STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 survey from 2/08/21 through 2/11/21. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for participation. The SA cited deficiencies at F550, F679 and F880. The facility held a license for 60 beds, with a census of 36.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		3/11/21

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

Electronically Signed | 03/06/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review, the facility failed to honor the resident's rights by not allowing them to smoke for three (3) of five (5) residents reviewed for smoking for Resident #15, Resident #24, and Resident #25. Findings include: Review of the facility's policy, "Resident Rights", revised 11/2017, revealed all residents in long term care facility have rights guaranteed to them under Federal and state law. Residents residing in this facility will be guaranteed a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. These rights Include: To participate in other activities, including social, religious, and community activities that do not interfere with rights of other residents. To reside and receive services in the facility with reasonable accommodation of resident needs and preferences. Review of the facility's policy, "Smoking Policies	F 550	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. 1. The corrective action of reinstating smoke breaks for residents identified on the Facility Smoker List was implemented on February 09, 2021. The corrective action of reinstating smoke breaks was accomplished and will be checked for achievement and sustainability by conducting an all staff in-service specific to Resident's Rights with regards to residents having the right to choose to and be able to participate in smoking and keeping a Smoke Break Log. 2. To identify other residents having the potential to be effected, on February 09, 2021 the Director of Nursing verified the smoking status of all residents to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 550	Continued From page 2	F 550		

and Regulations", revised 04/2015, revealed residents are permitted to smoke in designated areas. This policy noted the staff will monitor residents for safety purposes during smoking.

Review of the facility's list of smokers in the facility, dated 2/10/21, revealed five (5) residents were on the smoking list.

Resident #15
Observation 02/09/21 at 09:59 AM of Resident #15 lying in bed watching television. Resident is alert an oriented, speech is clear, able to make needs known.

During an interview on 02/09/21 at 09:59 AM, with Resident #15, revealed the facility has not allowed the residents to leave their rooms because they have two (2) COVID-19 positive residents on the COVID-19 unit. Resident #15 said he was told he could not smoke because all residents are quarantined. Resident #15 also said the nurse told him chew the nicotine gum to help with the sensation. Resident #15 said he refused the gum because he did not like it.

Record review of the Comprehensive Care Plan, revised 12/10/20, revealed Resident #15 has a potential for injury related to smoking. Interventions included supervision with smoking and was prescribed nicotine gum.

Record review of the Physician's Orders, dated 2/2021 revealed Resident #15 was ordered Nicotine four (4) milligrams (mg) chewing gum by mouth (PO) every (q) four (4) hours as needed (PRN) for nicotine cravings.

Record review of Resident #15's Quarterly

those who want to participate in smoking are on the Facility Smoker List and are allowed to smoke during designated smoke breaks.

3. On 02/10/2021, an all staff in-service was initiated by the Staff Development Nurse regarding Resident's Rights with regards to residents having the right to choose to and be able to participate in smoking. The facility Medical Director reviewed the policy □'Resident Rights'□ with no recommended changes to the policy during the facilities Quality Assurance Committee meeting on 02/11/2021.

