STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255275	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGNOLIA SENIOR CARE, LLC	3701 PETER QUINN DRIVE JACKSON, MS 39213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 1/6/2020 to 1/9/2020. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited deficiencies at F583 and F657. The census at time of survey was 54 with the facility certified for 60 beds.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583		1/31/20

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

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F 583	Continued From page 1 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to provide privacy during wound care for one (1) of four (4) resident care observations, Resident #10. Findings include: Review of the facility's "Resident Rights" policy, not dated, revealed a resident is entitled to privacy in accommodations, personal care, visits and meetings of family and resident groups. A review of the facility's "Clean Dressing Change" policy, dated 4/2017, revealed to screen for privacy during the care. An observation, on 01/08/20 at 10:40 AM, revealed sacral wound care was provided for Resident #10 by Registered Nurse (RN) #2/Wound Care Nurse, and assisted by RN #1. RN #2 closed the door and pulled the curtain between the beds. Resident #10's bed was located next to the outside window. RN #2 did not close the blinds to the window. RN #1 did not close the blinds or say anything about the blinds being open during the care. Resident # 10 was in bed lying on her right side with her back facing	F 583	1. The facility has taken measures to ensure personal privacy/confidentiality of records is achieved for all residents. Resident found to be affected by this is Resident #10. On 1/8/20 the Director of Nursing did a 1:1 inservice with the Registered Nurse(RN)/Charge Nurse and Registered Nurse(RN)/Wound Care Nurse on the policy related to Clean Dressing Change, Resident Rights and Privacy/Confidentiality of Records. 2. All residents that receive wound care treatments could be affected by this practice. 3. On 1/8/20 and 1/30/20 inservice training was conducted by the Director of Nursing for RN's and Licensed Practical Nurses (LPN) on Privacy/Confidentiality of Records and Resident Rights related to Clean Dressing Change. 4. The Director of Nursing will observe the Wound Care Nurse during wound care procedures to ensure provision of privacy, weekly for four (4) weeks starting on	

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F 583	Continued From page 2 the window with the open blinds. The window was located across from the front door of the facility. Resident #10's back and buttocks were facing the window during the whole wound care observation. An interview, on 01/08/20 at 10:55 AM, with RN #2/Wound Care Nurse, confirmed the window blinds were open, and she should have closed the blinds for privacy. She said any reasonable person would expect the blinds to be closed during care. An observation of Resident #10's room, on 01/08/20 at 2:05 PM, from the front door of the facility, one could see inside Resident #10's room and people was walking about in this area who could see into Resident #10's room at any time with the window blinds open. An interview, on 01/09/20 at 12:26 PM, revealed the Director of Nursing (DON) said the facility policy was to provide privacy during care and that would include closing the blinds.	F 583	1/31/2020. Any problems will be addressed in the monthly Quality Assurance Performance Improvement Committee meeting for effectiveness of the process. Necessary changes will be made to ensure substantial compliance.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		1/31/20

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F 657	Continued From page 3 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, record review and facility policy review, the facility failed to revise the Comprehensive Care Plan related to the Focus for Resident #10's behaviors. This concern was identified for one (1) of 16 resident care plans reviewed. Findings include: Review of the facility's "Reviewing and Revising the Care Plan" policy, dated 2/2017, revealed the care plan would be updated with the new or modified interventions, and the care plan will be modified as needed by the Minimum Data Set (MDS) Coordinator or other designated staff member. A review of the Care Plan for Resident # 10 revealed a Focus related to Resident #10's behaviors for verbally aggressive, rummaging through other's belongings, refusing care and episodes of wandering into other rooms.	F 657	1. The facility has taken measures to ensure timing and revisions to the Comprehensive Care Plan related to behaviors are done quarterly, annually and upon significant changes of status as needed to enhance the residents ability to meet his/her objectives, effective 1/9/2020. Resident found to be affected by this practice was Resident #10. On 1/9/20 the Minimum Data Set(MDS)/Care Plan Nurse reviewed and revised Resident #10□'s person-centered care plan to reflect wandering or behaviors toward staff no longer exist. Through observation and revision of the person-centered care plan, staff will monitor Q shift for any change of behavior for Resident #10. 2. By 1/31/20 the Director of Nursing conducted an audit to identify all residents who currently have person-centered	

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F 657	Continued From page 4 A review of the Behavior Monitoring on Resident #10's Medication Administration Record (MAR) for the month of January 2020 revealed no issues with behaviors. A review of the Quarterly Minimum Data Set (MDS) Section E, with an Assessment Reference Dates (ARD) of 10/11/19 and 12/27/19, revealed no behaviors were exhibited. An observation, on 1/7/2020 at 10:30 AM, revealed Resident #10 was in a Geri-chair, quiet and her eyes were closed. An interview, on 1/8/2020 at 10:45 AM, revealed RN #1 said Resident # 10 no longer walked and needed a lift to get up to the wheel chair. An observation, on 1/08/20 at 11:13 AM, revealed Resident #10 was in her room lying in bed with her eyes closed. Resident #10 was not observed at anytime with behaviors toward staff or wandering. An interview, on 1/08/20 at 3:16 PM, revealed the Director of Nursing said Resident # 10 had a significant change after a hospital return, and the resident no longer wanders or had issues with behaviors towards staff. An interview, on 1/09/20 at 11:03 AM, revealed Licensed Practical Nurse (LPN) #1/MDS Nurse stated that he was notified through physician orders and daily stand up meetings for changes in resident status. He confirmed Resident # 10 no longer wandered or had behaviors towards staff, but the problem was still current on the care plan. LPN #1 said he usually waited with	F 657	behavior care plans. All other person-centered care plans were found to be in compliance. 3. On 1/15/20 and 1/31/20 inservice training was conducted by the Director of Nursing for Registered Nurses and Licensed Practical Nurses and Certified Nursing A□ssistants on timing and revision of person-centered care plans related to behaviors. 4. The Director of Nursing, RN Charge Nurse and/or MDS/Care Plan Nurse will review daily orders Monday through Friday for eight (8) weeks to ensure person-centered care plans are revised, starting on 1/9/2020. Any problems will be addressed in the monthly Quality Assurance Performance Improvement Committee meeting for effectiveness of the process. Necessary changes will be made to ensure substantial compliance.	

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F 657	Continued From page 5 residents with a history of behaviors before he removed a problem. He said he could probably resolve Resident #10's behavior problems because she no longer wandered or acted out towards staff. LPN #1 said the importance to revise the care plan was to show the staff current resident status and current information for the resident on the care plan.	F 657		

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	255275	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/13/2020**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 000	Initial Comments ********** Survey conducted on 01/13/20 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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