

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

PRINTED: 10/16/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/15/2019
NAME OF PROVIDER OR SUPPLIER THE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 11 PECAN DRIVE COLUMBIA, MS 39429		
(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 ***After administrative review, this CMS 2567 has been amended*** The State Agency (SA) conducted an annual survey at the facility from 8/12/19 to 8/15/19. During the survey, the SA determined the facility was not in compliance with the requirements of participation for Medicare and Medicaid. The SA cited regulatory deficiencies at F602, F610, F623, F644, F645, F656, F689, F690, and F880. The census at the time of the survey entrance was 81, and the facility was certified for 86 beds.	F 000			
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 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. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, record reviews, and facility policy review, the facility failed to ensure the resident funds were free from misappropriation, for one (1) of four (4) Resident Trust Funds reviewed. Resident #61. Findings include: A review of the facility's Abuse and Neglect-Consumer Information Sheet, undated, revealed, according to the Nursing Home Reform	F 602	1. The following corrective actions were put into place for the resident found to have been affected by this deficient practice: A) A grievance form was initiated on Resident #61 and completed by Social Worker on 8/15/19 outlining the alleged money that was missing. B) An investigation into the missing money was completed by the Quality Assurance/Infection Prevention Nurse on		9/12/19

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

TITLE

(X6) DATE

Electronically Signed

09/13/2019

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 602	Continued From page 1 Act of 1987, all residents in nursing homes are entitled to receive quality care and live in an environment that improves or maintains the quality of their physical and mental health. This entitlement includes freedom from abuse and misappropriation of funds. Review of the facility's policy titled, "Abuse, Neglect, or Exploitation Policy, no date, revealed: Definition: Misappropriation of Resident Property- The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of resident's belongings or money without the resident's consent. Reporting: The complaint must be reported as soon as possible to the Administrator, Director of Nurses, and Facility Contact Person. Investigation: Any report of abuse, neglect or exploitation will be investigated by the Administrator, Director of Nurses, Social Services, Quality Assurance Committee, and Facility Security. Action: Any employee suspected of abuse, neglect or exploitation will be investigated and actions taken will at the discretion of administration. On 8/15/19 at 11:00 AM, an interview with Administrator #1, revealed nothing had been reported to him. On 8/15/19 at 11:01 AM, an interview with Administrator #2, revealed nothing had been reported to her. On 8/15/19 at 11:05 AM, an interview with the Assistant Administrator (AA), revealed she was not aware of anyone handling the resident roughly, but rather it was Certified Nursing Assistant (CNA) #5 (CNA #5 was also Resident #61's relative) taking the resident to the	F 602	8/19/19 and was faxed to the Mississippi State Department of Health & the Attorney General's Office. C) The Administrator provided Resident #61 with a lock box and key. Lock box was installed in resident's night stand and we suggested she use lockbox to keep her cash in to prevent any further mishaps. D) The Facility has suggested all current residents who keep money in their rooms or on their persons purchase a small lock box. E) The Administrator interviewed Resident #61's roommate on 8/15/19. During the interview the Administrator asked the roommate if she had ever had any money to come up missing and she replied No. 2. All residents who keep money in their rooms or on their persons have the potential to be affected by this deficient practice. 3. The following measures and systemic changes were put into place to ensure the deficient practice will not recur: A) An in-service was held by the Administrator on 9/6/19 for all employees that covered a resident's right to be free from abuse (including misappropriation), the facility policy on reporting abuse, and the facility's policy on investigating incidents. B) The Assistant Administrator was counseled by the Administrator on 8/19/19 about the importance of reporting potential allegations of misappropriation of resident funds to the proper departments		

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F 602	Continued From page 2 bathroom. The AA stated the resident had stated CNA #5 had not been talking to her. The AA also stated she asked CNA #5 to take someone with her when she went in to care for Resident #61. The AA stated Resident #61 reported to her that CNA #5 did not want to work with her (Resident #61) and that CNA #5 was acting like her daddy. The AA stated Resident #61 and CNA #5 just did not get along. The AA stated CNA #5 had started swapping out when she had to care for Resident #61. She also stated she had talked with the Resident #61's Resident Representative (RR) and the RR stated she gets along with her cousin, CNA #5. The AA stated Resident #61 thinks transferring on the sit to stand lift is handling her rough because she is unable to hold onto one side of the lift, and she thinks the staff is doing something to her. She stated Resident #61 feels she can do more than what she is able to do for herself. She also stated she does know it was the sit to stand lift that Resident #61 was referring to. The AA stated Resident #61 never reported to her that CNA #5 was handling her roughly. She stated she did not do an investigation because she did not feel there was anything to investigate because this happened before the last survey. She also stated Resident #61 stated she had some money missing but Resident #61 had found her money. The AA stated, Resident #61 had \$105.00 or \$106.00. She stated she was off from work the next day. She also stated, Resident #61 had given the Licensed Social Worker (LSW) \$100.00 and had gotten \$50.00 of it the other day from the LSW. She stated Resident #61 signed off on it in her (AA) office and she (AA) had the money in a little locked box. The AA stated that was the day Resident #61's son had come to the facility. She also stated Resident #61 has \$50.00 left. The AA stated she usually does not hold	F 602	so facility can begin investigation. C) Our admission agreement was amended by the Administrator on 9/5/19 to include language that suggests that if a resident wants to keep cash, checkbook and/or credit debit cards in their rooms, they may want to consider purchasing a lock box to keep their money in. 4. The facility plans to monitor the effectiveness of our plan by doing the following: A) The Social Worker, Administration and the Quality Assurance/Infection Prevention Nurse will communicate daily with each other during our morning stand-up meetings to ensure there have been no allegations of misappropriation of resident property. If we find that there has been an allegation, we will investigate immediately. B) The Social Worker, Administration and the Quality Assurance/Infection Prevention Nurse will be able to monitor the effectiveness of the plan immediately by reviewing our grievance logs weekly to ensure we have investigated any/all allegations of missing property that were reported through our grievance form. If any negative findings occur Quality Assurance will investigate those immediately. C) During our weekly Q/A meetings, we will discuss any potential investigations into missing resident property. 5. These corrective actions were completed on 9/12/19		

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F 602	Continued From page 3 money. She stated the resident had money missing last month and had brought some money to the office to the LSW and Front Office Worker #1 which was \$100.00. She stated "Wednesday" morning when she returned to work, the LSW gave her \$100.00 for Resident #61 and this was last week, but her days are kind of running together. The AA also stated when the resident's son was at the facility, Resident #61 had gotten \$50.00 of her money. She stated she rolled the camera back, and she did not see anyone go in or out of Resident #61's room. She also stated the next day Resident #61 brought the money to her office because she did not want to hold that amount of money. She stated she does not know the policy on when a resident has missing money. She also stated she generally handles it by telling the residents if they have any problems to let her know about it and she will roll the camera back. She stated she did not tell Administrator #1. She also stated she told the Director of Nursing (DON), but at that time, the money came back. She stated to her, the situation was over with because she (Resident #61) brought money to the office. She also stated, she asked the resident when she has that kind of large sums of money, she needs to have it locked up. She stated Resident #61 had not had that type of money before. The AA also stated she did not write anything down regarding the CNA situation or the money situation. She stated it is the facility's policy to investigate the resident's concerns, but she did not investigate because it was an issue that was resolved. She also stated other than the nurse that was standing in the hallway, no one knew about the situation. She stated she does not remember who that nurse was. She stated she should have gone to the Director of Nurses (DON) and the DON should	F 602			

