STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255318	A. BUILDING _____ B. WING _____	03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
J G ALEXANDER NURSING CENTER	25112 HIGHWAY 15 UNION, MS 39365

(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 recertification survey at the facility from 03/08/21 to 03/11/21. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited deficiencies at F565 and F641. The facility was licensed for 60 beds and had a census of 50 at the time of the survey.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.	F 565		4/8/21

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

Electronically Signed | 03/31/2021

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.

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F 565	Continued From page 1 §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, record review and facility policy review the facility failed to promptly resolve resident council grievances for eight (8) of eight (8) residents who attended the resident council meeting out of a census of 50 residents. Findings include: Review of the facility's "Grievance Policy", dated November 2016, revealed: It is the policy of this facility that the resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. The resident has the right to, and this facility will make prompt efforts to resolve grievances the resident may have. This facility grievance policy ensures the prompt resolution of all grievances regarding the residents' rights. Interview on 03/10/2021, at 10:00 PM with eight (8) of eight (8) residents in attendance of the resident council meeting revealed that eight (8) of eight (8) residents stated that they all have unresolved food issues. They have constantly on a regular basis complained about the food to no avail. The residents stated they never go hungry, they have more than plenty of snacks and	F 565	1. On 3/10/2021 the Certified Dietary Manager and Director of Nurses meet with each Resident that attended the Resident Council meeting on 3/10/2021 and updated food preferences accordingly. 2. All Residents have the potential to be affected by the same deficient practice. 3. A) On 3/23/21, the facility contracted [Exh. B] with the Certified Dietary Manager in order to improve the communication between the Residents and the Dietary Department via routing auditing [Exh. D] beginning 3/11/21 wherein the Certified Dietary Manager will actively interview Residents weekly according-to the MDS schedule wherein the amount of interviews conducted will be the same as the amount of MDS assessments scheduled in the weekly Care Plan meeting(s); and the Certified Dietary Manager will communicate any Resident concerns to the Kitchen Dietary Manager for immediate correction upon close of each Care Plan meeting and note status of resolution of resident concerns on audit [Exh. D] for QA review.	

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F 565	Continued From page 2 their families bring food. They stated that what comes to them from the kitchen is "terrible tasting and the food's texture is hard as a rock." Review of Section C of the most recent Minimum Data Set (MDS) revealed that all eight (8) residents in the resident council meeting had scored 11-15 on the Brief Interview for Mental Status (BIMS) which indicated all eight (8) residents in attendance at the resident council group meeting were cognitively intact. Review of the resident council minutes for the past six (6) months (September 2020 through February 2021) were obtained and reviewed. Each month the resident council issued food concerns and complaints of poor tasting and poor textured foods. The resident council minutes did not contain any written documentation of resolutions from the complaints issued by the residents. During the resident council meeting the eight (8) residents in attendance all confirmed that their food concerns were continuing to go on without resolution. Record review revealed that there was no documentation of residents being informed of the action taken to resolve their grievances. Interview on 3/9/2021, at 2:00 PM, with the Activities Director (AD) revealed that the residents issue complaints about the taste and texture of the food at each resident council meeting. The AD stated that after the food complaints are issued at the monthly meetings, she copies the minutes and faxes them to Dietary Manager (DM) in the kitchen. The AD stated that she has no knowledge of any responses from the DM. The AD states that she has "Bingo" money that the residents win playing	F 565	B) On 3/31/21, the Staff Development Coordinator conducted in-service for the Certified Dietary Manager and Dietary Manager related-to Resident Council in order to ensure monthly routine Dietary Department monthly attendance and proper Dietary Department receipt of Resident Council complaints and audit results in order that immediate dietary changes per resident request(s) can be made relevant to both pertinent audit findings and any complaints voiced in Resident Council. [Exh. C] C) On 3/11/21, the Director of Nurses initiated a weekly audit from Resident interviews and a monthly audit of Resident Council minutes to be conducted as often as the Resident Council decides to meet, and otherwise monthly, to be completed by the Certified Dietary Manager for at least three (3) months in order to ensure Resident Council grievances related-to Dietary Department service(s) are resolved in a timely manner. [Exh. D] D) Beginning 3/31/21, the Staff Development Coordinator will collect the results of all scheduled audit(s) and pertinent in-service(s) on a weekly basis for the Director of Nurses review and submission-to the monthly Quality Assurance Committee meeting in order to ensure all Resident Council dietary services grievance(s) are promptly identified and resolved. 4. Beginning 4/6/2021, the Quality	

