STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255050	A. BUILDING _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEFFERSON DAVIS COMMUNITY HOSPITAL ECF	1320 WINFIELD STREET PRENTISS, MS 39474

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual survey from 9/16/19 through 9/19/19. During the survey, the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements of participation. The SA cited deficiencies at F622, F623, F625, F641, F657, F842, and F880. The facility was licensed for 55 beds, and had a census of 51 at the time of survey	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the	F 622		10/18/19

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

Electronically Signed | 10/04/2019

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 622	Continued From page 1 resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or	F 622		

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F 622	Continued From page 2 discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to convey to the receiving provider, the basis for the transfer from the facility for one (1) of six (6) residents with hospital transfers, Resident #3 Findings Include: Review of a statement on facility letterhead, dated 9/19/19, and signed by the Director of Nursing (DON) revealed,"We do not have a policy and procedure that specifically addresses the information that is sent out with the resident to the hospital at time of discharge/transfer". Review of a document, provided by the facility, and signed by the DON, dated 9/19/19, revealed	F 622	1. All transfers and discharges beginning September 19, 2019 were updated for Resident #3 to convey to the receiving provider the basis for the transfer/discharge and Residents Representative contact information. 2. All Residents have the potential to be affected by this deficient practice. 3. An In-service was conducted 10/03/2019 by the Nurse Consultant for the Director of Nursing, Staff Development Nurse, Charge Nurses, Licensed Practical Nurses, Social Services Designee and Minimum Data Set Nurse, regarding the need to convey to the receiving provider as well as the Resident Representative, the medical	

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F 622	Continued From page 3 "Sending residents to the ER"- Transfer/discharge sheet once you fill it out in the computer (print). Record review of physician's orders, dated 8/8/19, 8/13/19, and 8/16/19, revealed Resident #3 was transferred from the facility to the hospital for evaluations. Record review of Resident #3's paper and computer chart revealed no documentation that a transfer summary containing Resident #3's medical status/ Resident Representative Contact information was sent to the receiving facility when Resident #3 was transferred to the hospital three (3) times. An interview on 09/17/19 at 1:25 PM, with the Director of Nursing (DON), revealed, "We do not have a transfer summary that was sent to the hospital for Resident #3. We are supposed to send a transfer summary including the reason for transfer to the hospital, Medication Administration Record, Resident Representative contact information, allergies, etc. but there was not one sent that I can find".	F 622	status of all transfer/discharges as well as the Residents Representative contact information. 4.The Director of Nursing and Staff Development Nurse will conduct an audit of all transfers/discharges and report daily in the Morning Staff Meeting. Any deficient practice will be corrected immediately. Findings will be reviewed in the weekly Quality Assurance Performance Improvement meeting and recommendations will be made as needed.	
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	F 623		10/18/19

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F 623	Continued From page 4 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- (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;	F 623		

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F 623	Continued From page 5 (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 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	F 623		

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F 623	Continued From page 6 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 record review, staff interview, and facility policy review, the facility failed to provide written documentation to the resident and/or resident's representative, of the reason for transfer/discharge to the hospital, for six (6) of six (6) hospitalizations reviewed out of 18 residents sampled, Residents #3, #21, #23, #28, #30, and #36. Findings include: A review of the facility's policy titled, "Bed-Holds and Returns", with a revision date of March 2017, revealed: Prior to a transfer, written information will be given to the residents and the resident representatives that explains the details of the transfer. Resident #36 Record review of the physician orders, dated 9/4/19, revealed an order to send Resident #36 to a local Behavior Hospital. The Nurse Progress Note, dated 9/4/19, indicated Resident #36 was observed walking up and down the hallway yelling and cursing staff, and when staff was trying to get the resident back to her room, the resident refused to put clothing on and refused to take medications as well. There was no documented evidence that a written notice was provided to the	F 623	1. All transfers/discharges beginning on September 19, 2019 for residents #36, #3, #23, #30, #2, #21 and #28 were updated to notify the Resident and Resident Representative of all transfer or discharges, the reasons for the move in writing and in a manner they understand. The facility will send a copy of the notice to a representative of the Office of the State Ombudsman. 2. All Residents have the potential to be affected by this deficient practice. 3. An in-service was conducted on 10/03/2019 by the Nurse Consultant for The Director of Nurses, Staff Development Nurse, Charge Nurses, Licensed Practical Nurses, Minimum Data Set Nurse, Social Service Designee, regarding notification to the Resident and Resident Representative of any transfers or discharges and the reasons for the move in writing. 4. The Director of Nursing and Staff Development Nurse will conduct an audit of all transfers/discharges and report daily in the Morning Staff Meeting. Any deficient practice will be corrected immediately. Findings will be reviewed in the weekly Quality Assurance Performance Improvement meeting and recommendations will be made as	