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F 602	Continued From page 4 take the next step, but she kind of handled it herself. She stated she thought everything was okay. She stated Resident #61 wants to go home tonight if she could. She also stated the resident was here previously, had gone to a facility in another town, and eventually returned to this facility. She stated the resident was wanting to go home before all of this occurred. She also stated if she failed to do something it was because of the relationship that she and Resident #61 has. This interview was conducted by speaker phone in the presence of another surveyor. On 8/15/19 at 11:35 AM, an interview with the Licensed Social Worker (LSW) revealed, Resident #61 had not reported anything to her about being unhappy with a CNA. She also stated the resident had not personally reported to her that she had some money missing. The LSW stated she had witnessed the AA giving the resident some money (\$50.00) this week out of \$100.00. She stated the rest of the \$50.00 is in the AA's office. The LSW stated Resident #61 always goes to the AA and does not open up to her (LSW). She stated the resident had not mentioned anything to her. She stated if a resident came to her with a concern regarding how a CNA for example, is caring for them, she would go through the chain of command. She stated she would go to Licensed Practical Nurse (LPN) #5. On 8/15/19 at 11:50 AM, an interview with the DON, revealed the resident had not mentioned anything to her regarding any CNA. She also stated the resident had not told her about any missing money.	F 602			

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F 602	Continued From page 5 On 8/15/19 at 12:00 PM, an interview with Resident #61, revealed she had gone to the AA because CNA #5 had stopped speaking to her. She stated she had not had a chance to talk to the AA about CNA #5 handling her roughly. She stated she had not told anyone about that. She also stated the AA came to her and gave her \$50.00, and she had \$50.00 left in the office. Resident #61 stated she wanted to draw half of the \$100.00 out. She stated the \$100.00 she had missing was about one month ago. She also stated a staff member brought her \$50.00 of the \$100.00 that was missing a month ago. Resident #61 also stated she told the AA and the AA said she would roll the camera back. Resident #61 stated she had another \$100.00 after the first \$100.00 went missing. She stated she had \$100.00 twice, but not at the same time. She stated she had the first \$100.00 about a month ago. Resident #61 stated the whole \$100.00 came up missing. She stated she had nine \$10.00 bills and two \$5.00 bills. She stated she had another \$5.00 and \$1.00 bill. She stated she did not tell anyone until one of the workers came into her room. Resident #61 told this worker that \$100.00 was taken out of her purse and her purse was taken from underneath her pillow. Resident #61 does not want to state the worker's name. She stated the first person she told was Resident #23, and then she told the AA and the AA told her (Resident #61) she was going to roll the camera back. She stated the AA told her that a woman was coming to talk to her and would want to know where the money came from. She stated the woman never came. She stated the AA stated she would have to get someone else to come. She stated that same worker (the worker that Resident did not want to give her name) came into her room that night and put \$50.00 in	F 602			

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F 602	Continued From page 6 the envelope. She stated the worker was going through her things and she saw the worker lift her hand and handed the envelope to her which had the \$50.00 in it. She stated the worker told her it was not \$100.00 but it was \$50.00. The resident stated she asked the worker where was her other \$50.00 at. She stated she never heard anymore from the AA. On 8/15/19 at 12:30 PM, an interview with Administrator #1 revealed, he would expect the Assistant Administrator to handle issues and does not expect her to bring everything to him. He stated the policy on misappropriation is to go through the proper chain of command. He stated anyone in the facility can go to Quality Assurance (QA). He also stated he would expect the staff to report abuse to the administrator. He stated if someone reported to him that a resident had money missing, he would conduct an investigation. A review of the facility's Face Sheet revealed, the facility admitted Resident #61, on 7/20/18, with diagnoses including Myoneural Disorder and Gastroesophageal Reflux Disease (GERD). A review of the most recent Yearly comprehensive Minimum Data Set (MDS) revealed, Resident #61 had a Brief Mental Status (BIMS) score of 15, which indicated she was cognitively intact.	F 602			
F 610 SS=D	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:	F 610			9/12/19

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F 610	Continued From page 7 §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: Based on record review, staff interviews, resident interviews, and facility policy review, the facility failed to initiate an investigation regarding an allegation of misappropriation of the Resident #61's Trust Fund, for one (1) of four (4) Resident Trust Funds reviewed. Findings include: A review of the facility's policy titled, "Abuse, Neglect, or Exploitation Policy", undated, revealed any report of abuse, neglect, or exploitation will be investigated by the Administrator, Director of Nursing, Social Services, Quality Assurance Committee, and Facility Security. Investigation shall include but is not limited to, questioning of the resident involved when appropriate. Questioning all staff members working in that area at the time of the incident suspected of abuse, neglect, or exploitation, who might have knowledge of the reported complaint. Questioning any family or visitors who might have knowledge of the incident. Written statements by	F 610	1. The following corrective actions were put into place for the resident found to have been affected by this deficient practice: A) A grievance form was initiated on Resident #61 and completed by Social Worker on 8/15/19 outlining the alleged money that was missing. B) An investigation into the missing money was completed by the Quality Assurance/Infection Prevention Nurse on 8/19/19 and was faxed to the Mississippi State Department of Health & the Attorney General's Office. 2. All residents who allege that abuse/misappropriation has occurred have the potential to be affected by this deficient practice. 3. The following measures and systemic changes were implemented to ensure the same deficient practice will not recur:		

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F 610	Continued From page 8 all staff questioned and signed by staff member. The resident's statement may be written by facility staff. Written statements by family questioned and by visitors questioned. An interview, on 8/15/19 at 11:00, revealed Administrator #1 stated nothing had been reported to him. An interview, on 8/15/19 at 11:01 AM, revealed Administrator #2 stated nothing had been reported to her. On 8/15/19 at 11:05 AM, an interview with the Assistant Administrator (AA), revealed she was not aware of anyone handling the resident roughly, but rather it was Certified Nursing Assistant (CNA) #5 (CNA #5 was also Resident #61's relative) taking the resident to the bathroom. The AA stated the resident had stated CNA #5 had not been talking to her. The AA also stated she asked CNA #5 to take someone with her when she went in to care for Resident #61. The AA stated Resident #61 reported to her that CNA #5 did not want to work with her (Resident #61) and that CNA #5 was acting like her daddy. The AA stated Resident #61 and CNA #5 just did not get along. The AA stated CNA #5 had started swapping out when she had to care for Resident #61. She also stated she had talked with the Resident #61's Resident Representative (RR) and the RR stated she gets along with her cousin, CNA #5. The AA stated Resident #61 thinks transferring on the sit to stand lift is handling her rough because she is unable to hold onto one side of the lift, and she thinks the staff is doing something to her. She stated Resident #61 feels she can do more than what she is able to do for herself. She also stated she does know it was	F 610	A) An in service was held on 9/6/19 by the Administrator for all employees that included going over the facility's policy on Investigating Accidents/Incidents. B) The Assistant Administrator was counseled on the importance of reporting potential allegations of misappropriation of resident funds to the proper department so facility can begin investigation. 4. The facility plans to monitor the effectiveness of our plan by doing the following: A) The Social Worker, Administration and the Quality Assurance/Infection Prevention Nurse will communicate daily with each other during our morning stand-up meetings to ensure there have been no allegations of misappropriation of resident property. If we find that there has been an allegation, we will investigate immediately. B) The Social Worker, Administration and the Quality Assurance/Infection Prevention Nurse will be able to monitor the effectiveness of the plan immediately by reviewing our grievance logs weekly to ensure we have investigated any/all allegations of missing property that were reported through our grievance form. If any negative findings occur Quality Assurance will investigate those immediately. C) During our weekly Quality Assurance meetings, we will discuss any potential investigations into missing resident property. 5. These corrective actions were		