4. To monitor performance, a smoking log will be kept at the nursing station beginning March 06, 2021 to document participation and refusals of residents included on the Facility Smoker List. The list will be checked by the Administrator at the end of each week for a minimum of three consecutive months. The Resident's Rights policy will be reviewed during monthly in-services for the next three months by the Staff Development Nurse for continued re-education of all staff. Any deficient practices will be brought to the facility Quality Assurance & Performance Improvement (QAPI) Committee by the Director of Nursing or Administrator for the purpose of evaluating a quality improvement plan to ensure the corrective actions have been achieved and sustained as well as determination if further monitoring is needed. Recommendations will be made if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 550	Continued From page 3 Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/17/20, revealed Resident #15 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact. Resident #24 During an interview on 02/09/21 at 09:53 AM with Resident #24, stated the facility refused to let the residents come out of the rooms to smoke. Resident #24 said the facility has two (2) COVID-19 positive residents on the COVID-19 unit. Resident #24 said the facility offered nicotine gum. Resident #24 also said she does not like being in the room all day with nothing to do. Resident #24 stated there is only so much on the television. Resident #24 stated she did not think it was fair. Record review of the Comprehensive Care Plan, revealed Resident #24 has potential for injury related to smoking. Record review of the Physician's Orders for Resident #24, dated 2/2021, revealed an order for Nicorette Chewing Gum, two (2) mg, two (2) pieces of gum PRN q four (4) hours to curb smoking cravings. Record review of Resident #24's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/11/21, revealed Resident #24 had a Brief Interview of Mental Status (BIMS) score of 12, which indicated the resident is cognitively intact. Resident #25	F 550	warranted. The QAPI Committee will meet at least quarterly beginning February 11, 2021. 5. The facility alleges compliance with F Tag 550 on March 11, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 550	Continued From page 4	F 550		

During an interview on 02/09/21 at 09:45 AM with Resident #25, revealed she is tired of staying in her room. Resident #25 stated she tries to stay out of trouble. Resident #25 said she does not like to complain, but she doesn't like that nicotine gum. Resident #25 stated, if you stick your head out the door you are told to go back in your room. Resident #25 also stated the residents are not allowed to smoke because they are quarantined. The facility has two (2) residents that are positive for COVID-19 in the building. Resident #25 said both residents are on the COVID-19 Unit, which is closed. Resident #25 stated she doesn't understand why they could not socially distance and smoke.

Record review of Resident #25's Physician's Orders, dated 2/2021, revealed an order for Nicorette chewing gum two (2) mg, two (2) pieces prn q four (4) hours, to curb smoking cravings.

Record review of the Comprehensive Care Plan, revised 1/12/21, revealed Resident #25 has a potential for injury related to smoking.

Record review of Resident #25's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/28/20, revealed Resident #25 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.