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F 623	Continued From page 7 resident/resident representative regarding information of Resident #36's transfer to the hospital on 9/4/19. On 9/17/19 at 1:45 PM, an interview with the Director of Nurses (DON) revealed the facility had not been notifying the resident or the Resident Representatives, in writing, of the reason for transfer to the hospital. On 9/17/19 at 2:07 PM, an interview with Resident #36's Resident Representative revealed no written notice of the reason for transfer to the behavior facility was provided. Resident #3 Record review of physician's orders dated 8/8/19, 8/13/19, and 8/16/19, revealed Resident #3 was transferred from the facility to the hospital for evaluations. Review of Resident #3's medical record revealed no documentation of a transfer letter to the Resident Representative regarding Resident #3's transfers from the facility to the hospital, prior, during, or shortly after the transfers. The facility failed to provide proof of a written transfer letter mailed to Resident #3's Resident Representative (RR). An interview on 09/17/19 at 11:45 AM, with the Business Office Director (BOD) revealed, "We have no documentation that we mailed the Resident Representative written notice of the hospital transfer on any of the days". An interview on 09/17/19 at 11:55 AM, with the DON revealed, "The process is that the hospital written transfer sheet should be mailed out the	F 623	needed.	

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F 623	Continued From page 8 next day after a Resident is transferred out of the facility. It should be mailed by the Social Service Department". An interview on 09/17/19 at 12:00 PM, with the Social Service Director (SSD), confirmed that she did not know of any transfer/bed hold letter that the facility mailed to the Resident Representative when the resident was transferred to the hospital. An interview on 09/17/19 at 1:25 PM, with the DON, revealed the facility did not have a transfer/bed hold sheet for Resident #3 for transfers to the hospital. The DON stated, "We don't have any written transfer/bed hold letters that were mailed to the Resident Representative. We don't have proof we mailed anything". Res #23 Review of a physician's order, dated 6/28/19, revealed Resident #23 was transferred from the facility to the hospital. Review of Resident #23's medical record revealed no written transfer letter to the Resident Representative regarding Resident #23's transfer from the facility. The facility failed to provide proof of a written transfer letter mailed to Resident #23's Resident Representative. Res #30 Review of a physician's order, dated 6/04/19, revealed Resident #30 was transferred from the facility to the hospital. Review of Resident #30's medical record revealed no written transfer letter to the Resident Representative regarding Resident #30's transfer out of the facility. The facility failed to provide	F 623		

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F 623	Continued From page 9 proof of a written transfer letter mailed to Resident #30's Resident Representative. Resident #21 Review of Resident #21's medical record revealed the resident was transferred to the hospital on 5/27/19, and returned to facility on 5/31/2019, for observation of Pneumonia. Review of Resident #21's medical record revealed no documented evidence of a written transfer notice to the Resident and/or Resident Representative for the 5/27/19 transfer to the hospital. During an interview on 09/17/19 at 1:37 PM, the DON confirmed the facility did not notify the Responsible Party of Resident #2, in writing, for transfer to hospital on 5/27/19. Resident #28 Record review revealed Resident #28 was transferred to the hospital on 9/3/2019, and returned on 9/7/2019, for diagnoses of Sepsis, Acute Kidney Infection, and Urinary Tract Infection (UTI). Review of Resident #28's medical record revealed no documented evidence of a written notice of transfer to the Resident and/or Resident Representative. On 09/18/19 at 3:03 PM, interview with the DON revealed a written notice of transfer was not provided to the Resident Representative regarding the transfer to the hospital on 9/3/19.	F 623		
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr	F 625		10/18/19

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F 625 SS=D	Continued From page 10 CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to notify the resident and/or resident representative of the facility policy for bed hold, for two (2) of six (6) hospitalizations reviewed, Resident #23, and Resident #30.	F 625	1. All transfers beginning on September 19, 2019 were update for residents #23, #30 to include a bed hold notice which includes the specific duration of the bed hold policy. 2. All Residents have the potential to be affected by this deficient practice.	