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F 610	Continued From page 9 the sit to stand lift that Resident #61 was referring to. The AA stated Resident #61 never reported to her that CNA #5 was handling her roughly. She stated she did not do an investigation because she did not feel there was anything to investigate because this happened before the last survey. She also stated Resident #61 stated she had some money missing but Resident #61 had found her money. The AA stated, Resident #61 had \$105.00 or \$106.00. She stated she was off from work the next day. She also stated, Resident #61 had given the Licensed Social Worker (LSW) \$100.00 and had gotten \$50.00 of it the other day from the LSW. She stated Resident #61 signed off on it in her (AA) office and she (AA) had the money in a little locked box. The AA stated that was the day Resident #61's son had come to the facility. She also stated Resident #61 has \$50.00 left. The AA stated she usually does not hold money. She stated the resident had money missing last month and had brought some money to the office to the LSW and Front Office Worker #1 which was \$100.00. She stated "Wednesday" morning when she returned to work, the LSW gave her \$100.00 for Resident #61 and this was last week, but her days are kind of running together. The AA also stated when the resident's son was at the facility, Resident #61 had gotten \$50.00 of her money. She stated she rolled the camera back, and she did not see anyone go in or out of Resident #61's room. She also stated the next day Resident #61 brought the money to her office because she did not want to hold that amount of money. She stated she does not know the policy on when a resident has missing money. She also stated she generally handles it by telling the residents if they have any problems to let her know about it and she will roll the camera back. She stated she did not tell Administrator #1. She	F 610	completed on 9/12/19.		

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F 610	Continued From page 10 also stated she told the Director of Nursing (DON), but at that time, the money came back. She stated to her, the situation was over with because she (Resident #61) brought money to the office. She also stated, she asked the resident when she has that kind of large sums of money, she needs to have it locked up. She stated Resident #61 had not had that type of money before. The AA also stated she did not write anything down regarding the CNA situation or the money situation. She stated it is the facility's policy to investigate the resident's concerns, but she did not investigate because it was an issue that was resolved. She also stated other than the nurse that was standing in the hallway, no one knew about the situation. She stated she does not remember who that nurse was. She stated she should have gone to the Director of Nurses (DON) and the DON should take the next step, but she kind of handled it herself. She stated she thought everything was okay. She stated Resident #61 wants to go home tonight if she could. She also stated the resident was here previously, had gone to a facility in another town, and eventually returned to this facility. She stated the resident was wanting to go home before all of this occurred. She also stated if she failed to do something it was because of the relationship that she and Resident #61 has. This interview was conducted by speaker phone in the presence of another surveyor. On 8/15/19 at 11:35 AM, an interview with the Licensed Social Worker (LSW) revealed, Resident #61 had not reported anything to her about being unhappy with a CNA. She also stated the resident had not personally reported to her that she had some money missing. The LSW	F 610			

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F 610	Continued From page 11 stated she had witnessed the AA giving the resident some money (\$50.00) this week out of \$100.00. She stated the rest of the \$50.00 is in the AA's office. The LSW stated Resident #61 always goes to the AA and does not open up to her (LSW). She stated the resident had not mentioned anything to her. She stated if a resident came to her with a concern regarding how a CNA for example, is caring for them, she would go through the chain of command. She stated she would go to Licensed Practical Nurse (LPN) #5. On 8/15/19 at 11:50 AM, an interview with the DON, revealed the resident had not mentioned anything to her regarding any CNA. She also stated the resident had not told her about any missing money. On 8/15/19 at 12:00 PM, an interview with Resident #61, revealed she had gone to the AA because CNA #5 had stopped speaking to her. She stated she had not had a chance to talk to the AA about CNA #5 handling her roughly. She stated she had not told anyone about that. She also stated the AA came to her and gave her \$50.00, and she had \$50.00 left in the office. Resident #61 stated she wanted to draw half of the \$100.00 out. She stated the \$100.00 she had missing was about one month ago. She also stated a staff member brought her \$50.00 of the \$100.00 that was missing a month ago. Resident #61 also stated she told the AA and the AA said she would roll the camera back. Resident #61 stated she had another \$100.00 after the first \$100.00 went missing. She stated she had \$100.00 twice, but not at the same time. She stated she had the first \$100.00 about a month ago. Resident #61 stated the whole \$100.00	F 610			

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F 610	Continued From page 12 came up missing. She stated she had nine \$10.00 bills and two \$5.00 bills. She stated she had another \$5.00 and \$1.00 bill. She stated she did not tell anyone until one of the workers came into her room. Resident #61 told this worker that \$100.00 was taken out of her purse and her purse was taken from underneath her pillow. Resident #61 does not want to state the worker's name. She stated the first person she told was Resident #23, and then she told the AA and the AA told her (Resident #61) she was going to roll the camera back. She stated the AA told her that a woman was coming to talk to her and would want to know where the money came from. She stated the woman never came. She stated the AA stated she would have to get someone else to come. She stated that same worker (the worker that Resident did not want to give her name) came into her room that night and put \$50.00 in the envelope. She stated the worker was going through her things and she saw the worker lift her hand and handed the envelope to her which had the \$50.00 in it. She stated the worker told her it was not \$100.00 but it was \$50.00. The resident stated she asked the worker where was her other \$50.00 at. She stated she never heard anymore from the AA. On 8/15/19 at 12:30 PM, an interview with Administrator #1 revealed, he would expect the Assistant Administrator to handle issues and does not expect her to bring everything to him. He stated the policy on misappropriation is to go through the proper chain of command. He stated anyone in the facility can go to Quality Assurance (QA). He also stated he would expect the staff to report abuse to the administrator. He stated if someone reported to him that a resident had money missing, he would conduct an	F 610			

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F 610	Continued From page 13 investigation. A review of the facility's Face Sheet revealed, the facility admitted Resident #61, on 7/20/18, with diagnoses including Myoneural Disorder and Gastroesophageal Reflux Disease (GERD). A review of the most recent Yearly comprehensive Minimum Data Set (MDS) revealed, Resident #61 had a Brief Mental Status (BIMS) score of 15, which indicated she was cognitively intact.	F 610			
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		9/12/19	

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F 623	Continued From page 14 (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part	F 623			

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F 623	Continued From page 15 C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to notify the resident/Resident Representative in writing of the reason for transfer to the hospital for two (2) of three (3) hospital transfers reviewed. Residents #20 and #37. Findings include:	F 623	1. The following corrective actions were put into place for the residents found to have been affected by the deficient practice: A) The Social Worker was counseled and retrained by the Administrator on 9/12/19 on the importance of having a reason for transfer on the Notice of Hospital Transfer		

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F 623	Continued From page 16 A review of the facility's policy titled, "Family Notification Policy", without a date, revealed the facility would notify the family with any transfer to another health care setting such as a hospital. The policy did not specify as to how the family would be notified. A review of Resident #20 Physician's Orders revealed an order, dated 4/28/19, to transfer on 4/28/19 related to a fall. A review of Resident #20's medical record did not reveal a letter notifying the Resident's Representative of a transfer to the hospital. An interview on 08/15/19 at 10:02 AM, with Social Services (SS) #1 revealed she was responsible for notifying the family and the Ombudsmen of facility initiated transfers/discharges. SS #1 said the nurses notified the family only by telephone at the time of Resident #20's transfer. Review of the Face Sheet revealed Resident #20 was admitted by the facility, on 9/29/11, with the included diagnosis of Hemiplegia. Resident #37 A review of Resident #37's Physician's Orders revealed an order, dated 7/28/19, to transfer to evaluation of confusion and congestion. Review of Resident #37's medical record revealed no documentation was provided to the resident or the Resident's Representative regarding the hospital transfer on 7/28/19.	F 623	form. B) The Administrator amended the facility's form titled Notice of Hospital Transfer on 9/12/19 to include the reason for transfer. C) All residents that have been transferred to the hospital since 8/15/2019 have been notified in writing of the transfer via the revised Notice of Hospital Transfer form. 2. All residents who are transferred to the hospital have the potential to be affected by this deficient practice. 3. The following measures and systemic changes were put into place to ensure the deficient practice will not recur: A) A policy titled "Hospital Transfer Notification Policy" was created by the Administrator on 9/12/19. This policy provides guidance to the facility on how we will notify families when a resident is transferred to a hospital. B) The Social Worker will notify the family of transfer to the hospital in writing using the "Notice of Hospital Transfer" form that has been modified by the Administrator on 9/12/19 to include the reason for hospital transfer. The notice will include the reason for the transfer, the effective date of the transfer, and the location of the transfer. This notification of hospital transfer will be provided to the resident and or resident's responsible party as		