During an interview on 02/11/21 at 11:14 AM, the Administrator confirmed the facility has not allowed the residents out of their rooms because two (2) residents tested positive and were placed on the COVID-19 unit. The Administrator also confirmed the residents were not allowed to smoke because of the positive residents on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 550	Continued From page 5 COVID-19 unit.	F 550		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and facility policy review the facility failed to provide an ongoing activities program for five (5) of (14) sampled residents, Resident #28, Resident #32, Resident #15, Resident #24, and Resident #25. The facility's, "Activity Programs and Activity Program Scheduling" policy, revised 11/17, revealed the facility has a policy in place to provide an ongoing program of activities. "Purpose: To assure that the activities program occurs within the context of each resident's comprehensive assessment and care plan, and is reflective of each resident's individual needs and interests." Resident #28 Record Review of the Face Sheet revealed Resident #28 was admitted on 2/27/21. She has diagnoses to include Anxiety Disorder and Major	F 679	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. 1. The corrective action of resuming a communal activities program as well as continuing in-room activities was accomplished by conducting an all staff in-service specific to Resident's Rights, conducting a one-on-one in-service between the administrator and activities director regarding communal activities and activity documentation, having the activities director work in the capacity of activity director full-time and enrolling the activity director in an upcoming activity	3/11/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 679	Continued From page 6 Depressive Disorder. Review of the Quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 12/18/20, revealed Resident #28 had a Brief Interview for Mental Status (BIMS) of 15, which indicated she was cognitively intact. Review of Care Plan implemented 3/27/2014, revealed Resident #28 enjoys Bingo and other activities. Review of the activity documentation revealed, since 12/28/20 through 2/9/21, the facility documented one (1) activity on 1/27/21 and the next activity on 2/9/21. There were no other activities documented from 12/28/20 through 2/9/21. On 02/09/21, at 9:31 AM, during an interview, Resident #28 stated she was really tired of the COVID-19 quarantine. Resident #28 stated, "We don't do anything but stay in our room. They don't come to our rooms and do any activities." On 2/9/21, at 1:45 PM, Resident #28 stated, "We have not done any kind of activities for a while. I am tired of staying in my room." Resident #28 stated, proper name-Activities #1, "is the activity director and she brought me a coloring book this past weekend. I enjoy Bingo. Sometimes I get in my bed and cry myself to sleep. I have major depression and it makes me feel depressed." On 2/10/21, at 1:12 PM, in an interview with Licensed Practical Nurse (LPN) #1, revealed Resident #28 usually would sleep until time for the 10:00 AM activity, which she attended. Then LPN #1 confirmed Resident #28 would sleep until	F 679	director course. The corrective action of resuming a communal activities program as well as continuing in-room activities began on February 11, 2021. 2. All residents residing in Perry County Nursing Center have the potential to be affected by the same deficient practice. 3. On February 11, 2021, an all staff in-service was initiated by the Staff Development Nurse regarding Resident Activities. On February 11, 2021 the activity director was in-serviced one-on-one regarding starting communal activities for residents who choose to participate in communal activities and continuing in-room activities for those who have a preference for in-room activities, properly documenting activities and attending an upcoming activity director course by the facility administrator. Beginning on March 08, 2021 the activity director will devote at least one hour of her schedule on at least four days of each week to activity documentation and planning. The activity director is registered to attend an upcoming Activity Director Course on April 12-16, 2021. The facility Medical Director reviewed the policy '□Activity Programs and Activity Program Scheduling'□ with no recommended changes to the policy during the facilities Quality Assurance Committee meeting on February 11, 2021. 4. In order to monitor and ensure the correction is achieved and sustained, beginning the week of March 08, 2021 the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 679	Continued From page 7 time for the 2:00 PM activity and she would also attend that activity. LPN #1 stated Resident #28 is very social and loves Bingo. On 02/11/21, at 8:28 AM, Resident #28 was observed up in her wheelchair rolling herself in the hall. State Agency (SA) said, "Good morning, you are out of your room." and Resident #28 replied, "Yes, we have been freed." Resident #32 Record review of the Face Sheet revealed Resident #32 was admitted on 1/28/20, with diagnoses of Alzheimer's Disease, Major Depression, and History of Falls. Review of Resident #32's Annual MDS, with the ARD of 1/12/21, revealed a BIMS score of eight (8) which indicates moderate cognitive impairment. Review of Resident #32's Care Plan, dated 5/11/20, revealed Resident #32 has an identified concern of being at risk for social isolation. The interventions noted Resident #32 are to have an activity calendar in room, have one on one activities to include music, television (TV), conversation, touch therapy, and exercise. Further review of Resident #32's Care Plan identified a problem on 3/17/20 that Resident #32 was at risk for Psychosocial well-being concerns related to medically imposed restrictions related to COVID-19 restrictions. One of the interventions was to provide in room activities of choice. Review of the documentation of activities from 3/1/20 to 2/9/21 revealed there was no documentation of in room activities since 5/12/20.	F 679	activity director will print proof of activities documented at the end of each week to be signed off on by the administrator for no less than three consecutive months. Any deficient practices will be brought to the facility Quality Assurance & Performance Improvement (QAPI) Committee by the Director of Nursing or Administrator for the purpose of evaluating a quality improvement plan to ensure the corrective actions have been achieved and sustained as well as determination if further monitoring is needed. Recommendations will be made if warranted. The QAPI Committee will meet at least quarterly beginning February 11, 2021. 5. The facility alleges compliance with F Tag 679 on March 11, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 679	Continued From page 8	F 679		

On 2/8/21 at 10:15 AM, Resident #32 was observed in bed under covers.

On 2/8/21 12:23 PM, Resident #32 was observed standing in her room.

On 2/8/21 at 12:40 PM, Residents #32 was in bed under the covers.

On 2/9/21 at 8:00 AM, Resident #32 was observed in her bed with the covers over her head.

On 2/9/21 at 12:30 PM, Resident #32 was observed in bed asleep.