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F 625	Continued From page 11 Findings Include: A review of facility policy titled "Bed-Holds and Returns", dated March 2017, revealed "Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy". Resident #23 Record review of a physician's order, dated 6/28/19, revealed Resident #23 was transferred from the facility to the hospital. Record review of Resident #23's medical record revealed no evidence of a bed hold letter delivered to Resident #23 or the Resident Representative. The facility failed to provide evidence of a documented bed hold letter for Resident #23. Res #30 Record review of a physician's order, dated 6/04/19, revealed Resident #30 was transferred from the facility to the hospital. Record review of Resident #30's medical record revealed no documented evidence of a bed hold letter delivered to Resident #30 or the Resident Representative. The facility failed to provide evidence of a bed hold letter for Resident #30. An interview on 09/17/19 at 12:00 PM, with the Social Service Director, regarding Resident #23 and Resident #30's transfers, revealed that she did not know of any transfer/bed hold letter that the facility mailed to the Resident Representative when the resident was transferred to the hospital.	F 625	3. An in-service was conducted on 10/03/2019 by the Nurse Consultant for The Director of Nurses, Staff Development Nurse, Charge Nurses, Licensed Practical Nurses, Minimum Data Set Nurse, Social Service Designee, regarding notification to the Resident and Resident Representative of the facility policy regarding bed hold. 4. The Director of Nursing and Staff Development Nurse will conduct an audit of all bed hold notices and report daily in the Morning Staff Meeting. Any deficient practice will be corrected immediately. Findings will be reviewed in the weekly Quality Assurance Performance Improvement meeting and recommendations will be made as needed.	

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F 625	Continued From page 12 An interview on 09/17/19 at 1:25 PM, with the Director of Nursing (DON), regarding Resident #23 and Resident #30's transfers, revealed there was no documented transfer/bed hold sheet for the residents for when they went out of the facility to the hospital. The DON stated, "We don't have any written transfer/bed hold letters that were given to the resident or mailed to the Resident Representative. We don't have proof we mailed anything".	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) for one (1) of 18 MDS assessments reviewed, Resident #21. Findings include: Review of a facility statement, regarding the Resident Assessment Instrument (RAI) Policy: A comprehensive assessment of a resident's needs shall be made within 14 days of the resident's admission. According to the M0210: RAI Version 3.0 Manual, "If a resident had a pressure ulcer/injury that healed during the look-back period of the current assessment, do no code the ulcer/injury on the assessment.	F 641	1. Resident #21 was assessed by the Director of Nursing on 10/04/2019 with no negative findings. The Minimum Data Set was updated for Resident #21 on 10/04/2019 by the Minimum Data Set Nurse to accurately reflect the Residents status. 2. All Residents have the potential to be affected by this deficient practice. 3. An in-service was conducted on 10/03/2019 by the Nurse Consultant for The Director of Nurses, Staff Development Nurse, Charge Nurses, Licensed Practical Nurses, Minimum Data Set Nurse, regarding the importance of accurate body assessments and appropriate documentation for Section M of the Minimum Data Set. 4. The Director of Nursing and Staff Development Nurse will conduct a review	10/18/19