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F 623	Continued From page 17 An interview, on 08/15/19 at 10:02 AM, with SS #1 revealed she said she was responsible for notifying family and the ombudsmen of the facility initiated transfers/discharges. SS #1 said she started emailing the notifications of bed hold to the Resident Representatives, but it did not include the written notification of the reason for transfer. She said the nurses notified the family by telephone at the time of Resident #37's transfer. Review of the Face Sheet revealed Resident was admitted by the facility, on 11/13/15, with the included diagnoses of History of Falling and Asthma.	F 623	soon as practicable. Also, the Social Worker is responsible for notifying Ombudsman of all hospital transfers. C) The facility now allows the family/resident to have the option of receiving this written notification via email or a hardcopy. 4. The facility will monitor and ensure that solutions are sustained by the following: A)The Social Worker will attend interdisciplinary meetings daily and review 24 hour report each week day to ensure knowledge of all hospital related transfers/discharges and that families receive written notice of hospital transfer/discharge as soon as practicable. B) The Social Worker will maintain copies of all transfer notices and will compare copies weekly against the daily census that is maintained by the Charge Nurse. C) The Quality Assurance and Infection Prevention Nurse has been made aware of these corrections. She will monitor them and bring any issues to the Quality Assurance and Performance Improvement Counsel during their quarterly meetings 5. These corrective actions were put into place 9/12/19		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F 644			9/12/19

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F 644	Continued From page 18 §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to make a Level II referral related to Resident #49's change in status for one (1) of four (4) residents reviewed for Preadmission Screening Resident Reviews (PASRR). Findings include: Review of a typed statement provided by the facility, on the facility's letterhead, no date or signature, revealed the facility followed the policies and procedures of (Name of Management Company) to complete PASRRs. A review of the "(Name of the Management Company)", Provider Manual, revised 7/3/13,	F 644	1. The following corrective actions were put into place for the resident found to have been affected by this deficient practice: A) The Social Worker was counseled by the Administrator on 9/12/19 on the importance of submitting a "change in status" form to Ascend when a significant change is discovered in a resident. B) The scenario involving Resident #49 was discussed with the Medicaid Program Nurse on 9/19/19. The Medicaid Program Nurse stated there is no reason to do a Level II on Resident #49 unless there are current behavior issues going on.		

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F 644	Continued From page 19 revealed when a resident experienced a significant status change, a PASRR Level II Change in Status Request form must be completed by the provider and faxed to (Name of Management Company). Significant changes included a resident who exhibits behavioral, psychiatric, or mood-related symptoms suggesting the presence of a diagnosis of mental illness . A review of the Diagnosis/History List, for Resident #49, revealed a diagnosis of Major Depressive Disorder, recurrent severe with psych symptoms dated 2/15/18, Major Depressive Disorder, recurrent 2/8/19, and Hallucinations 9/11/15. A review of Resident #49's "Department of Mental Health" Level II letter, dated 2/11/16, indicated the resident did not require specialized services because the resident was ruled out due to there was not sufficient evidence of serious mental illness. An interview, on 8/14/19 at 12:04 PM, revealed Social Services (SS) #1 said the referral for the Level II for Resident #49 had not been submitted, and she was unaware a referral was to be sent for residents with added mental disorder or diagnosis after admission. She also said she was not at this job when the diagnoses were added last year. SS #1 said she had a training planned about the PASSRs next week. She also said they use (Name of Management Company) for their policy to complete the PASSRs. Because the facility had no Level II designated as a major mental illness, no trigger was in place when the resident had a significant change.	F 644	2. All residents with a change in status have the potential to be affected by this deficient practice. 3. The following measures and systemic changes were put into place to ensure the deficient practice will not recur: A) The Social Worker will submit a Level II change in status request form for any resident exhibiting a "significant change" as defined by [Ascends Minimum Data Set criteria for notifying Ascend of a Pre-Admission Screening status change] beginning 8/15/19. B) The Social Worker will review Physicians Orders weekly in addition to reviewing mood interviews and consulting with the Interdisciplinary Team each morning to identify any such significant changes as defined by [Ascends Minimum Data Set criteria for notifying Ascend of a Pre-Admission Screening and Resident Review status change]. C) The "Pre-Admission Screening and Resident Review Information Policy" was revised on 9/12/19 by the Administrator to reflect current practice. D) The Social Worker and the Administrator attended Pre-Admission Screening training offered by the Medicaid Program Nurse at the Mississippi Medicaid Office in Jackson on 9/19/19 and received clarification on correct		

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F 644	Continued From page 20 Therefore, the facility failed to notify (Name of Management Company) when Resident #49 had added diagnoses. A review of Resident #49's Pre-Admission Screening (PAS), provided by the facility, revealed the PAS was dated 2/2/16 with "No" indicated for a diagnosis of major mental illness or recent history resident had a significant change. Therefore, the facility failed to notify (Name of Management Company) of the mental illness.	F 644	submission protocol of Level I, Level II and Status Change. 4. The facility will monitor its plan and ensure that correction is achieved by doing the following: A) The Admissions Nurse reviews charts daily on all new Physician's Orders and will communicate with the Social Worker if she discovers any criteria that would warrant a change in status on a particular resident. The Social Worker will then confirm that she already faxed the referral to Ascend. B) The Quality Assurance and Infection Prevention Nurse has been made aware of these corrections. She will monitor them and bring any issues to the Quality Assurance and Performance Improvement Counsel during their quarterly meetings. 5. These corrective actions were completed on 9/12/19.		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3) (i) of this section, unless the State mental health	F 645		9/12/19	

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F 645	Continued From page 21 authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i) The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,	F 645			

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F 645	Continued From page 22 (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record reviews, and facility policy review, the facility failed to accurately complete the Preadmission Screen (PAS) for one (1) of four (4) resident PASs reviewed. Resident #44. Findings include: A review of the facility's policy titled, "Preadmission Screening Resident Review (PASRR) Policy", undated, revealed it is the policy of this facility that the PASRR will be completed as follows: Completed on Long Term care residents only for admission, according to the guidelines from Medicaid, and faxed to Medicaid once completed following admission (long term care residents only). A review of the Resident Assessment Manual,	F 645	1. The following corrective actions were put into place for the resident found to have been affected by this deficient practice: A) The Social Worker was counseled by the Administrator on the importance of carefully reviewing and including all diagnoses of a major mental illness, recent history of a mental illness, and any history of taking psychotropic medication in the Pre-Admission Screening application. 2. All new admissions who require a Pre-Admission Screening and Resident Review to be completed have the potential to be affected by this deficient practice.		

