STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255294	A. BUILDING _____ B. WING _____	10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBOUGH HEALTH AND REHABILITATION CENTER	340 DESOTO AVE EXTENDED CLARKSDALE, MS 38614

(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 Survey Agency (SA) conducted an annual recertification survey at the facility from 9/30/19 to 10/3/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited the regulatory deficiencies F640 and F641. At the time of the survey, the census was 55, and the facility held a license for 60 beds.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		10/31/19

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

Electronically Signed | 10/29/2019

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	255294	A. BUILDING _____ B. WING _____	10/03/2019

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GREENBOUGH HEALTH AND REHABILITATION CENTER	340 DESOTO AVE EXTENDED CLARKSDALE, MS 38614

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F 640	Continued From page 1 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to complete a Discharge Minimum Data Set (MDS) Assessment for one (1) of 18 MDS assessments reviewed, Resident #2. Findings include: Review of a facility statement, dated 10/2/19, signed by the Administrator, revealed, "All Minimum Data Set "MDS" assessments are completed as required by the Resident Assessment Instrument (RAI) Manual". Review of the RAI OBRA - required Assessment Summary	F 640	Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged in the statement of deficiencies. This Plan of Correction is prepared solely as a matter of compliance with the Federal and State law. F640: 1. Resident #2's discharge Minimum Data Set (MDS) assessment was completed and transmitted on 10/2/2019 by the MDS nurse.	

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	255294	A. BUILDING _____ B. WING _____	10/03/2019

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GREENBOUGH HEALTH AND REHABILITATION CENTER	340 DESOTO AVE EXTENDED CLARKSDALE, MS 38614

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F 640	Continued From page 2 (cont.), page 2-17, October 2018, revealed, "Discharge Assessment - return not anticipated (Non-comprehensive) MDS Completion Date (Item Z0500B) No Later Than Discharge Date + 14 calendar days, Transmission Date No Later Than MDS Completion Date + 14 calendar days..." Review of the MDS Tracking/Discharge Roster revealed Resident #2's Discharge Assessment Reference Date (ARD) was 5/30/19, and the assessment had not been submitted; the assessment was 111 days overdue. Review of the Physician's Order Sheet revealed an order, dated 5/24/19, to discharge the resident to a Personal Care Home on 5/28/19 - 5/29/19. During an interview, on 10/02/19 at 10:00 AM, Licensed Practical Nurse #1(LPN)/ MDS Coordinator, stated, "She's on my case mix roster. It wasn't done, I don't know what happened in May, I have been in MDS for two (2) years". She stated she usually had assessments done by day three (3) of the ARD. LPN #1 confirmed Resident #2's discharge assessment should have been done, signed, and completed by 6/2/19. In an interview on 10/2/19 at 11:00 AM, the Administrator stated it was the policy of the facility to follow the RAI Manual for submission of the MDS.	F 640	2. On 10/4/19, the MDS nurse completed a 100% audit of the Tracking/Discharge roster to determine anyone else with potential for this same issue for timeliness and accuracy of discharge assessments and transmissions to ensure they were completed within the Resident Assessment Instrument (RAI) Manual guidelines. Only one other discharge assessment was affected and that assessment was completed and transmitted on 10/4/2019 by the MDS nurse. 3. On 10/4/19, the MDS nurse, Director of Nursing (DON), and Assistant Director of Nursing (ADON) were in-serviced on timeliness of discharge MDS completion and submission per the RAI guidelines by the Nursing Home Administrator (NHA). 4. Starting 10/21/19, all discharges will be discussed in the weekday morning meeting among the Interdisciplinary Team (IDT) members and added to the MDS calendar. The MDS nurse will audit discharged resident records weekly to ensure completion of discharge MDS assessments and transmissions. Results of these audits will be brought to the Quality Assurance Performance Improvement (QAPI) meeting monthly with recommendations as needed to ensure continued compliance.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		10/31/19

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	255294	A. BUILDING _____ B. WING _____	10/03/2019

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F 641	Continued From page 3 §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 ensure that a Discharge Minimum Data Set (MDS) Assessment was completed accurately for one (1) of 18 MDS reviewed, Resident #52, as evidenced by the MDS was coded for discharge to the hospital and the resident was discharged home. Findings include: Review of the Resident Assessment Instrument (RAI) for MDS coding, used by the facility for their policy, revealed to review the medical record, including the discharge plan and discharge orders, for documentation of the discharge location. Review of the discharge Minimum Data Set (MDS) for Resident #52, with an Assessment Reference Date (ARD) of 7/2/19, revealed in section A2100 the discharge status was to an Acute Hospital. Review of the physician's orders, dated 7/2/19, revealed Resident #52 was to be discharged home with Home Health for follow-up care. On 10/1/19 at 4:54 PM, an interview with the Director of Nursing (DON) confirmed Resident #52's discharge MDS with the Assessment Reference Date (ARD) of 7/2/19, was coded for discharge to an acute hospital and the resident	F 641	F641: 1. Resident #52's discharge Minimum Data Set (MDS) assessment was corrected and transmitted on 10/2/2019 by the MDS nurse. 2. On 10/4/19, the MDS nurse completed a 100% audit of residents on the discharge/tracking roster to determine any other residents with the potential for this same accuracy issue of the discharge location. There were no other residents identified. 3. On 10/4/19, the MDS nurse, Director of Nursing (DON), and Assistance Director of Nursing/Registered Nurse Assessor were in-serviced on accuracy of the MDS and coding per the RAI guidelines by the Nursing Home Administrator (NHA). 4. Starting 10/14/19, all discharges will be discussed in the weekday morning meeting among the Interdisciplinary Team (IDT) members to verify discharge location. The MDS nurse will verify discharge location with the business office manager, physician orders, and RN MDS assessor prior to coding the MDS. Starting 10/21/19, the DON and/or NHA nurse will audit discharged resident records weekly to ensure accuracy of the discharge location of the MDS	

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	255294	A. BUILDING _____ B. WING _____	10/03/2019

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GREENBOUGH HEALTH AND REHABILITATION CENTER	340 DESOTO AVE EXTENDED CLARKSDALE, MS 38614

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F 641	Continued From page 4 was discharged home. The DON stated she remembered the resident went home with Home Health. On 10/2/19 at 3:28 PM, an interview with Licensed Practical Nurse (LPN) #1/MDS Coordinator, confirmed the discharge MDS for Resident #52, on 7/2/19, was coded as being discharged to the acute hospital and he was discharged home with Home Health. LPN #1 revealed she does not know how it got coded wrong.	F 641	assessments. Results of these audits will be brought by the DON/NHA to the Quality Assurance Performance Improvement (QAPI)meeting monthly with recommendations as needed to ensure continued compliance.	

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	255294	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/01/2019**

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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 | 10/21/2019

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 10/03/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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Electronically Signed | 10/21/2019

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