, and checkoffs. LPN #2 said during her training she educates the TNA's and CNA's that the TNAs cannot provide care without licensed or certified personnel. LPN #2 confirmed she cannot provide an in-service with TNA #1 indicating she was trained to only provide care with a licensed or certified person. LPN #2 confirmed TNA #1 failed to follow the care plan because Resident #31 was a two (2) person assist with all ADL's. During an interview on 9/16/21 at 2:30 PM, with CNA #2 confirmed TNA #1 failed to follow the facility policy and failed to follow the care plan by	F 656			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 providing incontinent care to Resident #31 without having a licensed or certified person present. interview on 9/16/21 at 3:30 PM, with TNA #1 confirmed she provided incontinent care without a CNA or Nurse with her. TNA #1 said she was told by CNA #1 her supervisor that she only needed another staff member in the room when a lift is used for transfer. TNA #1 said she was not told that she could not provide incontinent care to the residents alone. TNA #1 said she has provided incontinent care alone with multiple residents. TNA #1 also said she read Resident #31 care plan when she first started working at the facility. TNA #1 said she forgot what the care plan said. Resident #31 should have 2 people with care. TNA #1 confirmed she did not ask any of the other staff for assistance because she has provided incontinent care without help multiple times and there was no negative outcome. TNA #1 said she was not told that she could not provide care to residents without a CNA or nurse present. During an interview on 9/16/21 at 04:00 PM, with LPN #3 confirmed TNA #1 failed to follow the care plan because Resident #31's care plan indicates Resident #31 is extensive assist with all ADL's. Resident #31 should have 2 people while providing incontinent care, baths, tuning, positioning, dressing and Hoyer lifts. LPN #3 said she expects the staff to follow the care plan. Record review of Resident #31's Face Sheet revealed Resident #31 was admitted to the facility on 3/27/2020, with the diagnoses that included Major Depressive Disorder, Hypertension, Dementia and current diagnoses of Unspecified Fracture lower end of right femur and Unspecified	F 656			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 35 Fracture lower end of left femur. Record review of the admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 06/09/21 revealed Resident#31 had a Brief Interview For Mental Status (BIMS) score of 14 which indicates Resident #31 is cognitively intact. The facility provided an acceptable Removal Plan on 9/30/21, for the IJ. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: Removal Plan Immediate Jeopardy (IJ) was called on 9/28/2021 at 12:35 PM. The IJ template was provided on 9/28/2021 at 12:35 PM. Beginning 7/3/2021 when Temporary Nursing Assistant (TNA) #1 failed to obtain the necessary assistance to provide incontinent care to resident #31 resulting in a major injury with fracture of bilateral knees. The State Agency notified the Administrator and the Director of Nursing (DON) that an IJ had been identified. Brief Summary of Events The facility failed to ensure a resident was protected from neglect as evidence by (AEB) an unlicensed TNA neglected to obtain assistance required when providing incontinent care that resulted in Resident #31 obtaining a fracture. ON 7/3/21, immediate action was taken by the cart nurse to notify the doctor and obtain bilateral knee x-rays. The facility failed to follow the comprehensive care plan while providing incontinent care AEB Resident #31 is extensive assist and always needs two people during care.	F 656			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 36 The facility failed to ensure a vulnerable resident was protected from accidents and hazards when a TNA #1 failed to ask for help while providing incontinent care, which caused Resident #31 to fall with a major injury to bilateral knees. The facility failed to protect Resident #31 and other residents from potential for further injury during the investigation process by not removing TNA #1 from the facility following an incident on 7/3/2021. The Facility continued to allow TNA #1 to work until 7/05/21. Corrective Action: - On 7/3/2021, the Administrator provided education to the Charge Nurse, two (2) TNAs, 2 Cart Registered Nurses (RN), and three (3) Certified Nursing Assistants (CNA) directly involved in the fall of Resident #31. On 7/3/2021, the in-service topics included following the Activities of Living (ADL) Care Plan and Care Guide, Abuse and Neglect, and Residents' Rights. On 7/4/2021 and 7/5/2021, the Administrator continued in-servicing with all staff on the above topics. No staff will be allowed to work until in-services are completed. - On 07/03/21, the Administrator identified that Resident #31 sustained a fall with injury and initiated an investigation. - On 07/05/2021 at 10:24 AM, the Administrator suspended TNA #1 until further notice to complete investigation. On 07/05/2021 the Administrator conducted and completed the investigation. On 07/12/21 the Administrator terminated TNA #1. - On 7/5/2021 at 10:00 AM, each resident under the care from TNA #1 who was identified	F 656			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 37 as at risk for falls was assessed with no further falls identified. 5. On 07/05/2021 at 10 AM, the Minimum Data Set Nurse (MDS) conducted a 100 percent audit of Resident's Fall Risk Assessments and Care Plans for accuracy with no concerns identified. 6. Each resident has a care guide specific to their needs located in a binder at each nurse's station. These are reviewed by the CNAs prior to the start of each shift and to be followed to provide care to the residents. On 07/05/2021, the MDS Nurse performed a 100 percent audit of the care guides with no concerns identified. On 07/05/2021 The Administrator in-serviced CNAs and TNAs on the following: ADL care guides specific to each resident. On 07/05/2021, the MDS Nurse performed a 100 percent audit on ADLs of residents identified at risk for falls and failure to follow the ADL Plan of Care. All residents at risk needing two-person assist were identified and reviewed. On 9/16/2021, the Staff Development Nurse educated all TNAs and CNAs on providing resident care only with a CNA or Nurse present, no staff will be allowed to work until in serviced. TNAs and CNAs were instructed to review ADL care plan prior to each shift. 19 of the 40 residents were identified as at risk for falls and failure for the ADL Plan of Care to be followed. A form was developed and created for all TNA new hires to have proper education, training, and understanding that they must work directly with a licensed CNA and to follow and know their ADL plan of care. On 9/21/2021, the Staff Development Nurse educated all staff that all TNA's can only provide resident care with a CNA or Nurse present, no staff will be allowed to work until in-serviced.	