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F 645	Continued From page 23 dated October 2018, revealed all individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level 1 Preadmission Screening Resident Review (PASRR) completed to screen for possible mental illness (MI), intellectual disability (ID), ("mental retardation/MR") in federal regulation)/developmental disability (DD), or related condition. Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. A record review of the most recent comprehensive Admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/26/19, revealed the MDS was coded to indicate Resident #44 had not been evaluated by a Level II PASRR. The most recent Admission comprehensive MDS assessment was also coded to include a diagnosis of Psychotic Disorder. Review of the Comprehensive Care Plan revealed a Focus for Psychotropic Drug - Risperdal for Psychosis and Delusional Disorder. At risk for side effects. The Onset Date was 3/19/19. Review of the PAS dated, 3/20/19, indicated the resident did not have a diagnosis of a major mental illness, recent history of a major mental illness, and did not take, or have a history of taking psychotropic medication. A review of the Diagnosis and History List revealed the resident had a diagnosis of	F 645	3. The following measures and systemic changes were put into place to ensure the deficient practice will not recur: A)The Social Worker and the Health Information Manager (HIM) will review admission diagnoses beginning 9/13/19 to ensure any diagnosis of a major mental illness, recent history of a mental illness, and any history of taking psychotropic medication are captured prior to submission of Pre Admission Screen. B) The "Admission Check Off List" created by the Administrator on 9/12/19 has been put into place and will include initials of Social Worker and Health Information Manager (HIM) showing both have reviewed diagnoses for Mental Illness/Mental Retardation upon admission. C) The "PASSR Policy" has been revised by the Administrator on 9/12/19 to include corrective measures that were put into place. 4. The facility will monitor its plan and ensure correction is maintained by the following: A) The Admissions Nurse will review charts daily to ensure the Pre-Admission Screen is on the resident chart. If a chart is missing a Pre-Admission Screen, the Admissions Nurse will report findings to the Social Worker so that she can ensure the Pre-Admission Screening and Resident Review was completed and then added to the resident s chart. B) The Quality Assurance and Infection Prevention Nurse has been made aware		

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F 645	Continued From page 24 Psychosis, dated 3/19/19. On 8/15/19 at 10:30 AM, an interview with the Director of Nursing (DON), revealed the resident had a diagnosis of Psychosis upon admission. On 8/15/19 at 3:31 PM, an interview with the Licensed Social Worker (LSW) #1, revealed, the resident was admitted on 3/19/19 and a Level II referral should have been done. She also stated the PAS was not completed accurately. A review of the facility's Face Sheet revealed, the facility admitted Resident #44 on 3/19/19 with a diagnosis of Psychosis.	F 645	of these corrections. She will monitor them and bring any issues to the Quality Assurance and Performance Improvement Counsel during their quarterly meetings 5. These corrective actions were put into place on 9/12/19.		
F 656 SS=D	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		9/12/19	

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F 656	Continued From page 25 (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: Based on observation, staff interview, record review, and facility policy the facility failed to follow the Resident #15's Comprehensive Care Plan related to falls, and Resident #33's Comprehensive Care Plan for Foley catheter care, for two (2) of 23 resident care plans reviewed for one (1) of 23 resident care plans reviewed. Findings include: A review of the facility's policy titled "Total Care Plan Policy", without a date, revealed the facility would identify the problems that would affect the resident and his/her care needs. The Care Plan would identify problems that affect the resident and his/her care needs, and address areas	F 656	1. The following corrective actions were put into place for the resident found to have been affected by the deficient practice: A) Since Resident #15's last fall on 6/11/19, new intervention was implemented on 6/12/19 to "allow staff to assist with pulling down brief and pants during toileting" there have been no falls since that new intervention. B) An in-service was held on 9/6/19 by the Director of Nursing for the entire nursing department that addressed the importance of following the plan of care for all residents, with an emphasis on remaining in the bathroom with Resident #15 while she is in there.		

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F 656	Continued From page 26 identified on the Minimum Data Set MDS, and the Care Area Trigger (CAT)s. Resident #15 A review of the Resident #15's Comprehensive Care Plan revealed the Problem/Need, dated 10/23/12, for the risk of falls due to an unsteady gait and a diagnosis of Parkinson's Disease. Interventions included staff to stay in the bathroom with the resident while being toileted related to fall risk. Review of Resident #15's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/22/19, revealed in section J1900B the resident fell two or more times since the prior assessment with injury (not major). A review of Resident 15's, "Resident Incident Report", dated 6/11/19, revealed Resident #15 was assisted by Certified Nursing Assistant (CNA) #1 to the bathroom. CNA #1 removed the resident's walker from the bathroom. While Resident #15 was standing in front of the commode pulling her down pants and brief, Resident #15 started to fall, but CNA #1 was not able to break the fall. Resident #15 fell to the floor hitting her face and forehead and knee. The incident report noted an abrasion to the forehead and right side of neck and lip. Resident #15 was sent to Emergency Room (ER) for evaluation without any orders on return for treatment on her medical record. Review of a handwritten statement, dated 6/11/19, by CNA #1, on the facility's Written Statement on Accident/incident was attached to Resident #15's incident report. CNA #1 stated,	F 656	2. All residents who are at risk for falls have the potential to be affected by this deficient practice. 3. The following measures and systemic changes were put into place to ensure the deficient practice will not recur: A) The Social Worker will interview Resident #15 weekly beginning on 9/12/19 to ensure staff is staying with her while she is in the restroom. B) The findings from Social Worker's interview will be presented to the Quality Assurance/Infection Prevention Nurse each week. C) If needed, the Quality Assurance/Infection Prevention Nurse will review video recordings to ensure staff did/did not remain in the restroom with resident. 4. The facility plans to monitor the effectiveness of our plan by doing the following: A) The Quality Assurance/Infection Prevention Nurse will bring the findings of the Social Worker interviews to our weekly Quality Assurance meetings. B) If staff are found not staying with the resident while she is toileting we will counsel, in-service and discipline if necessary. 5. These corrective actions were completed on 9/12/19.		

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F 656	Continued From page 27 she turned her back to Resident #15 to move the walker out of the way of the resident, and when she turned around the resident was falling. A review of Resident 15's "Resident Incident Report", dated 4/11/19, revealed the resident was found in front of bathroom door by Licensed Practical Nurse (LPN) #1 with a laceration to the right brow, and was sent to the ER for evaluation. The documentation noted on the incident report revealed the fall was not witnessed. A review of Resident 15's "Resident Incident Report", dated 2/11/19, revealed the resident was in the bathroom and stood up by herself, and lost her balance, leaned against the wall and then slid to the floor. LPN #4 documented the CNAs were reminded that Resident #15 cannot be left alone in the bathroom and discussed with the Director of Nursing (DON). No injuries were reported on the incident report. The incident was documented as non-witnessed. An interview, on 8/14/19 at 2:43 PM, with LPN #1 revealed Resident #15 had a history of not calling for help when she would go to the bathroom, but that had improved now. LPN #1 said she did help when Resident #15 fell, on 4/11/19, but was not her nurse and couldn't recall who the aide was that day. An interview, on 8/14/19 at 3:28 PM, with LPN #4, revealed she was present when Resident #15 fell on 2/11/19. She said she completed the incident report and said CNA #2 assisted Resident #15 to the bathroom, but left Resident #15 in the bathroom to answer another call light. LPN #4 said when CNA #2 came back to the bathroom,	F 656	1. The following corrective actions were put into place for the resident found to have been affected by this deficient practice. A) Certified Nursing Assistant #6 was counseled and retrained on the importance of following the plan of care with regard to catheter/perineal care by the Director of Nursing on 9/5/19. B) Certified Nursing Assistant #6 also had to demonstrate proper catheter care on 9/5/19 while the Certified Nursing Assistant Coordinator observed. C) Resident #33 was monitored for signs/symptoms of any possible infection due to improper catheter care; no infection was noted. 2. The 6 residents who have a foley catheter and require catheter care to be provided have the potential to be affected by this deficient practice. 3. The following measures and systemic changes were put into place to ensure the deficient practice will not recur: A) An in-service was held for all Nursing Staff on 9/6/19 by the Certified Nursing Assistant Coordinator about the importance of following the plan of care regarding catheter/perineal care. A demonstration of proper catheter care was also performed. B) The Certified Nursing Assistant Coordinator performs pop-in visits while Certified Nursing Assistants are about to perform peri/catheter care in order to observe and ensure the care plan is being followed as it pertains to peri/catheter care.		