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F 641	Continued From page 13 Record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/02/2019, Section M revealed documentation that Resident #21 had a Stage 2 Pressure Ulcer. Record review of the Physician's Progress note, revealed documentation that the Pressure Ulcer for Resident #21 was "Healed" on 6/20/19. Record Review of the Wound/Skin Management Documentation Record, revealed on 06/24/2019, the wound for Resident #21 was intact. On 09/17/19 at 11:24 AM, an interview with Director of Nursing (DON) revealed Resident #21 had no Pressure Ulcer. During an interview on 09/17/19 at 11:25 AM, Register Nurse #1 confirmed Resident #21's physician documented that #21's Stage 2 ulcer was healed on 6/20/19. On 09/17/19 at 3:30 PM, observation of Resident #21 revealed no pressure ulcers. On 09/18/19 at 09:08 AM, an interview with Licensed Practical Nurse #1/MDS Coordinator, and the Director of Nursing, revealed the Stage 2 wound for Resident #21 healed on 6/20/2019, and the MDS was inaccurately coded. Licensed Practical Nurse #1, stated, "I did not observe the wound". On 09/18/19 at 10:56 AM, an interview with Resident #21's Physician revealed Resident #21's wound had healed on 6/20/2019, and orders should have been written to discontinue the treatment.	F 641	of all body audits and report daily to the Morning Staff Meeting. Any deficient practice will be corrected immediately. Findings will be reviewed in the weekly Quality Assurance Performance Improvement meeting and recommendations will be made as needed.	

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F 657	Continued From page 14	F 657		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to revise the Comprehensive Care Plan to reflect a soft wrist splint and interventions, for Resident #3 and the use of an indwelling catheter for Resident #38, for two (2) of 18 care plans reviewed.	F 657	1. The Comprehensive Care Plan was updated for residents #3 on 10/04/2019 and #38 on 09/17/2019 by the Minimum Data Set Nurse to accurately reflect the Residents status. 2. All Residents have the potential to be affected by this deficient practice.	10/18/19

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F 657	Continued From page 15 Findings Include: A review of facility policy titled, "Care Plans-Comprehensive", (no date) revealed, "Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. The Care-Planning interdisciplinary team is responsible for the review and updating of care plans. Resident #3 Record review of the Working Care Plan on the chart, and the most current care plan, initiated 12/12/18, through the review date of 9/30/19, revealed Resident #3's care plan was not revised to include a soft wrist splint and/or interventions related to the splint. Review of an incident report timeline, provided by the facility, revealed Resident #3 had a right wrist splint placed, per Primary Care Provider, on 8/13/19, for a non-displaced distal radial fracture. An observation on 09/16/19 at 8:53 AM, revealed a soft wrist splint noted on Resident #3's right wrist. During an interview on 09/18/19 at 11:07 AM, the Director of Nursing (DON) stated, after reviewing the current care plan and the working care plan on the chart, "The right wrist splint interventions are not on the Resident's current care plan or on the working care plan in the chart". An interview on 09/18/19 at 11:20 AM, with LPN #1 MDS/Care Plan Nurse, revealed the soft wrist splint and interventions were not care planned, and they should have been. LPN #1 stated, "The	F 657	3. An in-service was conducted on 10/03/2019 by the Nurse Consultant for The Director of Nurses, Staff Development Nurse, Charge Nurses, Licensed Practical Nurses, Minimum Data Set Nurse, Social Service Designee, regarding the revision of Care Plans to reflect the Residents current condition. 4. The Director of Nursing and Staff Development Nurse will conduct a 100% review of all Care Plans and audit weekly as they are updated. Any deficient practice will be corrected immediately. Findings will be reviewed in the weekly Quality Assurance Performance Improvement meeting and recommendations will be made as needed.	

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F 657	Continued From page 16 nurse who checks the orders when a resident returns from an appointment, is responsible to write the order and care plan the order if needed". An interview on 09/18/19 at 1:37 PM, with the DON, revealed, "It is the RN Supervisor or the LPN's responsibility to check a resident back in after an appointment and they are supposed to write any orders that return with the resident. Then, whoever writes the order, is supposed do to create or update the care plan specific to the order". Resident #38 Review of Resident #38's comprehensive care plan, with a target date of 11/30/19, revealed a care plan related to the resident's incontinence, however, there was no care plan for an indwelling urinary catheter. On 9/17/19 at 9:19 AM, an observation revealed Certified Nursing Assistant (CNA) #1, assisted by CNA #2, performed catheter care for Resident #38. The resident was observed to have an indwelling urinary catheter. On 9/17/19 at 11:00 AM, an interview with the Director of Nurses (DON) revealed there was no physician's order or care plan for the indwelling urinary catheter for Resident #38. On 9/17/19 at 11:10 AM, an interview with Licensed Practical Nurse (LPN) #1 revealed a care plan had not been developed for the resident's indwelling urinary catheter. She also stated the current care plan did not reflect the resident's current status regarding the indwelling urinary catheter.	F 657		