Review of Activity notes date 12/24/20 through 2/9/21, revealed there was no documentation of any activities for Resident #32.

On 2/9/21 at 12:41 PM in an interview with Activities #2, revealed since May, she has been working part time, 3 to 4 days a week, only as a CNA. When she was asked when was the last time she conducted activities she replied, around May and then today.

On 02/11/21 at 09:01 AM in an interview with CNA #1 revealed Resident #32 likes to color, visit, talk, and play Bingo. She really has been the same since we have been on lock down.

On 02/11/21 at 09:05 AM in an interview with CNA #2 revealed residents likes to color. She stated her behaviors have been the same since we locked down for COVID-19.

On 02/11/21 at 09:06 AM an unsampled resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 679	Continued From page 9	F 679		

was sitting by the Nurses' Station and stated, "I am so glad to be out of my room, aren't you?" This resident then sang, "God Bless America", in a really loud voice.

Resident #15
During an interview on 02/09/21, at 09:59 AM, with Resident #15, she stated the facility has not allowed them to leave their rooms because they have two (2) positive residents on the COVID-19 Unit. Resident #15 said the facility does not allow them to do any type of activities. Resident #15 said he is bored and going stir crazy. Resident #15 said he is tired of TV.

Record review of the Comprehensive Care Plan revealed, Resident #15 should have social involvement with independent activities. Interventions are to post activity calendar where the resident can easily view, encourage to attend activities of choice, respect resident's choice in regard to limited/no activity, resident enjoys smoking and interaction with other residents during smoke times. Resident #15 is also care planned to be at risk for psychosocial well-being concern related to medically imposed restrictions related to COVID-19 restrictions.

Record review of Resident #15's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/17/20, revealed Resident #15 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.
.
Resident #24
During an interview on 02/09/21, at 09:53 AM, with Resident #24, she confirmed the facility has quarantined the residents to their rooms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 679	Continued From page 10	F 679		

Resident #24 said she does not like being in the room all day with nothing to do. Resident #24 also said there is only so much on the television.

Record review of the Comprehensive Care Plan, dated 1/4/21, revealed Resident #24 is at risk for social isolation and has the potential for mood state related to the diagnosis of Anxiety. Resident is at risk for psychosocial well-being concern related to medically imposed restrictions related to COVID-19 restrictions. Resident #24 needs encouragement and assistance to attend activities. Resident #24's interventions are to place activity calendar in room, encourage self-initiated activities, one on one activities, music, TV, conversation, touch therapy, exercise,. provide residents with reading, invite resident to church, bingo, and group discussion.

A review of Resident #24's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/11/21, revealed Resident #24 had a Brief Interview of Mental Status (BIMS) score of 12, which indicated the resident is cognitively intact.

Resident #25
During an interview on 02/09/21, at 09:45 AM, with Resident #25 revealed she is tired of staying in her room. Resident #25 said she makes every effort not to complain. Resident #25 also said if you stick your head out the door you are told to go back in your room. Resident #25 said both residents that are COVID-19 positive are on the COVID-19 Unit so she does not understand why they could not socially distance and smoke. Resident #25 said she is tired of watching TV. Resident #25 stated the facility has not provided activities since December.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 679	Continued From page 11	F 679		

Review of the Comprehensive Care Plan revealed the Resident #25 needs encouragement and assistance to attend activities. The interventions are to place an activity calendar in Resident #25's room, encourage her to attend self-initiated activities, one on one activities, music, TV, touch therapy, exercise, provide resident with reading, invite the resident to church, bingo and group discussion and transport resident to activities. This Care Plan noted Resident #25 is at risk for social isolation. Resident #25 has a potential for altered mood state related to the diagnosis of Schizophrenia. Resident is at risk for psychosocial well-being concern related to medically imposed restrictions related to COVID-19 restrictions.

A review of Resident #25's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/28/20, revealed Resident #25 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact.