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F 656	Continued From page 28 the resident was on the floor. LPN #4 said Resident #15 had no injuries. LPN #4 also said she was aware the resident's care plan said to stay with the resident while in the bathroom. LPN #4 said the expectation for nurses and aides was to follow the care plan. An interview, on 8/14/19 at 2:51 PM, with CNA #2, revealed she said she was Resident #15's CNA when she fell on 2/11/19. CNA #2 said she helped Resident #15 to the toilet in the bathroom and had heard a call light that had been "going off for about 5 minutes" and went to answer it. CNA #2 said she asked Resident # 15 to not get up and that she would return. CNA #2 said when she got back, Resident #15, was leaning on the wall by the hand rail on the floor. CNA #2 said she was aware Resident #15's care plan said the resident needed to have someone to stay with her in the bathroom, but she knew the other staff members were busy with other residents and wanted to answer the light. CNA #2 said she had received education and had not left the resident by herself anymore. An interview, on 8/15/19 at 8:36 AM, with Resident # 15 revealed she always was helped and that no one has left her alone in the bathroom. Resident #15 said this place was a good home. She also said she was getting in her recliner this morning from her wheelchair, and a nurse walked by and reminded her not to get up without calling for help. An interview, on 8/15/19 at 9:31 AM, revealed the DON said the expectation was to follow the care plan specific to Resident #15. An interview, on 8/15/19 at 2:13 PM, with LPN #	F 656	4. The facility will continue to monitor and ensure the quality of catheter care remains high through the following: A) During orientation, Certified Nursing Assistants must watch a video on the proper method for performing catheter care. They also spend at least two weeks with an experienced Certified Nursing Assistant to get hands-on training and can be corrected if any improper care is observed. Finally, the Certified Nursing Assistant must pass a skills test which is given by Certified Nursing Assistant Coordinator, which includes catheter care. The Certified Nursing Assistant is not allowed to take care of a resident by herself until she can pass this skills check-off. B) Nursing staff attend a mandatory in-service on catheter/ perineal care at least every 6 months. The Certified Nursing Assistant Coordinator conducts these in- services. C) In addition, Certified Nursing Assistants are tested annually on their skills. they must demonstrate competency in all areas of resident care, including catheter care. The Certified Nursing Assistant Coordinator conducts these skills checks. D) Quality Assurance and Performance Improvement meetings are held quarterly to discuss the effectiveness of our interventions that we put into place. We will examine the progress of our corrective actions through monitoring data such as the number of Urinary Tract Infections we have. If the Quality Assurance and Performance Improvement Council notices our infection rates are increasing,		

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F 656	Continued From page 29 2/MDS Nurse revealed the expectation of the staff was to follow the care plan specific to each resident. She confirmed Resident #15's care plan stated to stay with the resident while in the bathroom. Resident #33 Review of Resident #33's Comprehensive Care Plan, revealed the Problem/Need, dated 2/15/2014, for a history of Urinary Retention and inability to void. At risk for Urinary Tract Infections, and the presence of a Foley catheter. Interventions included Foley catheter care every shift. On 8/14/19 at 9:35 AM, an observation revealed, CNA #6 assisted by CNA #7 performed Resident #33's catheter care. CNA #6 had already set up her barrier and supplies. Both CNA #6 and CNA #7 washed their hands and applied clean gloves. CNA #6 set up two (2) basins, one was to wash Resident #33, and one was to rinse the resident. When CNA #6 was cleaning Resident #33's penis she wiped the resident's penis three times (x3) without rotating her washcloth, then placed that washcloth in the soiled linen bag. CNA #6 retrieved another washcloth and wiped the resident's penis again twice (x2). When CNA #6 rinsed the resident's penis area she wiped two times (x2) without rotating the washcloth and placed that washcloth in the soiled linen bag. CNA #6 retrieved another washcloth and wiped the resident's penis area three time (x3) without rotating the washcloth. CNA #6 then dried the resident's penis area, and while drying the area she used a patting motion times five (x5) without rotating the towel, then patted the area dry again three times (x3) and again four times (x4) without	F 656	they will make adjustments to our approach during these meetings. These corrective actions were completed on 9/12/19.		

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F 656	Continued From page 30 rotating the towel. On 8/14/19 at 3:00 PM, an interview with CNA #6 revealed she stated she, "wiped too many times." CNA #6 stated she should have wiped one time and folded her washcloth before she wiped again. She also stated wiping too many times causes germs to spread. On 8/15/19 at 2:13 PM, an interview with Licensed Practical Nurse (LPN) #2/MDS Nurse, revealed she would expect the staff to follow the comprehensive care plan. Review of the Physician's Orders revealed an order, dated 4/29/19, to change the Foley catheter (18 French (FR) with a 10 cubic centimeter (cc) bulb every 30 days and as needed) for the diagnosis of Neurogenic Bladder. A record review of the most recent Quarterly Minimum Data set (MDS) assessment, with an Assessment Reference Date (ARD) of 6/3/19, revealed Resident #33 was coded for an indwelling catheter.	F 656			
F 689 SS=D	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 by:	F 689		9/12/19	

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F 689	Continued From page 31 Based on resident interview, staff interview, record review, and facility policy review, the facility failed to prevent falls for one (1) of three (3) residents reviewed for falls. Resident #15. Findings include: A review of the facility's policy titled, "Fall Protocol Policy", without a date, revealed the facility would evaluate possible alternative interventions to help prevent falls. A review of the Resident #15's Comprehensive Care Plan revealed staff was to stay in the bathroom with the resident while being toileted related to her fall risk. Review of Resident #15's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/22/19, revealed in section J1900B the resident fell two or more times since the prior assessment with injury (not major). A review of Resident 15's, "Resident Incident Report", dated 6/11/19, revealed Resident #15 was assisted by Certified Nursing Assistant (CNA) #1 to the bathroom. CNA #1 removed the resident's walker from the bathroom. While Resident #15 was standing in front of the commode pulling her down pants and brief, Resident #15 started to fall, but CNA #1 was not able to break the fall. Resident #15 fell to the floor hitting her face and forehead and knee. The incident report noted an abrasion to the forehead and right side of neck and lip. Resident #15 was sent to Emergency Room (ER) for evaluation without any orders on return for treatment on her medical record.	F 689	1. The following corrective actions were put into place for Resident #15, who was affected by the deficient practice: A) Since last fall on 6/11/19, a new intervention was implemented on 6/12/19 to "allow staff to assist with pulling down brief and pants during toileting" and there have been no falls since that new intervention. B) Director of Nursing provided an in service to all nursing staff held on 9/6/19 that addressed the importance of following the plan of care for Resident #15, with an emphasis on remaining in the bathroom with the Resident while she is in there. 2. All residents are at risk for falls and have the potential to be affected by this deficient practice. Residents are assessed by interdisciplinary team at least quarterly for fall risk using the Fall Assessment Tool. 3. The following measures and systemic changes were put into place to ensure the deficient practice will not recur: A) The Social Worker will interview Resident #15 weekly beginning on 9/12/19 to ensure staff is staying with her while she is in the restroom. B) The findings from the Social Worker's interview will be presented to the Quality Assurance nurse each week beginning on 9/13/19.		