F 656			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 38 7. The Administrator requested an in-person Quality Assurance Performance Improvement (QAPI) meeting to review events leading to this occurrence and corrective action taken. QAPI meeting occurred on July 8, 2021, and included the Administrator, Director of Nursing, Medical Director, MDS Nurse, Wound Care Nurse, Care Plan Nurse, Medical Records Nurse, Infection Preventionist, Physical Therapist, Administrator Assistant, and the Billing Office Manager. The meeting specifically discussed this fall, identified cause of the fall, number of previous falls, fall risk and potential harm, prevention of recurrence, abuse/neglect, following ADL care plan, Resident's Rights, ADL support and serious injury/harm and reporting. On 07/06/21, the Administrator in serviced the DON and Charge Nurse on the topic of removing any staff from the building for alleged violations of abuse, neglect, exploitation, or misappropriation of resident property until the investigation is completed. No changes to fall policy were required after being reviewed by QAPI. 8. On 9/16/2021, a form was created for all TNA hire in packets to ensure all TNA new hires have proper education, training, and understanding that they must work directly with a licensed CNA. 9. The Administrator and DON conducted a 100 percent audit on all accidents and incidents from 07/04/2021 through 9/30/2021 to ensure that injury or negative outcomes was not identified related to unsupervised TNAs. On 07/05/21, the Administrator in-serviced all staff on fall related policies. Falls are reviewed at stand up meeting every morning and Quarterly Quality Assurance (QA) meeting. On 07/05/21 at 7AM, the	F 656			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 39 Administrator continued on-going in servicing to reiterate with all staff that TNAs must provide care only with CNA assist. 10. The facility alleges that all corrective actions to remove the IJ were completed on 9/30/21, and the IJ was removed on 10/1/21. On 10/2/21, the State Survey Agency (SSA) validated the facility's Removal Plan by staff interviews, record reviews, and review of in-service sign-in sheets. The SSA verified the facility had implemented the following measures to remove IJ: Validation: 1. The SSA validated through interview with the Administrator and in-service sign in sheets that on 7/3/2021, the Administrator provided education to the Charge Nurse, two (2) TNAs, 2 Cart Registered Nurses (RN), and three (3) Certified Nursing Assistants (CNA) directly involved in the fall of Resident #31. On 7/3/2021, the in-service topics included following the Activities of Living (ADL) Care Plan and Care Guide, Abuse and Neglect, and Residents' Rights. On 7/4/2021 and 7/5/2021, the Administrator continued in-servicing with all staff on the above topics. No staff will be allowed to work until in-services are completed. 2. The SSA validated through interview on 10/1/21 that on 07/03/21, the Administrator identified Resident #31 sustained a fall with injury and initiated an investigation. 3. The SSA validated through interview and record review that on 07/05/2021 at 10:24 AM, the Administrator suspended TNA #1 until further	F 656			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 40 notice to complete investigation and on 07/05/2021 the Administrator conducted and completed the investigation. On 07/12/21 the Administrator terminated TNA #1. 4. The SSA validated through interview with DON and record review that on 7/5/2021 at 10:00 AM, each resident under the care from TNA #1 who was identified as at risk for falls was assessed with no further falls identified. 5. The SSA validated through interview with the Minimum Data Set Nurse (MDS) nurse and record review on 07/05/2021 at 10 AM, the MDS nurse conducted a 100 percent audit of Resident's Fall Risk Assessments and Care Plans for accuracy with no concerns identified. 6. The SSA validated through staff interviews, record reviews and signed in-services that each resident has a care guide specific to their needs located in a binder at each nurse's station. These are reviewed by the CNAs prior to the start of each shift and to be followed to provide care to the residents. On 07/05/2021, the MDS Nurse performed a 100 percent audit of the care guides with no concerns identified. On 07/05/2021 The Administrator in-serviced CNAs and TNAs on the following: ADL care guides specific to each resident. On 07/05/2021, the MDS Nurse performed a 100 percent audit on ADLs of residents identified at risk for falls and failure to follow the ADL Plan of Care. All residents at risk needing two-person assist were identified and reviewed. On 9/16/2021, the Staff Development Nurse educated all TNAs and CNAs on providing resident care only with a CNA or Nurse present, no staff will be allowed to work until in serviced. TNAs and CNAs were instructed to review ADL	F 656			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 41 care plan prior to each shift. 19 of the 40 residents were identified as at risk for falls and failure for the ADL Plan of Care to be followed. A form was developed and created for all TNA new hires to have proper education, training, and understanding that they must work directly with a licensed CNA and to follow and know their ADL plan of care. On 9/21/2021, the Staff Development Nurse educated all staff that all TNA's can only provide resident care with a CNA or Nurse present, no staff will be allowed to work until in-serviced. 7. The SSA validated through staff interviews, record review and signed in-service sheets that the Administrator requested an in-person Quality Assurance Performance Improvement (QAPI) meeting to review events leading to this occurrence and corrective action taken. The QAPI meeting occurred on July 8, 2021, and included the Administrator, Director of Nursing, Medical Director, MDS Nurse, Wound Care Nurse, Care Plan Nurse, Medical Records Nurse, Infection Preventionist, Physical Therapist, Administrator Assistant, and the Billing Office Manager. The meeting specifically discussed this fall, identified cause of the fall, number of previous falls, fall risk and potential harm, prevention of recurrence, abuse/neglect, following ADL care plan, Resident's Rights, ADL support and serious injury/harm and reporting. On 07/06/21, the Administrator in serviced the DON and Charge Nurse on the topic of removing any staff from the building for alleged violations of abuse, neglect, exploitation, or misappropriation of resident property until the investigation is completed. No changes to fall policy were required after being reviewed by QAPI.	F 656			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 42 8. The SSA validated through an interview with the Administrator and record review that on 9/16/2021, a form was created for all TNA's hire in packets to ensure all TNA new hires have proper education, training, and understanding that they must work directly with a licensed CNA. 9. The SSA validated through record review, signed in-services and interview with the Administrator and DON that a 100 percent audit was conducted on all accidents and incidents from 07/04/2021 through 9/30/2021 to ensure that injury or negative outcomes was not identified related to unsupervised TNAs. On 07/05/21, the Administrator in-serviced all staff on fall related policies. Falls are reviewed at stand up meeting every morning and Quarterly Quality Assurance (QA) meeting. On 07/05/21 at 7AM, the Administrator continued on-going in servicing to reiterate with all staff that TNAs must provide care only with CNA assist. 10. Amendment 12/2/21 - The SSA validated that all corrective actions to remove the IJ had been completed as of 7/8/21, and the IJ removed on 7/8/21.	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 - §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	F 689		11/4/21	