On 2/9/21 at 2:00, PM, an interview with the Administrator and LPN #2/Staff Development Nurse revealed when asked to speak to the Activity Director, they stated Activity #1 currently works nights from 7 PM to 7 AM because she is the CNA for the COVID-19 unit and is currently at home asleep.

On 2/10/21 at 8:15 AM, in an interview with Activity #1, revealed she has been the Activity Director since the end of September/first of October. She stated I am not a certified Activity Director and because of COVID-19 they have not been able to send me for training. I have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 679	Continued From page 12 working on the COVID-19 Unit as a Certified Nursing Assistant (CNA) on the COVID-19 Unit and I usually work 7:00 PM to 7:00 AM. When asked who does the activities while you are working on the COVID-19 as the CNA she stated, whoever has time, sometimes the dietary staff. Asked where the activity documentation is kept when they do the activities, she replied they document it on paper or in a notebook and I keep the notebook with me in my car. Asked about Resident #32, she stated she likes to socialize and likes to come and sit in Bingo and watch. She stated Resident #32 also enjoys talking with her roommate and I. Asked a second time where the documentation for Resident #32 activities is because there is no documentation since December 2020 in her chart and she replied it should be in Resident #32's chart.	F 679		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		3/11/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 880	Continued From page 13	F 880		

staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 880	Continued From page 14 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to follow Standard Infection Control Precautions related to removing gloves and performing hand hygiene prior to applying a dressing to a wound to prevent the possible spread of infection for two (2) of three (3) wound care observations. [Resident #14 and Resident #24] Findings Include: The facility's, "Standard Precautions", revised June 2014, General Infection Prevention and Control Nursing Policies revealed it is the policy of this facility that all nursing activities will be performed in a manner to minimize the potential for infection in residents, staff, and visitors. The facility's, "Dressing Change Policy and Procedure", dated March 2018, noted for staff to perform hand hygiene, put on disposable gloves, remove dressing, pull gloves over dressing and discard into appropriate plastic waste bag. Perform hand hygiene, put on disposable gloves, cleanse the area as ordered, remove gloves, perform hand hygiene, apply disposable gloves, dress the areas as prescribed, and perform hand hygiene.	F 880	By submitting the enclosed materials, we are not admitting to the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. 1. The corrective action of educating the wound care nurse, Registered Nurse #1, on proper infection control procedures during wound care will be accomplished by a one-one-one in-service by the Director of Nursing on February 11, 2021. Additionally, all residents who received wound care by Registered Nurse #1 on February 11, 2021 were assessed by the Director of Nursing with no adverse effects found on February 11, 2021. 2. All residents have the potential to be affected. 3. To ensure the deficient practice regarding infection control will not recur, Registered Nurse #1 was educated on proper infection control procedures during wound care by means of a one-on-one in-service initiated by the Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 880	Continued From page 15 Resident # 14 On 02/10/21, at 9:22 AM, Registered Nurse (RN) #1 was observed, during Percutaneous Endoscopic Gastrostomy (PEG) tube care, using her soiled gloves to apply a clean dressing. She failed to remove her soiled gloves, perform hand hygiene and don (put on) clean gloves prior to the application of the clean dressing. On 02/10/21, at 1:30 PM, interviewed RN #1 stated she should have washed her hands and applied new gloves after she cleaned the PEG tube site, prior to putting on clean dressing. On 2/11/21 at 9:00 AM in an interview with License Practical Nurse (LPN)/Infectious Preventionist (IP) #2, confirmed RN #1 should have wash hands and changed gloves prior to putting on the clean dressing. LPN/IP #2 revealed by not washing hands and putting on clean gloves could cause contamination of the wound. Record review of the Face Sheet revealed Resident #14 was admitted to the facility on 11/20/20, with the diagnosis of Epilepsy, Gastrostomy, Dysphasia, Anxiety, Chronic Obstructive Pulmonary Disease, Parkinson Disease, Chronic Kidney Disease, Hypertension, and Gastro-Endo Esophageal Reflux. Record review of the Physician Orders for Resident #14, dated 2/9/21, revealed an order to cleanse the PEG site with saline, place a split gauze under the PEG daily and secure with paper tape.	F 880	Nursing on February 11, 2021. Facility nursing staff were educated by the staff development nurse beginning February 11, 2021 regarding infection control. The facility Medical Director reviewed the policy □Infection Prevention and Control□ with no recommended changes to the policy during the facilities Quality Assurance Committee Meeting on February 11, 2021. 4. In order to monitor and ensure the correction is achieved and sustained, beginning the week of February 15, 2021 the Director of Nursing will perform observations of wound care two times weekly for four weeks, then once weekly for four weeks. Any deficient practices will be brought to the facility Quality Assurance & Performance Improvement (QAPI) Committee by the Director of Nursing or Administrator for the purpose of evaluating a quality improvement plan to ensure the corrective actions have been achieved and sustained as well as determination if further monitoring is needed. Recommendations will be made if warranted. The QAPI Committee will meet at least quarterly beginning February 11, 2021. 5. The facility alleges compliance as of March 11, 2021 for F tag 880.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 880	Continued From page 16	F 880		