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F 657	Continued From page 17 During an interview on 09/18/19 at 8:54 AM, Registered Nurse (RN) #3 revealed Resident #38 returned from the hospital (8/19/19) with the catheter and had not had any complications from the urinary catheter.	F 657		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance	F 842		10/18/19

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F 842	Continued From page 18 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and facility policy review, the facility failed to ensure accuracy of the medical record,	F 842	1. Resident #3 was assessed by the Director of Nursing on 10/04/2019 with no negative findings. Resident #38 was	

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F 842	Continued From page 19 related to a soft wrist splint and an indwelling urinary catheter, for two (2) of 18 resident medical records reviewed, Resident #3 and Resident #38. Findings include: A review of the facility's policy titled" Medication Orders" with a revision date of November 2014, revealed a current list of orders must be maintained in the clinical record of each resident. A review of the facility's documented statement, signed by the Director of Nursing (DON), not dated, revealed the facility does not have a policy and procedure that specifically addresses the input of orders after a hospital return. Resident #38 A record review of the physician's orders for September 2019, revealed there was no order for Resident #38's indwelling urinary catheter. The most recent Discharge-Return Anticipated Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 8/27/19, was coded to include an indwelling urinary catheter. The resident had a catheter for entire seven (7) day look-back period. On 9/17/19 at 9:15 AM, an observation revealed Resident #38 lying in bed with his eyes open. Resident #38 was observed with an indwelling urinary catheter. On 9/17/19 at 11:00 AM, an interview, with the Director of Nurses (DON), confirmed the medical record was inaccurate related to no physician's order for the indwelling urinary catheter for Resident #38. She also stated the physician orders did not reflect the resident's current status	F 842	assessed by the Director of Nursing on 9/17/2019 with no negative findings. A Clarification Order was obtained for Resident #3 on 10/04/2019 and Resident #38 on 09/17/2019 by the Minimum Data Set Nurse to accurately reflect the Residents status. 2. All Residents have the potential to be affected by this deficient practice. 3. An in-service was conducted on 10/03/2019 by the Nurse Consultant for The Director of Nurses, Staff Development Nurse, Charge Nurses, Licensed Practical Nurses, Minimum Data Set Nurse, Social Service Designee, regarding the importance of accuracy of medical records including transcription of Physicians Orders. 4. The Director of Nursing and Staff Development Nurse will conduct a review of all Physicians Orders for accuracy and report daily to the Morning Staff Meeting. Any deficient practice will be corrected immediately. Findings will be reviewed in the weekly Quality Assurance Performance Improvement meeting and recommendations will be made as needed.	

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F 842	Continued From page 20 regarding the indwelling urinary catheter. The DON stated Resident #38 had the catheter upon his hospital return (8/19/19). On 9/18/19 at 8:54 AM, an interview, with Registered Nurse (RN) #3, revealed the resident returned from the hospital with the catheter, had poor kidney function, and is unable to urinate on his own. She also stated she would have to look at the chart to make sure of the diagnoses. She stated the resident had not had any complications from the urinary catheter that she is aware of. Resident #3 Review of Physician orders for August 2019, revealed no Physician's order for a soft wrist splint to Resident #3's right wrist on 8/13/19. Review of an incident report timeline, provided by the facility, documented on 8/13/19, revealed Resident #3 received a right soft wrist splint, placed per Primary Care Provider, due to a nondisplaced distal radial fracture. An observation on 09/16/19 at 8:53 AM, revealed a soft wrist splint noted on Resident #3's right wrist. An interview on 09/18/19 at 11:00 AM, with the facility Medical Director, revealed he applied the soft splint to Resident #3's wrist in the Emergency Room on 8/13/19. An interview on 09/18/19 at 11:07 AM, with the Director of Nursing (DON), revealed there should have been an order written for Resident #3's splint when she returned from the hospital. The DON confirmed the medical record was inaccurate because there was no order written for	F 842		