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 by: Amendment 12/07/2021 Upon secondary review with CMS Regional Office and State Quality Assurance review, the State Survey Agency (SSA) determined the Immediate Jeopardy to be removed on 7/8/21 for F689 and the scope and severity was lowered to "D", while the facility develops and implements a plan of correction and monitors effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Based on staff interview, record reviews and facility policy review the facility failed to ensure a vulnerable resident was protected from accidents and hazards when a Temporary Nursing Assistant (TNA) failed to obtain the required assistance while providing incontinent care which caused a fall with a major injury for Resident #31. The facility failed to ensure the residents were free from rodents in the facility as evidenced by (AEB) a mouse was seen in the bed with Resident #31 and mouse droppings were under four (4) residents beds and in chests of drawers for seven (7) of 16 residents reviewed for accidents and hazards. Resident #3, Resident #6, Resident 12, Resident #13, Resident #31 and Resident #35, Resident #42. On 7/3/21, TNA #1 neglected to obtain the assistance required when providing incontinent care for Resident #31. TNA #1 turned the resident to her side without removing the pillows from the resident's feet. This resulted in Resident #31 falling to the floor and sustaining bilateral femur fractures. The resident underwent intramedullary nailing surgery to her bilateral femur fractures on 7/8/21. The facility failed to protect Resident #31	F 689	1.Immediate action(s) taken for the resident(s) found to have been affected include: On 07/03/2021 the on-call physician was made aware of Resident #31s fall, with the physician requesting x-rays of bilateral legs. On 07/03/2021, X-ray Personnel obtained the x-rays as ordered, revealing bilateral femur fractures. On 07/03/2021, the on-call doctor was made aware of the x-ray results, giving a telephone order to send Resident #31 to the emergency room. Resident #31 was transferred to the local hospital emergency department as ordered. The resident underwent intramedullary nailing surgery to her bilateral femur fractures on 7/8/2021 at an offsite orthopedic surgical center. On 07/12/2021, the Administrator terminated TNA #1 in efforts to prevent a reoccurrence of an accident. On 10/7/2021, the Administrator was made aware of an unobserved lesion to Resident #31s left great toe. On 10/7/2021, the Cart Nurse contacted Resident #31s Primary Care Physician (PCP), making him aware of the unobserved lesion, accepting and implementing new orders. On 10/7/2021, the Administrator notified the on-call Maintenance Personnel of a mouse sighting in Resident #31s room/bed. On 10/7/2021, Resident #31 was immediately removed from her room and transferred to an available room in the facility. On 10/7/2021, the Wound Care Nurse was notified of the lesion to the left great toe and reassessed the lesion with		

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 and other residents from potential for further injury during the investigation process by not removing TNA #1 from the facility following the incident on 7/3/2021. The facility continued to allow TNA #1 to work until 7/05/21. The State Survey Agency (SSA) extended the survey upon receipt of two (2) complaint investigations, CI: #18152 dated 10/08/21 and CI# 18165 dated 10/11/21 from an anonymous complainant alledging the facility is infested with rats. The complainant revealed that a rat was observed chewing on Resident #'s 13 feeding tube. The Complainant also said a rat was observed in the Resident's boot on one of her feet. The Complainant said the rat had eaten part of Resident #31's foot. The Complainant also said the staff is killing the rats because the facility Administration refuses to do anything about them. The facility's failure to provide supervision for a resident who is vulnerable and needs extensive assistance with all care is likely to cause injury and harm to other residents. This is evidenced by Resident #31 falling to the floor receiving bilateral femur fractures. These actions had the likelihood to cause all residents residing in the facility serious harm, serious injury, serious impairment, or possible death. The situation was determined to be an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) that began on 7/3/21 when TNA #1 failed to obtain the required assistance resulting in Resident #31 falling from bed and receiving a major injury. The facility Administrator was notified of the IJ on 9/28/21 and provided the IJ Template.	F 689	measurements documented. On 10/7/2021, the Exterminator treated Resident #31s room for pest control. On 10/7/2021, Maintenance Personnel performed an environmental check of Resident #31s room in attempt to identify cause(s) of pest. These potential causes were corrected by the Maintenance Department on 10/7/2021. On 10/7/2021, housekeeping performed a terminal cleaning of Resident #31s room. This incident was taken before the QA team on 10/12/2021 to be discussed for interventions to prevent a future reoccurrence. On 10/7/2021, the Lead CNA placed a container in Resident #31s room for opened food storage. On 10/7/2021, the Administrator in-serviced staff on pest interventions to be implemented immediately upon suspicion or sightings of pest. 2. Identification of other residents having the potential to be affected was accomplished by: The Administrator identified 19 of the 40 residents as at risk for falls, while in the care of Temporary Nursing Assistant (TNA) #1. On 07/05/2021, the Minimum Data Set (MDS) Nurse conducted a 100 percent audit of Residents' Fall Risk Assessments and Care Plans for accuracy with no concerns identified. On 07/05/2021, each resident who was identified at risk for falls was assessed with no further falls identified. On 07/05/2021, the Minimum Data Set Nurse performed a 100 percent audit of the Care Guides with no concerns identified. All		

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 The State Survey Agency (SSA) received an acceptable Removal Plan on 9/30/21, in which the facility alleged that all corrective actions were completed as of 9/30/21, and the IJ was removed on 10/1/21. (Amendment 12/2/21 - The SSA determined that the IJ was removed on 7/8/21) The SSA validated the Removal Plan on 10/2/21 and determined the IJ to be removed on 7/8/21. Therefore, the scope and severity for IJ at CFR 483.25(d)(1)(2)-Accidents Hazards/supervision/devices (F689) was lowered to "D", while the facility develops and implements a plan of correction and monitors effectiveness of systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Review of the facility's "Accident and Incidents-Investigating and Reporting", dated 07/2017, revealed "Policy Statement: It is the policy that all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator... Policy Interpretation and Implementation...5. The Nurse Supervisor/ Charge Nurse and/or the department director or supervisor shall complete a Report of Incident/ Accident form and submit the original of the Director of Nursing services within 24 hours. of the incident or accident. 6.The Director of Nursing shall ensure that the Administrator receives a copy of the Report of Incident/Accident form for each occurrence. 7.Incident/Accident reports will be reviewed by the Quality Assurance (QA) committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities."	F 689	residents at risk needing two-person assist were identified and reviewed. On 10/7/2021, the Lead Certified Nursing Assistant (CNA) performed room rounds and monitored for pests, with no additional problems identified. With a census of 39, we identified that the 16 residents located on the 300-hall have the potential to be affected (these are Residents located in rooms on the same hall as Resident #31). Beginning on 11/8/2021, all of the rooms on the 300-hall have been placed on the maintenance list to be assessed for potential pest entry points with identified areas to be corrected. Once Maintenance has completed their assessments and corrections, Housekeeping Staff will perform a terminal cleaning on all rooms on the 300-hall. The Lead CNA placed containers in all residents rooms identified as having the potential of being affected. This incident was taken to QA on 10/27/2020 3.Actions taken/systems put into place to reduce the risk of future occurrence include: On 07/04/2021, the Administrator provided in servicing to the Charge Nurse, Cart Nurse, Temporary Nursing Assistants (TNA), and Certified Nursing Assistants (CNA) involved in Resident #31s direct care. The in-service topics included: following the Activities of Daily Living Care Plans and Care Guides, Abuse and Neglect, and Residents Rights. On 07/04/2021 and 07/05/2021, the Administrator continued in-servicing with		