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F 689	Continued From page 32 Review of a handwritten statement, dated 6/11/19, by CNA #1, on the facility's Written Statement on Accident/incident was attached to Resident #15's incident report. CNA #1 stated, she turned her back to Resident #15 to move the walker out of the way of the resident, and when she turned around the resident was falling. A review of Resident 15's "Resident Incident Report", dated 4/11/19, revealed the resident was found in front of bathroom door by Licensed Practical Nurse (LPN) #1 with a laceration to the right brow, and was sent to the ER for evaluation. The documentation noted on the incident report revealed the fall was not witnessed. A review of Resident 15's "Resident Incident Report", dated 2/11/19, revealed the resident was in the bathroom and stood up by herself, and lost her balance, leaned against the wall and then slid to the floor. LPN #4 documented the CNAs were reminded that Resident #15 cannot be left alone in the bathroom and discussed with the Director of Nursing (DON). No injuries were reported on the incident report. The incident was documented as non-witnessed. An interview, on 8/14/19 at 2:43 PM, with LPN #1 revealed Resident #15 had a history of not calling for help when she would go to the bathroom, but that had improved now. LPN #1 said she did help when Resident #15 fell, on 4/11/19, but was not her nurse and couldn't recall who the aide was that day. An interview, on 8/14/19 at 3:28 PM, with LPN #4, revealed she was present when Resident #15 fell on 2/11/19. She said she completed the incident	F 689	C) If needed, the Quality Assurance nurse will review video recordings to ensure staff did/did not remain in the restroom with Resident #15. 4. The facility plans to monitor the effectiveness of our plan by doing the following: A) The Quality Assurance nurse will bring the findings of the Social Worker interviews to our weekly Quality Assurance meetings. The Quality Assurance committee will make recommendations and/or changes as needed. B) If findings result in staff not staying with the resident while she is toileting, the Administrator will counsel, in-service and discipline staff when necessary. C) Other residents that have falls will continue to be assessed by the Quality Assurance Nurse and the Interdisciplinary Team and new interventions will be put into place to prevent future falls. The Staff will be educated on new interventions and resident care plan amended to reflect the new intervention. 5. These corrective actions were completed on 9/12/19.		

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F 689	Continued From page 33 report and said CNA #2 assisted Resident #15 to the bathroom, but left Resident #15 in the bathroom to answer another call light. LPN #4 said when CNA #2 came back to the bathroom, the resident was on the floor. LPN #4 said Resident #15 had no injuries. LPN #4 also said she was aware the resident's care plan said to stay with the resident while in the bathroom. LPN #4 said the expectation for nurses and aides was to follow the care plan. An interview, on 8/14/19 at 2:51 PM, with CNA #2, revealed she said she was Resident #15's CNA when she fell on 2/11/19. CNA #2 said she helped Resident #15 to the toilet in the bathroom and had heard a call light that had been "going off for about 5 minutes" and went to answer it. CNA #2 said she asked Resident # 15 to not get up and that she would return. CNA #2 said when she got back, Resident #15, was leaning on the wall by the hand rail on the floor. CNA #2 said she was aware Resident #15's care plan said the resident needed to have someone to stay with her in the bathroom, but she knew the other staff members were busy with other residents and wanted to answer the light. CNA #2 said she had received education and had not left the resident by herself anymore. A review of a facility's "In-Service Meeting", dated 2/6/19, revealed CNA #2 attended the education related to fall prevention safety. An interview, on 8/15/19 at 8:36 AM, with Resident #15, revealed she stated she was helped and that no one has left her alone in the bathroom. Resident #15 said this place was a good home. She also said she was getting in her recliner this morning from her wheelchair, and a	F 689			

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F 689	Continued From page 34 nurse walked by and reminded her not to get up without calling for help. An interview, on 8/15/19 at 9:31 AM, revealed the DON said CNA #2 was instructed and educated after the fact with a write up in her file for not following the care plan resulting in a fall. Review of the Face Sheet revealed Resident #15 was admitted by the facility, on 10/23/12, with diagnoses that included Parkinson's Disease and Tremors. Review of Resident #15's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/4/19, revealed a Basic Interview for Mental Status (BIMS) was coded a 15, which indicated no cognitive impairment.	F 689			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690		9/12/19	

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F 690	Continued From page 35 indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record reviews, and facility policy review, the facility failed to provide catheter care in a manner to prevent possible cross contamination for one (1) four (4) resident catheter care observations. Resident #33. Findings include: A review of the facility's policy titled, "Incontinent care Policy", undated, revealed: Wipe area only once with same cloth, change cloth or fold cloth to clean side and clean from front to back. A review of the facility's policy titled, "Catheter Care Policy", undated, revealed it is the policy of this facility that catheter care will be done as follows: Wiping buttock from the anal area upward and cleanse the catheter from the body to the end of the catheter, never from the end of the	F 690	1. The following corrective actions were put into place for the resident found to have been affected by this deficient practice. A) Certified Nursing Assistant #6 was counseled and retrained on the importance of following the plan of care with regard to catheter/perineal care by the Director of Nursing on 9/5/19. B) On 9/5/19, Certified Nursing Assistant #6 also had to demonstrate proper catheter care while the Certified Nursing Assistant Coordinator observed. C) Resident #33 was monitored for signs/symptoms of any possible infection due to improper catheter care; no infection was noted. 2. The 6 residents who have a foley catheter and require catheter care to be		

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F 690	Continued From page 36 catheter toward the body. On 8/14/19 at 9:35 AM, an observation revealed CNA #6 assisted by CNA #7 performed Resident #33's catheter care. CNA #6 had already set up her barrier and supplies. Both CNA #6 and CNA #7 washed their hands and applied clean gloves. CNA #6 set up two (2) basins, one was to wash Resident #33, and one was to rinse the resident. When CNA #6 was cleaning Resident #33's penis she wiped the resident's penis three times (x3) without rotating her washcloth, then placed that washcloth in the soiled linen bag. CNA #6 retrieved another washcloth and wiped the resident's penis again twice (x2). When CNA #6 rinsed the resident's penis area she wiped two times (x2) without rotating the washcloth and placed that washcloth in the soiled linen bag. CNA #6 retrieved another washcloth and wiped the resident's penis area three time (x3) without rotating the washcloth. CNA #6 then dried the resident's penis area, and while drying the area she used a patting motion times five (x5) without rotating the towel, then patted the area dry again three times (x3) and again four times (x4) without rotating the towel. On 8/14/19 at 3:00 PM, an interview with CNA #6 revealed she stated she, "wiped too many times." CNA #6 stated she should have wiped one time and folded her washcloth before she wiped again. She also stated wiping too many times causes germs to spread. An interview, on 8/14/19 at 3:17 PM, with Registered Nurse (RN) #1, revealed when CNA #6 wiped more than once without rotating her washcloth that caused cross contamination and infection control issues.	F 690	provided have the potential to be affected by this deficient practice. 3. The following measures and systemic changes were put into place to ensure the deficient practice will not recur: A) An in-service was held for all Nursing Staff on 9/6/19 by the Certified Nursing Assistant Coordinator about the importance of following the plan of care regarding catheter/perineal care. A demonstration of proper catheter care was also performed. B) The Certified Nursing Assistant Coordinator performs pop-in visits while Certified Nursing Assistants are about to perform peri/catheter care in order to observe and ensure the care plan is being followed as it pertains to peri/catheter care. 4. The facility will continue to monitor and ensure the quality of catheter care remains high through the following: A) During orientation, Certified Nursing Assistants must watch a video on the proper method for performing catheter care. They also spend at least two weeks with an experienced Certified Nursing Assistant to get hands-on training and can be corrected if any improper care is observed. Finally, the Certified Nursing Assistant must pass a skills test which is given by the Certified Nursing Assistant Coordinator, which includes catheter care. The Certified Nursing Assistant is not allowed to take care of a resident by herself until she can pass this skills check-off.		