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F 842	Continued From page 21 the wrist splint. An interview on 09/18/19 at 1:37 PM, with the DON, revealed the RN Supervisor or the LPN who checks a resident back in after an appointment are supposed to write any orders that return with the resident. She stated whoever writes the order, is supposed to create or update the care plan, specific to the order. The DON confirmed there was no Physician's order written for Resident #3's splint, nor a care plan updated with written interventions for the soft right wrist splint.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, 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;	F 880		10/18/19

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F 880	Continued From page 22 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 23 §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 of observation, record review, staff interview, and facility policy review, the facility failed to provide a Percutaneous Endoscopic Gastrostomy (PEG) tube dressing change in a manner to prevent cross contamination for two (2) of two (2) resident PEG tube care sites observed, for Resident #23 and Resident #38. This was evidenced by allowing resident clothing to touch/cover the PEG site, after cleaning and prior to applying a dressing, during treatment for Resident #23 and the RN touching items with ungloved hands prior to the PEG care for Resident #38. The facility also failed to provide wound care in a manner to prevent cross contamination for one (1) of four (4) resident wound care observations, Resident #31. This was evidenced by the RN touching items with ungloved hands prior to performing the treatment. Findings include: A review of the facility's policy titled, "Infection Control Guidelines for all Nursing Procedures", with a revision date of May 2017, revealed: Standard Precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious disease. A review of Perry and Potter Nursing Skills and Procedures, eighth edition, page 123, revealed: use of personal protective equipment reduces transmission of microorganisms.	F 880	1. Residents #31, #38 and #23 were assessed by the Director of Nursing on 9/18/2019 with no negative findings. Registered Nurse #1 was in-serviced on the techniques to provide a safe, sanitary and comfortable environment to avoid development and transmission of communicable diseases and infections in regards to wound care for Residents #31, #38 and #23 on 09/18/2019 by the Director of Nursing. 2. Six Residents with Percutaneous Endoscopic Gastrostomy (PEG) tubes have the potential to be affected by this deficient practice. 3. An in-service was conducted on 10/03/2019 by the Nurse Consultant for The Director of Nurses, Staff Development Nurse, Charge Nurses, Licensed Practical Nurses, Minimum Data Set Nurse, Social Service Designee, regarding the importance of proper techniques for prevention of development and transmission of communicable diseases and infections. 4. The Director of Nursing and Staff Development Nurse conducted a review through return demonstration of all nurses providing wound care starting 9/19/2019. Starting on 10/18/2019 weekly return demonstrations will begin for thirty days and then once monthly for ninety days. Any deficient practice will be corrected immediately. Findings will be reviewed in	

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F 880	Continued From page 24 A review of facility policy titled, "Policies and Practices-Infection control", dated May 2017, revealed, "The facility's infection control policies are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections". A review of facility policy titled, "Gastrostomy/Jejunostomy Site Care", dated March 2018, revealed: The purpose of this procedure is to promote cleanliness and to protect the Gastrostomy or Jejunostomy site from irritation, breakdown and infection. Resident #31 On 9/18/19 at 9:48 AM, observation of wound care revealed RN #1 used her ungloved hands to place 10 dry 4 x 4 gauze dressings on a Styrofoam plate, sprayed the dressings with normal saline that she had gotten out of her treatment cart, then gloved and performed the wound care on Resident #31, using the 4 x 4 gauze. Resident #31's soiled dressing was observed to have a moderate amount serosanguious drainage. Resident #31's wound bed was pink with scattered red tissue. Resident #38 On 9/18/19 at 11:28 AM, an observation revealed, while RN #1 set up her supplies, she retrieved the 4 x 4 gauze dressings with her ungloved hands and placed them on a Styrofoam plate. She washed her hands, turned on the overbed light, and applied clean gloves, without washing her hands. She removed the soiled tube feeding dressing, washed her hands, applied clean gloves and performed the site care.	F 880	the weekly Quality Assurance Performance Improvement meeting and recommendations will be made as needed.	