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 Review of the facility's "Fall Risk Assessment Policy", revised March 2018, revealed " Policy Statment, The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and establish a resident-centered falls prevention plan based on relevant assessment information... Policy Interpretation and Implementation...7. The staff, with the support of the attending physician, will evaluate functional and psychological factors that my increase fall risk, including ambulation, mobility, gait balance, excessive motor activity, Activities of Daily Living (ADL) capabilities, activity tolerance, continence, and cognition...." Interview on 09/16/21 at 09:00 AM, with the Director of Nursing (DON) revealed on 7/3/21 Resident #31 fell out of the bed to the floor while TNA #1 as providing care. The DON also stated that on 7/6/21 TNA #1 came to the facility and re-enacted the incident. The DON said TNA #1 said she was providing incontinent care alone and turned Resident #31 to the right side. TNA #1 said she did not remove the pillows from the resident's feet. TNA #1 said Resident #31 slid to the floor on her knees. Resident #31 was still holding on to the bedrails. TNA #1 revealed she notified Licensed Practice Nurse (LPN) #1. The DON said TNA #1 confirmed she had read Resident #31's plan of care. TNA #1 said she knew Resident #31 was a two (2) person assist with bed mobility, but she thought she could do it without help. The DON said the TNA's and Certified Nursing Assistants (CNA) are trained that TNAs should not provide care without a license person being present.	F 689	staff on the above topics. On 07/05/2021, the Administrator suspended TNA #1 until further notice to complete the investigation. On 07/05/2021, the Administrator conducted and completed the investigation. Beginning 10/2/2021, the Director of Nursing (DON) will review Daily Assignment Sheets to ensure that the CNA and TNA staff remain properly paired to perform direct care weekly for a year and a log will be maintained by the DON weekly for four weeks, then monthly for three weeks, and then quarterly for a year. Beginning on 10/2/2021, the Lead CNA began observational rounds to monitor for proper staffing as set forth by the Daily Assignment Sheets, and he will continue to make these observational rounds weekly for a year, and a log will be maintained by the Lead CNA for a year. The Staff Development Nurse and the Administrator from a non-affiliated sister facility presented a directed in-service for all non-contracted staff, the Assistant Director of Maintenance, the Director of Housekeeping, and the Director of Therapy on Freedom from Abuse, Neglect, and Exploitation on 11/10/2021. On 10/02/2021, a rodent checklist was placed at each Nursing Station for Nursing Staff to complete in the event that a rodent is suspected or detected. On 10/08/2021, the Lead CNA placed plastic containers in each residents room to ensure that all opened food is properly stored, and he will continue making sure that plastic containers are in Long-Term Care Residents rooms weekly. Beginning 10/8/2021, all Long-Term Care Residents		

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 During an interview on 09/16/21 at 10:25 AM, with the Administrator revealed TNA #1 had been through the CNA class but she has not taken her test. The Administrator said TNA #1 was paired with CNA #1. The Administrator said on 7/3/21 LPN #1 called her and said Resident #31 had slid to the floor during care. The Administrator said she was told Resident #31's feet got tied up in the sheets. Resident #31 was kicking and fell out of the bed while TNA #1 was providing incontinent care. The Administrator said she came to the facility and started the investigation. The Administrator confirmed TNA #1 was not suspended at that time. The Administrator gave orders to the nurses that TNA #1 should not provide care to any of the residents without supervision. The Administrator said on 7/6/21 TNA #1 was called in to do a re-enactment of the incident. The Administrator said TNA #1 said she raised the bed to her waist. TNA #1 turned the resident over without moving the pillows. TNA #1 said she had just read Resident #31 care plan and knew that she was a two (2) person assist with Activities of Daily Living (ADL's). TNA #1 said she thought she could do the care without assistance. The Administrator said it was determined during the investigation TNA #1 did not remove the pillows when she turned Resident #31, this caused the resident to fall out of bed. The Administrator said in-services were started with the staff on Abuse/Neglect, Resident rights, Following the care plan, ADL supporting and Accidents and Incidents. A Quality Assurance (QA) meeting was done 7/8/21. The Administrator said the Ombudsman, Mississippi State Department of Health (MSDH) and the Attorney General's (AG's) Office was notified on 7/3/21. The Administrator stated that TNA #1 was suspended 7/5/21 and terminated 7/12/21	F 689	rooms will be placed on a schedule to be terminally cleaned every quarter and as needed (PRN), and a log of these cleanings will be maintained by the Housekeeping Director for a year. On 10/07/2021, Resident #31 and all other Residents on the 300-hall that were identified as being potentially affected, received room inspections by the Maintenance Department to look for any rodent points of entry. Then, beginning on 10/08/2021, we moved Resident #31 and initiated moving the other Residents on the 300-hall from their rooms to receive terminal cleanings, and then any problems that were identified during the Maintenance environmental inspections have corrections initiated and are in progress. Beginning 10/8/2021, all Long-Term Care Residents rooms will be placed on a schedule to be inspected by the Maintenance Department to monitor for rodent points of entry quarterly, and those logs of the inspections and finding will be maintained by the Assistant Director of Maintenance for a year. The Exterminator will be notified by the Maintenance Department for a return visit for any detection of rodents. Rodent traps, if indicated, will be placed in any resident(s) room(s) for two weeks after rodent sighting. Beginning 10/8/2021, the grounds surrounding the facility will be inspected weekly by the Maintenance Department to monitor for ants for a year, and a log will be maintained. On 10/7/2021, the Lead CNA performed room rounds and audited for pests with no additional problems notified, and he will		