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F 565	Continued From page 3 bingo and that she shops for the residents with their Bingo winnings, and that the residents request snacks and food items more than any item. The AD stated that the facility has ample snacks in abundance for the residents and that the residents were never hungry. The AD confirmed that the residents never issue any complaints much outside of poor tasting and poor quality food. The AD stated that the DM does not come to the facility and talk to the residents about their food issues. The nursing home facility sends a list to the kitchen about the issues and requests of the residents. The residents are allowed to request whatever they want to eat and the kitchen attempts to honor their requests. The AD stated that the poor taste of the food was a monthly concern issued at resident council meetings. Interview on 3/10/2021 at 3:20 P.M. with the Dietary Manager (DM) revealed that he had not been faxed copies of the Resident Council minutes since August 2020. He had not been notified of food concerns or complaints from the residents. He stated that if he were asked to attend resident council he would gladly attend, but he had not been requested to attend the meetings. The DM did confirm that he had not sent written responses or called to give verbal response. The DM did confirm he had not sent documentation of his food resolutions to the facility or to the residents. The DM stated that he "just made the changes and honored the requests." The DM stated he has only received one (1) copy of resident council minutes in August 2020 for all the 2020 year. He stated that the owners of the nursing home facility would not allow him inside of the facility because of COVID-19. The DM had not visited with the	F 565	Assurance Committee will receive the data related-to audit(s) and in-service(s) on a monthly basis for three months, determine pertinent corrective measures as well as the continued frequency of audit(s) and in-service(s) based-upon results achieved.	

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F 565	Continued From page 4 residents since prior to March 2020. Interview with the Director of Nursing (DON) on 3/10/2021, at 3:30 PM, revealed that she would make sure that the DM was allowed inside the building to visit with the residents and to attend resident council meeting if invited. The DON did not have copies of communications from the DM concerning food complaints and she did not have any facility responses to the resident's grievances from resident council meetings. Interview on 3/10/2021, at 4:00 PM, with the Resident council members for a follow up from the meeting of 3/10/2021 at 10:00 AM revealed that the DM stated that he would meet with them in person, if invited, and try to resolve their dietary issues. The residents stated that they would be even more happy when their food issues were resolved. The residents stated, "we just want to be heard." Our issues with the food requests have been an on-going thing, it did not just occur during the pandemic of COVID-19.	F 565		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility policy review, and record review, the facility failed to complete and submit a discharge Minimum Data Set (MDS) for one (1) of 19 resident MDS's reviewed, Resident #1. Findings include:	F 641	1) On January 20, 2021 the MDS Coordinator completed the discharge without return anticipated assessment for Resident #1 and MDS submission was completed on 3/10/21. [EXH.E] 2) All residents have the potential to be affected by the same deficient practice.	4/8/21

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F 641	Continued From page 5 Review of facility's "Assessment Frequency/Timeliness" policy, dated 01/14/2020, revealed: "The purpose of this policy is to provide a system to complete standardized assessments in a timely manner, according to the current Resident Assessment Instrument (RAI) Manual." The policy also revealed, "a discharge assessment will be completed within 14 days of the discharge date." An interview with the MDS Coordinator on 03/10/21, at 10:02 AM, revealed Resident #1 was sent to the Emergency Room on 01/20/2021 and passed away approximately three (3) hours later. The MDS Coordinator stated she wrote the resident's information in a notebook to prepare to enter it into the computer. She stated she tested positive for COVID-19 the next day and was off work for 15 days. Stated she was working from home, but this resident's assessment "fell through the cracks" and was not entered into the computer or submitted. Stated she failed to communicate the need for the assessment to the MDS Nurse, so therefore, the assessment was not completed. An interview with the MDS Nurse on 03/10/21, at 03:20 PM, revealed she completes the Medicaid assessments, except for the discharge Medicaid assessments. She stated the discharge assessments are completed by the MDS Coordinator. She stated she does not do the discharge assessments, but if needed, she could "probably complete one". An interview with the Director of Nursing (DON) on 03/10/2021, at 3:30 PM, revealed both the MDS Coordinator and the MDS Nurse should be	F 641	3) A. An in-service was conducted on 3/11/2021 by the Director of Nurses for the MDS Coordinator and MDS Nurse related to timely submission of discharge MDS(s). [EXH.F] B. The MDS Coordinator and MDS Nurse began an MDS discharge audit on 3/11/2021 to be conducted for every month for three months then every other month for four months for all residents discharged from the facility in order to ensure all discharge MDS(s) are submitted per MDS guidelines. [EXH.G] C. The Staff Development Coordinator will receive the result(s) of all scheduled audit(s) and in-services and submit the same to the Quality Assurance Committee on a monthly basis in order to ensure that resident discharge MDS(s) are properly submitted in a timely manner. 4) Beginning April 6, 2021, the Quality Assurance Committee will receive the data related-to all pertinent audit(s) and in-services on a monthly basis for at least three months, and determine pertinent corrective measures as well as the continued frequency of relevant audit(s) and in-services based-upon results achieved.	

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F 641	Continued From page 6	F 641		

able to complete the required MDS assessments. She stated the MDS should be completed as required. The DON confirmed the facility failed to complete and submit the discharge MDS assessment in a timely manner.

Record review revealed Resident #1 was admitted to the facility on 01/9/2018, with diagnoses which included Chronic Diastolic (Congestive) Heart Failure, Parkinson's Disease, Muscle Weakness, Dementia, and Cardiomegaly. Review of facility notes revealed Resident #1 was transferred to the Emergency Room on 01/20/2021 by ambulance. Review of facility notes revealed the Emergency Room notified the facility the resident had expired. Review of physician's order revealed on 01/20/2021, Resident #1 was sent to the Emergency Room due to Tachycardia and a change in the level of consciousness.

Review of resident's most recent MDS was a quarterly assessment dated 10/29/2020.