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	255050	A. BUILDING _____ B. WING _____	09/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 25 On 9/18/19 at 11:48 AM, an interview with RN #1 revealed it was a habit for her to retrieve the 4 x 4 gauze with her bare hands and not use gloves. She also stated it made total common sense, that not wearing gloves while handling the 4 x 4 gauze dressings with bare hands, would cause cross contamination. On 9/18/19 at 11:50 AM, an interview with the Director of Nurses (DON) revealed RN #1 should have used gloves, because she had touched a lot of other things in her treatment cart. The DON stated not using gloves to handle the 4 x 4's could cause cross contamination. On 9/19/19 at 9:56 AM, an interview with RN #2 revealed that RN #1 should have used gloves and not her bare hands, while handling the 4 x 4 gauze dressings, to prevent hand to hand contact with the supplies. She also stated RN #1 could pass germs to the residents by using her bare hands to handle the 4 x 4 gauze dressings. Resident #23 An observation on 09/17/19 at 9:45 AM, revealed RN #1/Wound Care Nurse, entered Resident #23's room, washed and dried her hands, and then turned the faucet off with her clean hand. RN #1 left the room, pulled keys out of her pocket, and opened the wound care cart, then returned the keys to her pocket. RN #1 placed several gauze dressings onto a Styrofoam plate, using her bare hands, then opened the drawer of the wound cart, took out a spray bottle of wound cleanser, wet the gauze, and returned the cleanser to the drawer. RN #1 sanitized her hands, gloved, grabbed the side of Resident #23's geri-chair, and pushed the chair to the side, so she could get to the Resident's stoma. RN #1 pulled up Resident #23's shirt, removed the soiled	F 880		

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	255050	A. BUILDING _____ B. WING _____	09/19/2019

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F 880	Continued From page 26 dressing, and cleaned and dried the resident's stoma. RN #1 pulled the resident's shirt over the stoma between intervals, allowing the shirt to touch the dirty and clean stoma. With gloves on, RN #1 pulled Resident #23's shirt down after applying a new dressing, then, picked up Resident #23's baby doll and handed it to the resident, prior to removing her gloves and washing her hands. An interview on 09/18/19 at 11:50 AM, with RN #1 revealed, "I do remember reaching in and getting the gauze with my ungloved hands. It is an infection control issue". RN #1 stated she remembered pulling the shirt back down over the cleaned wound, and stated "I mean, what's the point of cleaning the wound if your going to put the shirt back on it. It was contaminated and should have been re-cleaned after the shirt touched it, and before putting a clean dressing on it. I know you probably seen me move the chair with my gloves on, but I don't remember it. I probably did it self-consciously. The wound definitely should have been re-cleaned, prior to putting a clean dressing on". An interview on 09/18/19 at 12:06 PM, with the Director of Nursing (DON), revealed the nurse should not have gotten the gauze with her bare hands, because of cross contamination. The DON stated, "If she pulled the shirt back over the wound after cleaning it, and before applying a clean dressing, it was cross contamination also". An interview on 09/19/19 at 9:45 AM, with RN #2, revealed she would possibly consider it an infection control issue with the nurse pulling the shirt back over a cleaned stoma, before applying a clean dressing. She stated she would also	F 880		

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F 880	Continued From page 27 consider it a possible infection control issue with the nurse picking up the 4 x 4 gauze with her ungloved hands and placing it onto the plate. She stated, "You need a barrier between the clean gauze and your hands. You wouldn't want hand to hand contact with something you're going to use on a resident. You could pass germs to a resident". Record review of a facility document titled, "JD-ECF treatment check log Nurse Check off", dated 3/16/16, revealed RN #1 received training in "Any cross contamination with treatment".	F 880		

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	255050	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/23/2019**

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

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

Electronically Signed | 10/04/2019

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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E 000	Initial Comments ********** Survey conducted on 09/23/19 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

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