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 because she had been identified as having the potential of placing residents' at a safety at risk, leading the facility to terminate her employment. Interview on 09/16/21 at 12:51 PM, with CNA #1 said she was assigned to work with TNA #1 on 7/3/21. CNA #1 she went on the other side of the building to stock the linen cart. CNA #1 also revealed TNA #1 was at the nurse's station when she went to stock the cart. CNA #1 said she did not know CNA #1 was providing incontinent care without her until Resident #31 was reported on the floor. CNA #1 revealed LPN #2 and CNA #2 in-serviced the staff daily that TNAs cannot provide care without assistance of a licensed or certified staff member. CNA #1 said TNA #1 has not had any other instances where she provided care without assistance. Interview on 09/16/21 at 01:54 PM, with Registered Nurse (RN) #1 said she was the supervisor for the day. RN #1 said LPN #1 came down the hall extremely upset stating Resident #31 got her feet tied up in the sheets and slid out of the bed. RN #1 said she thought LPN #1 was in the room with TNA #1 while she was providing care. RN #1 said she received an order for an X-ray of Resident #31's bilateral knees from the medical doctor. During an interview with LPN #2 on 09/16/21 at 2:15 PM, confirmed the staff is trained during orientation and annually on Activities of daily Living (ADL) task, skills, and checkoffs. LPN #2 said during her training she tells the TNA's and CNA's that the TNAs cannot provide care without licensed or certified personnel. LPN #2 confirmed she cannot provide an in-service with TNA #1 indicating she was trained to only provide care	F 689	continue room rounds and monitor for pests weekly for a year. The Staff Development Nurse and the Administrator from a non-affiliated Sister Facility in-serviced all non-contracted staff, the Assistant Director of Maintenance, the Director of Maintenance, the Director of Therapy, and the Director of Housekeeping on Maintains Effective Pest Control on 11/10/2021. The Staff Development Nurse and Administrator from a non-affiliated sister facility also in-serviced on Accidents/Hazards/Devices on 11/10/21. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: Beginning the week of 10/2/2021, the Staff Development Nurse will monitor the Lead CNAs documentation to monitor for any problems or concerns and will keep a log of findings weekly x4 weeks, then monthly x 3 months, and then quarterly for one year. The fall of Resident #31 was taken to the QA Committee on 07/08/2021 for review. This incident and a review of Residents Rights was taken again to the QA team on 10/27/2021, and the QA Committee will continue meeting monthly for three months on these topics. Any new recommendations by the QA Committee will be implemented. Also, beginning on 10/8/2021, the Staff Development Nurse will monitor the logs of findings kept by the Assistant Director of Maintenance, the Director of Environmental Services, and the Lead CNA to prevent reoccurrence weekly for		

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 with a licensed or certified person. During an interview with CNA #2 on 9/16/21 at 2:30 PM, revealed he is at work every day at 6:00 AM. CNA #2 said he has a meeting with the CNA's and TNA's. CNA #2 reminds the staff that the TNA's can only provide care to residents with a licensed or certified person. TNAs cannot provide care without a certified CNA or a nurse being present. CNA #2 confirmed TNA #1 failed to follow the facility policy by providing incontinent care to Resident #31 without having another CNA or nurse present. During an interview with TNA #1 on 9/16/21 at 3:30 PM, revealed she checked on Resident #31 and noted the resident had an incontinent episode. TNA #1 confirmed she provided incontinent care without a CNA or Nurse with her. TNA #1 revealed she was told by CNA #2 that she only needed another staff member in the room when a lift is used for transfer. TNA #1 said she was not told that she could not provide incontinent care to the residents alone. TNA #1 said she has provided incontinent care alone with multiple residents. TNA #1 said she reviewed Resident #31's care plan when she first started working at the facility. TNA #1 said she did not remember Resident #31 plan of care required two (2) persons assist with ADL's. TNA #1 confirmed she did not ask any of the other staff for assistance because she has provided incontinent care without help multiple times and the resident was ok. Review of the facility's Nurse Aides Information Sheet plan of care revealed Resident #31 requires two person/extensive assist with incontinent care, Hoyer lifts, bed baths, showers,	F 689	four weeks, then monthly for three months and then quarterly for a year. On 10/12/2021, the QA team met and discussed rodent issues and concerns and the incident related to Resident #31. This event was taken to the Quality Assurance (QA) Committee again on 10/27/2021 with no new recommendations. The QA Committee will meet on this topic monthly for three months. Any new recommendations from the QA committee will be added and implemented.		

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 turn and reposition and dressing. Record review of Resident #31's Care Plan with a Problem Onset date of 03/27/2020 revealed "(Formal Name) decline in ability to perform self care activities, (Formal Name) is unable to bear weight, (Formal Name) at risk for soiling clothing ...Approaches: Provide extensive assistance X2 (of two persons) with bed mobility...Provide total assistance X2 with toileting ..." Record review of the Face Sheet revealed Resident #31 was admitted to the facility on 3/27/20 with diagnoses which included Major depressive disorder, Dementia, Psychotic disorder with delusions, Anxiety disorder, and Sarcopenia. Record review of Resident #31's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/09/2021 revealed Resident # 31 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #31 is cognitively intact. CI #18152 and CI #18165 Review of the facility's, "Pest Control", dated 8/20/18, revealed policy to establish a safe and reliable method of pest and rodent control for (Formal Name of Facility) .Procedure:1. Pest Control for the facility will be through a licensed, bonded commercial firm. 2. The pest control action will be carefully coordinated with appropriate Administrator and/or Director of Nursing and the Director of Maintenance. 3. Spraying and other means of pest control will be performed during a time of low patient flow. Generally, the day will be Friday afternoon to reduce the level of fumes for patients, staff. 4.	F 689			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 Recording of chemical spraying for (Formal Name) will be done through the use of a pest control spray log. The person in charge of maintenance will insure that entries in the log are completed in an accurate and timely basis.5. Spraying and pest control activities will be kept to an absolute minimum." During an observation of the facility on 10/12/21 at 09:00 AM, revealed Resident # 13 lying in bed with the head of the bed elevated. The Resident was nonverbal with Jevity 1.2 infusing at (@) 50 cubic centimeters (cc)/hour (hr) per continuous tube feeding. The Resident did not have any lesions or broken skin noted on either foot. The SSA observed mice droppings in the residents chest of drawers. The SSA also observed a cardboard mouse hotel noted under the resident's bed. The SSA also observed Resident #31's left big toe on 10/12/21 at 9:00 during the tour. The toe had two (2) red areas. No blood or drainage was noted. The SSA observed mice hotels in all the residents' rooms on the 300 halls underneath their beds. During an interview on 10/12/21 at 09:15 AM, the Administrator confirmed the facility has a problem with mice. The Administrator said the staff notified her of the mice in the building about a month and a half ago. The Administrator said the staff told her they saw mice at the nurse's station and in the offices on the 300 halls. The Administrator said the maintenance department put out sticky traps at the nurse's station, offices, and utility rooms. The