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F 690	Continued From page 37 Review of the Physician's Orders revealed an order, dated 4/29/19, to change the Foley catheter (18 French (FR) with a 10 cubic centimeter (cc) bulb every 30 days and as needed) for the diagnosis of Neurogenic Bladder. A record review of the most recent Quarterly Minimum Data set (MDS) assessment, with an Assessment Reference Date (ARD) of 6/3/19, revealed Resident #33 was coded for an indwelling catheter.	F 690	B) Nursing Staff attend a mandatory in-service on catheter/ perineal care at least every 6 months. The Certified Nursing Assistant Coordinator conducts these in services. C) In addition, Certified Nursing Assistants are tested annually on their skills. They must demonstrate competency in all areas of resident care, including catheter care. The Certified Nursing Assistant Coordinator conducts these skills checks. D) Quality Assurance and Performance Improvement meetings are held quarterly to discuss the effectiveness of our interventions that we put into place. We will examine the progress of our corrective actions through monitoring data such as the number of Urinary Tract Infections we have. If the Quality Assurance and Performance Improvement Council notices our infection rates are increasing, they will make adjustments to our approach during these meetings. 5. These corrective actions were completed on 9/12/19.		
F 880 SS=D	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	F 880		9/12/19	

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F 880	Continued From page 38 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, 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	F 880			

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F 880	Continued From page 39 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. §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 observations, staff interview, record review, and facility policy review, the facility failed to ensure the prevention for possible cross contamination and spread of infection for one of five days (1 of 5) days of the survey as evidenced by staff's failure to wear gloves during resident contact (Resident #79) and to wash hands after the resident contact. Findings include: A review of the facility's policy titled, "Hand Washing Policy", without a date, revealed hand washing would be done after any direct contact with another person. Review of the facility's policy titled, "Infection Control - Isolation Policy", no date, revealed it is the policy of the facility that isolation will be used as follows: In order to prevent spread of infection. In the least restrictive form possible. Isolation	F 880	1. The following corrective actions were put into place for the resident found to have been affected by this deficient practice: A) Licensed Practical Nurse #3 was counseled on 9/5/19 by our Quality Assurance/Infection Prevention Nurse on the importance of wearing gloves when having physical contact with a resident who has open sores. B) Licensed Practical Nurse #3 was also counseled by our Pharmacy Consultant, on the importance of performing hand hygiene after any direct contact with another person to prevent possible cross contamination as it relates to med pass. C) The Housekeeping Department cleans/disinfects the hallway rails daily. 2. All residents have the potential to be affected by this deficient practice,		

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F 880	Continued From page 40 form to be determined by the physician, or facility Infection Control Nurse. A sign will be placed on the outside of the door to indicate that visitors should see the nurse before entering the room. Notify family of isolation precautions. Technique: Isolation techniques utilized by this facility included 2. Wound and skin isolation such as Shingles. Resident equipment should be placed in the room for individual use. Resident specific equipment must be disinfected prior to removing from isolation room, which includes thermometer, blood pressure cuff, stethoscope, and any other equipment that actually touches the resident. Personal protective equipment will be used when indicated. Review of the facility's policy titled, "Occupational Exposure Policy", no date, revealed that in the case occupational exposure these steps will be taken, which included clean and disinfect the exposed area. An observation, on 8/12/19 at 11:03 AM, revealed Resident #79 was propelling his wheelchair and positioned his oxygen tubing on his face. Resident #79 had wounds that were noted on top of his scalp that were red and open to air, but no drainage noted. Resident #79 was observed touching the hallway rails by the dayroom across from the West Wing nurse's desk. Licensed Practical Nurse (LPN) #3 was at the desk and assisted Resident #79 in his wheelchair, and then pushed the resident away from the rail without using gloves. Resident # 79 scratched the top of his head and wheeled himself down the hallway to the other nurse's desk. LPN #3 went back to her medication cart and did not perform hand hygiene, typed on her computer keyboard, and used the mouse. LPN #3 then put on gloves and	F 880	especially those who are under the care of Licensed Practical Nurse #3. 3. The following measures and systemic changes were put into place to ensure the deficient practice will not recur: A) An in-service for all staff was held on 9/6/19 by our Quality Assurance/Infection Prevention Nurse about the importance of following the facility's protocol on infection control. B) An in-service was held on 9/6/19 for all employees by our Staff Development nurse that focused on the importance of proper hand washing. 4. The facility will continue to monitor and ensure that potential cross-contamination incidents are prevented through the following: A) Infection Control Prevention Plan The facility has an Infection Control Prevention Program in place which investigates, controls and prevents infections in the facility. An infection control surveillance map is used to track infections in the facility. The facility has an Infection Control Isolation Policy in place to prevent the spread of infection and decide what procedures should be applied to an individual resident. The Quality Assurance/Infection Prevention Nurse will maintain records of infections and any related corrective actions. B) During orientation, each nurse spends 6 weeks training with an experienced nurse to get hands-on training and can be corrected if any infection		

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F 880	Continued From page 41 set up mediations for another resident. An interview, on 8/12/19 at 11:10 AM, revealed LPN #3 said Resident #79 had Shingles, but rarely complains. She said he will scratch at it late in evenings. LPN #3 also said Resident #79 won't stay in his room because of mental status. A review of Resident # 79's Physician's Orders, dated 8/7/19, revealed he was on valacyclovir 1000 milligrams (mg) one (1) three times a day for seven days for Varicella Zoster (Shingles) of the scalp. Further review of Resident #79's Physician's Orders revealed no order for any type isolation. A review of the Care Plan, for Resident #79, revealed the Problem/Need, dated 7/16/19, for risk for skin problems related to a history of shingles prior to admission, and possible reoccurrence. The Approaches included the administration of the valacyclovir. An interview, on 8/13/19 at 11:20 AM, revealed Certified Nurse Assistant (CNA) #4 said she was not aware of any infection precautions with Resident #79. She said he was in Physical Therapy at present time. An interview, on 8/14/19 at 7:33 PM, revealed the Director of Nursing (DON) said the medication for Varicella Zoster was ordered because Resident #79 had been complaining of pain without any open wounds. The DON also stated the resident would pick at them and open the scabs back up. The DON said Resident #79 usually wore a cap to cover his head. The DON stated the policy was to keep the blisters covered on his head because the wounds were open. The DON	F 880	control/cross-contamination issues are observed. C) Nursing Staff attend in-services on infection control every 6 months. D) In addition to our Pharmacy Consultant watching med pass on our nurses quarterly, the Quality Assurance/Infection Prevention Nurse will observe one med pass weekly and both will report to our Director of Nursing if any errors were observed. E) Quarterly Quality Assurance and Performance Improvement meetings are held and this is when we would discuss the effectiveness of these corrective actions. If the Quality Assurance and Performance Improvement Council notices our infection rates are increasing, they will make adjustments to our approach during these meetings. 5. These corrective actions were completed on 9/12/19.		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/15/2019
NAME OF PROVIDER OR SUPPLIER THE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 11 PECAN DRIVE COLUMBIA, MS 39429		
(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 42 confirmed LPN #3 should have performed hand hygiene after assisting the resident. The DON also said the concern was the cross contamination from the resident scratching and touching his hands then other areas of the facility that could spread the infection.	F 880			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2019
NAME OF PROVIDER OR SUPPLIER THE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 11 PECAN DRIVE COLUMBIA, MS 39429		
(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	
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			

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

TITLE

(X6) DATE

Electronically Signed

09/03/2019

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/16/2019
NAME OF PROVIDER OR SUPPLIER THE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 11 PECAN DRIVE COLUMBIA, MS 39429		
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E 000	Initial Comments ***** Survey conducted on 08/16/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000			

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

TITLE

(X6) DATE

Electronically Signed

09/03/2019

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.