Record review of the Comprehensive Minimum Data Set (MDS) for Resident #14, with an Assessment Reference Date (ARD) of 11/27/20, revealed the MDS was coded in Section K-K0510B2 and was checked for a feeding tube.

Record review of the Care Plan for Resident #14 revealed the resident has a feeding tube with interventions to cleanse the PEG site with saline and place a split gauze under the PEG daily and as needed.

Resident #24
On 02/10/21, at 9:30 AM, during the Nephrostomy Site Wound Care for Resident #24, Registered Nurse (RN) #1 cleansed the overbed table, let the overbed table dry, and brought supplies in room. RN #1 was observed to provide site care but did not wash or sanitize her soiled hands and did not apply clean gloves between the dirty and clean dressing. RN #1 used the soiled gloves to apply the clean dressing around the Nephrostomy Site Wound.

On 02/10/21 at 1:30 PM, during an interview RN #1 stated she should have washed her hands and applied new gloves after she cleaned the Nephrostomy Tube Site, prior to applying the clean dressing.

Record review of the Face Sheet revealed Resident #24 was admiited on 1/4/21 with the diagnosis of Acute Pyelonephritis, Abnormal Weight Loss, Cirrhosis of Liver, Cognitive Communication Deficit, Weakness, Anxiety, Hypertension, Type 2 Diabetes Mellitus, Urine Tract Infection (10/23/20), Viral Hepatitis, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 880	Continued From page 17	F 880		

Centrilobular Emphysema.

Record review of the Physician Orders for Resident #24 dated 1/5/21, revealed an order to cleanse the Nephrostomy Site to the Right Flank Daily with Saline, Cover with split Gauze and secure with paper tape.

Record review of the Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 1/11/21, revealed under section H0100c: Appliances, that the ostomy was checked.

Record review of the Care Plan for Resident #24 dated 1/4/21, revealed Resident #24 has a Nephrostomy tube with the interventions to cleanse the nephrostomy site on the right flank daily with saline, cover with a split gauze and secure with paper tape.

On 02/10/21, at 2:00 PM, during an interview with the DON revealed the wound care nurse should have followed the facility's infection control policy and changed her gloves and washed her hands at least the minimum of three (3) times. The DON revealed this would be an infection control issue that could cause wound infection if a nurse does not apply a clean dressing with clean hands and gloves.

On 2/11/21, at 9:00 AM, during an interview LPN/IP #2, she confirmed RN #1 should have wash hands and changed gloves prior to putting on the clean dressing. LPN/IP #1 revealed by not washing soiled hands and putting on clean gloves could cause contamination of the site.

Record review of an in-service on Infection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255159	A. BUILDING _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY COUNTY NURSING CENTER	202 BAY AVENUE WEST RICHTON, MS 39476

(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 880	Continued From page 18 Control on 7/20/21, revealed RN #1's signature was on the Infection Control Orientation Checklist.	F 880		