Administrator said she was notified on 10/7/21 at 06:00 AM that Resident #31 had a mouse in her bed. The Administrator also said	F 689			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 she was told Resident #31 had a possible bite on her left toe. The Administrator said she immediately notified maintenance and started an investigation. Resident #31 was assessed and removed from that room. The Resident's room was thoroughly cleaned. The Administrator said she was told the mice has only been seen at night. The day shift said they have not seen any mice. The Administrator said the (Formal name of pest control company) comes out monthly and sprays for all pest and rodents. The facility is in the process of reconstruction of the 200, 300 and 400 halls. The Administrator also said the facility is removing all the residents off the 300 hall and re-doing their rooms first because of the mice citings. Review of the facility's, "pest control invoice", revealed the pest control company made a visit to the facility on 9/9/21 and 9/30/21. During an interview on 10/12/21 at 10:30 AM, CNA #2 confirmed the facility has problems with mice. CNA #2 said he has removed 4 mice out of the building in the last few months. CNA #2 said he removed two (2) out of Residents rooms and two (2) out of the nurse's offices. CNA #2 said the mice were in the mice hotels. CNA #2 revealed he started seeing and hearing about the mice in the building about eight months ago when the facility started reconstruction on the kitchen. CNA #2 said maintenance put out sticky traps at the nurse's station and in the utility closet. CNA #2 said the staff will call him if a mouse enters the mouse hotel to remove it. During an interview on 10/12/21 at 11:00 AM, with RN # 2 revealed he was consulted to assess Resident #31's wound on her left great toe. RN	F 689			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 #2 said the lesion measured at 0.4 centimeters (cm) x 0.3 cm x 0.2 cm. The wound was red and open with no drainage or odor. RN #2 said he received an order to cleanse the area with normal saline, apply triple antibiotic cream and cover with a dry dressing. RN #2 said he has seen CNA #2 taking a mouse out of the facility in the mouse hotel. He has not removed any mice himself. During an interview on 10/12/21 at 11:15 AM, with the Maintenance Director confirmed the facility has a problem with mice in the facility. The Maintenance Director said this was brought to his attention about a month and a half ago. The staff complained of seeing mice running across the nurse's station. The Maintenance Director said he put out sticky traps at the nurses station and in the utility rooms. The Maintenance Director also said (name of pest control company) comes out monthly and as needed. The pest control company has placed five (5) bait stations under the facility with mice bait. The Maintenance Director said it was brought to his attention again on the 10/7/21, when he was told Resident #31 had a mouse in her bed. The Maintenance Director said he put out 38 mouse baits on the rehab side of the facility in the residents' rooms and 17 on the long-term side. The Maintenance Director said no one has reported seeing any mice on the Rehab side. During an interview on 10/12/21 at 12:30 PM, with the Medical Director (MD) revealed he looked at the resident's foot and believe she has two (2) lesions on her left toe. From what, he does not know. The MD said he could not tell what kind of bite it is. The MD said the Resident was started on Doxycycline which is appropriate for a mouse bite. The Resident is also ordered triple antibiotic	F 689			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 cream every shift and as needed. During an interview on 10/12/21 at 1:00 PM, with Resident #31's primary Physician confirmed he was notified on 10/7/21 that Resident #31 could have received a possible mouse bite. The primary Physician said he ordered Doxycycline 100 milligrams (mg) orally twice a day, for ten days. During an interview on 10/12/21 at 2:00 PM, with the local pest control staff revealed he treats the facility once a month for all pest and rodents. The facility will call him for extra treatments when needed. He said he was called on 10/7/21 for an extra treatment because the facility saw a mouse in a resident's bed. He stated he placed bait stations under the facility. He has recommended that the facility would put snap traps out at the nurse's station and in the utility closets. He said he told them not to put them in the resident's room. He said he doesn't know why the facility has seen an increase in mouse citings. During an interview per phone on 10/12/21 at 8:30 PM, with CNA #3 said she pulled Resident #31's cover back to provide incontinent care. CNA #3 said she saw the mouse run in Resident #31's boot. CNA #3 said she screamed. CNA #4 pulled the cover off the bed. The mouse ran down the bed and jumped off the bed and ran in a hole that was next to the closet in the resident's room. CNA #3 said she had never seen a mouse in a resident's bed before. CNA #3 said she has seen mice for several months running down the hall and at the nurse's station. CNA #3 said she has seen mice droppings in several residents' drawers. She reported the mice to CNA #2. She reported the maintenance department put out sticky traps.	F 689			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 55 During an interview per phone on 10/12/21 at 8:45 PM, with LPN #3 confirmed she was called into Resident #31's room by CNA #3 and CNA #4. LPN #3 said the mouse ran out of Resident #31's Prevalon boot and jumped off the bed onto the floor and ran in a hole in the wall under the closet door. LPN #3 said there was mouse droppings on the floor and in the residents' bed linen from top to bottom of the bed. Resident #31 had two (2) open lesions to her left great toe, active bright red blood was noted on the residents left toe. The primary Physician ordered doxycycline 100 mg orally twice a day times ten days. The wounds were cleansed with normal saline and triple antibiotic ointment was applied. The Administrator, DON and family was notified of the incident. During an interview per phone on 10/12/21 at 9:00 PM, with CNA #4 revealed she was attempting to provide incontinent care to Resident #31. CNA #4 said CNA #3 pulled the cover back on Resident #31. A mouse ran into Resident #31's Prevalon boot. CNA #4 said she pulled the cover off the bed and the mouse ran out of the boot up to the head of the bed and jumped off the bed and ran in a hole in the wall near the closet. CNA #4 also said the mouse had droppings from the head of the bed to the bottom. There were mouse droppings all over the floor. CNA #4 said she has seen mice running up and down the halls several times ever since the facility started tearing down the kitchen eight months ago. CNA #4 said she reported the mice to the CNA #2. CNA #2 reported it to maintenance. CNA #4 said maintenance put out sticky traps. CNA #4 said she has seen mouse droppings in several of the resident's drawers on the 300 hall.	F 689			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 56 During an observation on 10/13/21 at 10:00 AM, of the rooms on the 300 halls with CNA #2 revealed mouse droppings in the chest of drawers and on the floor under the Residents beds in four (4) resident rooms. Resident #3, Resident #6, Resident #12, and Resident #35 resided in the rooms that were identified with mouse droppings. Record review of the Face Sheet revealed Resident #3 was admitted to the facility with the diagnoses that included Dementia with behavioral disturbance, Hypertension, and History of falls. Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/18/21 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of eight (8) that indicated Resident #3 has moderate cognitive impairment. Record review of the Face Sheet revealed Resident #6 was admitted to the facility on 12/29/17 with diagnoses that included Alzheimer's disease, Diabetes Mellitus, and Hypertension. Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/25/21 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of three (3) that indicated Resident #6 has severe cognitive impairment. Record review of the Face Sheet revealed Resident #12 was admitted to the facility on 10/14/13 with diagnoses that included Multiple Sclerosis, Dementia and Rhabdomyolysis.	F 689			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 57 Record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/8/21 revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of ten (10) that indicated Resident #12 has moderate cognitive impairment. Interview with Resident #12 on 10/13/21 at 10:15 AM, revealed she has not seen any mice in her room. She did not know she had mice droppings in her chest of drawers and under her bed. Record review of the Face Sheet revealed Resident #31 was admitted to the facility on 03/27/20 with diagnoses that included Major depressive disorder, Dementia, Psychotic disorder with delusions, Anxiety disorder, and Sarcopenia. Record review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/21/2021 revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of one (1) which indicated Resident #31 has severe cognitive impairment. Record review of the Face Sheet revealed Resident #35 was admitted to the facility on 11/3/19 with diagnoses that included Amputation of the Right Leg, Peripheral Vascular Disease (PVD), Diabetes Mellitus and High Blood Pressure. Record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/28/21 revealed Resident #35 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) that indicated Resident #35 is cognitively intact.	F 689			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 58 Record review of the Face Sheet revealed Resident #42 was admitted to the facility on 9/28/21 with diagnoses that included Osteomyelitis, Diabetes Mellitus, and Hypertension. Record review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/5/21 revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) that indicated Resident #42 is cognitively intact. Interview on 10/13/21 at 10:42 AM, with Resident #42 confirmed he saw a mouse run across the floor in his room. He also said he has reported it to CNA #2 that he saw mice droppings under his bed. The Resident said CNA #2 put a mouse hotel in his room and he has not seen them again. The facility provided an acceptable Removal Plan on 9/30/21, for the IJ. Review of the facility's Removal Plan revealed the facility took the following actions to remove the IJ: Removal Plan Immediate Jeopardy (IJ) was called on 9/28/2021 at 12:35 PM. The IJ template was provided on 9/28/2021 at 12:35 PM. Beginning 7/3/2021 when Temporary Nursing Assistant (TNA) #1 failed to obtain the necessary assistance to provide incontinent care to resident #31 resulting in a major injury with fracture of bilateral knees. The State Agency notified the Administrator and the Director of Nursing (DON) that an IJ had been identified.	F 689			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021	
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452			
(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 59 Brief Summary of Events The facility failed to ensure a resident was protected from neglect as evidence by (AEB) an unlicensed TNA neglected to obtain assistance required when providing incontinent care that resulted in Resident #31 obtaining a fracture. ON 7/3/21, immediate action was taken by the cart nurse to notify the doctor and obtain bilateral knee x-rays. The facility failed to follow the comprehensive care plan while providing incontinent care AEB Resident #31 is extensive assist and always needs two people during care. The facility failed to ensure a vulnerable resident was protected from accidents and hazards when a TNA #1 failed to ask for help while providing incontinent care, which caused Resident #31 to fall with a major injury to bilateral knees. The facility failed to protect Resident #31 and other residents from potential for further injury during the investigation process by not removing TNA #1 from the facility following an incident on 7/3/2021. The Facility continued to allow TNA #1 to work until 7/05/21. Corrective Actions: 1. On 7/3/2021, the Administrator provided education to the Charge Nurse, two (2) TNAs, 2 Cart Registered Nurses (RN), and three (3) Certified Nursing Assistants (CNA) directly involved in the fall of Resident #31. On 7/3/2021, the in-service topics included following the Activities of Living (ADL) Care Plan and Care Guide, Abuse and Neglect, and Residents' Rights. On 7/4/2021 and 7/5/2021, the Administrator continued in-servicing with all staff on the above topics. No staff will be allowed to work until in-services are completed.			F 689			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 60 2. On 07/03/21, the Administrator identified that Resident #31 sustained a fall with injury and initiated an investigation. 3. On 07/05/2021 at 10:24 AM, the Administrator suspended TNA #1 until further notice to complete investigation. On 07/05/2021 the Administrator conducted and completed the investigation. On 07/12/21 the Administrator terminated TNA #1. 4. On 7/5/2021 at 10:00 AM, each resident under the care from TNA #1 who was identified as at risk for falls was assessed with no further falls identified. 5. On 07/05/2021 at 10 AM, the Minimum Data Set Nurse (MDS) conducted a 100 percent audit of Resident's Fall Risk Assessments and Care Plans for accuracy with no concerns identified. 6. Each resident has a care guide specific to their needs located in a binder at each nurse's station. These are reviewed by the CNAs prior to the start of each shift and to be followed to provide care to the residents. On 07/05/2021, the MDS Nurse performed a 100 percent audit of the care guides with no concerns identified. On 07/05/2021 The Administrator in-serviced CNAs and TNAs on the following: ADL care guides specific to each resident. On 07/05/2021, the MDS Nurse performed a 100 percent audit on ADLs of residents identified at risk for falls and failure to follow the ADL Plan of Care. All residents at risk needing two-person assist were identified and reviewed. On 9/16/2021, the Staff Development Nurse educated all TNAs and CNAs on providing resident care only with a CNA or Nurse present, no staff will be allowed to work	F 689			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 61 until in serviced. TNAs and CNAs were instructed to review ADL care plan prior to each shift. 19 of the 40 residents were identified as at risk for falls and failure for the ADL Plan of Care to be followed. A form was developed and created for all TNA new hires to have proper education, training, and understanding that they must work directly with a licensed CNA and to follow and know their ADL plan of care. On 9/21/2021, the Staff Development Nurse educated all staff that all TNA's can only provide resident care with a CNA or Nurse present, no staff will be allowed to work until in-serviced. 7. The Administrator requested an in-person Quality Assurance Performance Improvement (QAPI) meeting to review events leading to this occurrence and corrective action taken. QAPI meeting occurred on July 8, 2021, and included the Administrator, Director of Nursing, Medical Director, MDS Nurse, Wound Care Nurse, Care Plan Nurse, Medical Records Nurse, Infection Preventionist, Physical Therapist, Administrator Assistant, and the Billing Office Manager. The meeting specifically discussed this fall, identified cause of the fall, number of previous falls, fall risk and potential harm, prevention of recurrence, abuse/neglect, following ADL care plan, Resident's Rights, ADL support and serious injury/harm and reporting. On 07/06/21, the Administrator in serviced the DON and Charge Nurse on the topic of removing any staff from the building for alleged violations of abuse, neglect, exploitation, or misappropriation of resident property until the investigation is completed. No changes to fall policy were required after being reviewed by QAPI. 8. On 9/16/2021, a form was created for all TNA	F 689			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 62 hire in packets to ensure all TNA new hires have proper education, training, and understanding that they must work directly with a licensed CNA. 9. The Administrator and DON conducted a 100 percent audit on all accidents and incidents from 07/04/2021 through 9/30/2021 to ensure that injury or negative outcomes was not identified related to unsupervised TNAs. On 07/05/21, the Administrator in-serviced all staff on fall related policies. Falls are reviewed at stand up meeting every morning and Quarterly Quality Assurance (QA) meeting. On 07/05/21 at 7AM, the Administrator continued on-going in servicing to reiterate with all staff that TNAs must provide care only with CNA assist. 10. The facility alleges that all corrective actions to remove the IJ were completed on 9/30/21, and the IJ was removed on 10/1/21. On 10/2/21, the State Survey Agency (SSA) validated the facility's Removal Plan by staff interviews, record reviews, and review of in-service sign-in sheets. The SSA verified the facility had implemented the following measures to remove IJ: Validation: 1. The SSA validated through interview with the Administrator and in-service sign in sheets that on 7/3/2021, the Administrator provided education to the Charge Nurse, two (2) TNAs, 2 Cart Registered Nurses (RN), and three (3) Certified Nursing Assistants (CNA) directly involved in the fall of Resident #31. On 7/3/2021, the in-service topics included following the Activities of Living (ADL) Care Plan and Care Guide, Abuse and	F 689			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 63 Neglect, and Residents' Rights. On 7/4/2021 and 7/5/2021, the Administrator continued in-servicing with all staff on the above topics. No staff will be allowed to work until in-services are completed. 2. The SSA validated through interview on 10/1/21 that on 07/03/21, the Administrator identified Resident #31 sustained a fall with injury and initiated an investigation. 3. The SSA validated through interview and record review that on 07/05/2021 at 10:24 AM, the Administrator suspended TNA #1 until further notice to complete investigation and on 07/05/2021 the Administrator conducted and completed the investigation. On 07/12/21 the Administrator terminated TNA #1. 4. The SSA validated through interview with DON and record review that on 7/5/2021 at 10:00 AM, each resident under the care from TNA #1 who was identified as at risk for falls was assessed with no further falls identified. 5. The SSA validated through interview with the Minimum Data Set Nurse (MDS) nurse and record review on 07/05/2021 at 10 AM, the MDS nurse conducted a 100 percent audit of Resident's Fall Risk Assessments and Care Plans for accuracy with no concerns identified. 6. The SSA validated through staff interviews, record reviews and signed in-services that each resident has a care guide specific to their needs located in a binder at each nurse's station. These are reviewed by the CNAs prior to the start of each shift and to be followed to provide care to the residents. On 07/05/2021, the MDS Nurse performed a 100 percent audit of the care guides	F 689			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 64 with no concerns identified. On 07/05/2021 The Administrator in-serviced CNAs and TNAs on the following: ADL care guides specific to each resident. On 07/05/2021, the MDS Nurse performed a 100 percent audit on ADLs of residents identified at risk for falls and failure to follow the ADL Plan of Care. All residents at risk needing two-person assist were identified and reviewed. On 9/16/2021, the Staff Development Nurse educated all TNAs and CNAs on providing resident care only with a CNA or Nurse present, no staff will be allowed to work until in serviced. TNAs and CNAs were instructed to review ADL care plan prior to each shift. 19 of the 40 residents were identified as at risk for falls and failure for the ADL Plan of Care to be followed. A form was developed and created for all TNA new hires to have proper education, training, and understanding that they must work directly with a licensed CNA and to follow and know their ADL plan of care. On 9/21/2021, the Staff Development Nurse educated all staff that all TNA's can only provide resident care with a CNA or Nurse present, no staff will be allowed to work until in-serviced. 7. The SSA validated through staff interviews, record review and signed in-service sheets that the Administrator requested an in-person Quality Assurance Performance Improvement (QAPI) meeting to review events leading to this occurrence and corrective action taken. The QAPI meeting occurred on July 8, 2021, and included the Administrator, Director of Nursing, Medical Director, MDS Nurse, Wound Care Nurse, Care Plan Nurse, Medical Records Nurse, Infection Preventionist, Physical Therapist, Administrator Assistant, and the Billing Office Manager. The meeting specifically discussed this	F 689			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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 65 fall, identified cause of the fall, number of previous falls, fall risk and potential harm, prevention of recurrence, abuse/neglect, following ADL care plan, Resident's Rights, ADL support and serious injury/harm and reporting. On 07/06/21, the Administrator in serviced the DON and Charge Nurse on the topic of removing any staff from the building for alleged violations of abuse, neglect, exploitation, or misappropriation of resident property until the investigation is completed. No changes to fall policy were required after being reviewed by QAPI. 8. The SSA validated through an interview with the Administrator and record review that on 9/16/2021, a form was created for all TNA's hire in packets to ensure all TNA new hires have proper education, training, and understanding that they must work directly with a licensed CNA. 9. The SSA validated through record review, signed in-services and interview with the Administrator and DON that a 100 percent audit was conducted on all accidents and incidents from 07/04/2021 through 9/30/2021 to ensure that injury or negative outcomes was not identified related to unsupervised TNAs. On 07/05/21, the Administrator in-serviced all staff on fall related policies. Falls are reviewed at stand up meeting every morning and Quarterly Quality Assurance (QA) meeting. On 07/05/21 at 7AM, the Administrator continued on-going in servicing to reiterate with all staff that TNAs must provide care only with CNA assist. 10. Amendment 12/2/21 - The SSA validated that all corrective actions to remove the IJ had been completed as of 7/8/21, and the IJ removed on 7/8/21.	F 689			

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

PRINTED: 12/27/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2021
NAME OF PROVIDER OR SUPPLIER GEORGE REGIONAL HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 859 WINTER ST LUCEDALE, MS 39452		
(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	