| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255226 | A. BUILDING _____ B. WING _____ | 10/30/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| NATCHEZ REHABILITATION AND HEALTHCARE CENTER | 344 ARLINGTON AVENUE NATCHEZ, MS 39120 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>The State Agency conducted an annual recertification along with complaint(s) MS #15768, MS #16087, and MS#15893, from 10/28/19 to 10/30/19. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA did not substantiate MS #15768, MS #16087 and MS #15893, with no citations related to the complaints. The SA cited F641 and F755 during the survey.<br><br>The facility was licensed for 58 beds, with a current census of 46. | F 000 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, record review, and facility policy review, the facility failed to accurately code a Minimum Data Set (MDS) related to medication, for one (1) of 21 MDS assessments reviewed, Resident #35.<br><br>Findings include:<br><br>Review of the RAI (Resident Assessment Instrument) manual for coding section N0410E, Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or | F 641 | Preparation and submission of this plan of correction by Natchez Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal law.<br><br>F641:<br><br>1. On 10/31/2019, the Minimum Data Set (MDS) Registered Nurse (RN) Coordinator modified and submitted | 11/22/19 |

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

Electronically Signed | 11/19/2019

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| F 641 | Continued From page 1<br>reentry if less than 7 days). Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here.<br><br>Review of the Resident #35's MDS with an Assessment Reference Date (ARD) of 9/24/19, revealed Section N0410E was coded "7", related to the number of days taking an anticoagulant.<br><br>Review of Resident #35's physician orders, dated 9/17/19, revealed she was currently taking Plavix (clopidogrel) 75 milligram (mg) every day and ASA (Aspirin) 81 mg every day.<br><br>Review of Resident #35's Medication Administration Record (MAR), for the look back period for the MDS, revealed resident received ASA 81 mg and Plavix 75 mg for the month of September 2019.<br><br>During an interview on 10/29/19 at 4:08 PM, Registered Nurse (RN) #1, MDS Nurse, confirmed Resident #35 was on aspirin and Plavix, and had coded the MDS in error. She stated she was told to code the MDS the same as you would for an anticoagulant. She said she had a "sticky note" on her computer as a reminder to code Plavix as an anticoagulant. RN #1 reviewed the RAI manual and stated Plavix (clopidogrel) was not to be coded in Section N as an anticoagulant. | F 641 | corrections to the Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 9/24/2019 Section N0410E, which is the section under Medications Review that requires anticoagulant therapy coding in the last seven (7)days, for Resident #35.<br><br>2. On 10/31/2019, the MDS RN Coordinator conducted an audit of MDS assessments submitted in October 2019 with active orders for Plavix to determine if the MDS assessment was coded to reflect accurate anticoagulant therapy. Two (2) MDS assessments were audited with one additional issue noted. The MDS RN Coordinator modified and submitted the correction for the additional finding.<br><br>3. On 10/31/2019, in-service was conducted by the Regional Case Mix RN with the MDS RN on the requirements to accurately code MDS assessment Section N0410E per the Resident Assessment Instrument (RAI) manual.<br><br>4. Effective 11/15/2019, the Regional Case Mix Specialist RN will conduct an audit weekly for four (4) weeks then monthly for three (3)months and quarterly thereafter on MDS assessments to review accuracy of coding of Section N0410E . A report of audit findings will be submitted by the MDS Coordinator to the Quality Assurance Performance Improvement Committee monthly for three (3) months for further review and recommendations. The Administrator is responsible for monitoring and compliance. | |

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| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, record review, and facility policy review, the facility failed to remove expired medication (med) from the storage room and medication cart for one (1) of | F 755 | F755:<br><br>1. On 10/29/2019, the Director of Nurses(DON) Registered Nurse (RN) | 11/22/19 |

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| F 755 | Continued From page 3<br>five (5) med pass observations.<br><br>Findings include:<br><br>Review of a facility's "Storage of Medication" policy, dated April 2017, revealed the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.<br><br>On 10/29/19 at 11:15 AM, an observation with Licensed Practical Nurse (LPN) #1, of the medication storage room, revealed Fexofenadine Hydrochloride tablets USP 180 milligram (MG) Antihistamine 24 hour relief Allergy, with an expiration date of 06/2019.<br><br>On 10/29/19 at 11:40 AM, an observation of Medication Cart A, with LPN #2, revealed Fexofenadine Hydrochloride tablets USP 180 MG/Antihistamine 24 hour relief Allergy, with an expiration date of 06/2019.<br><br>Record review revealed a monthly medication room inspection by the pharmacist dated 10/25/2019.<br><br>During an interview on 10/29/19 at 11:55 AM, the Director of Nursing (DON) stated the medication (Fexofenadine) should have been pulled on or by the expiration date. She stated medications are rotated when they come in, by the central supply staff. The DON stated the Pharmacist comes in the facility once a month to check the medication room. | F 755 | pulled Fexofenadine Hydrochloride tablets USP 180 milligram (MG)Antihistamine 24 hour relief Allergy with expiration date of 6/2019 from medication room and medication cart A for destruction. The Director of Nurses (DON) Registered Nurse (RN) conducted an audit for active and discharge residents dating back to 1/1/19 with orders for Fexofenadine Hydrochloride. There were no residents with orders for this medication.<br><br>2. All residents have the potential to be affected by this deficient practice. On 10/29/2019, and again on 11/13/19 the Director of Nurses(DON) Registered Nurse(RN) conducted an audit of the two(2) medication carts, medication storage room (1), treatment cart(1), and supply room(1) for any expired medications. No other outdated medications were noted.<br><br>3. On 10/31/19, an in-service was initiated by the Director of Nurses (DON) Registered Nurse (RN) with licensed nursing staff on the Storage of Medication Policy. Effective 11/13/2019, licensed nurses will be responsible for logging and verification using the Medication Expiration form to confirm no outdated medication exist on the medication carts at the beginning of their shift.<br><br>4. Effective 11/15/19, the Director of Nurses(DON) Registered Nurse (RN) will conduct an audit of medication cart, medication storage room, treatment cart, | |

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| F 755 | Continued From page 4 | F 755 | and supply room to ensure there are no outdated medications present. This audit will be conducted weekly for four (4) weeks then every two (2) weeks for three (3) months and quarterly thereafter. Storage of Medication policy in services will be conducted monthly for a period of four (4) months and ongoing with newly hired licensed nurses. A report of audit findings will be submitted by the Director of Nurses (DON) Registered Nurse (RN) to the Quality Assurance Performance Improvement Committee monthly for four (4) months for further review and recommendations. The Administrator and Director of Nursing are responsible for monitoring and compliance. | |

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| | 255226 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **10/29/2019** |

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| **NATCHEZ REHABILITATION AND HEALTHCARE CENTER** | **344 ARLINGTON AVENUE NATCHEZ, MS 39120** |

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| K 000 | INITIAL COMMENTS<br><br>42 CFR 483.70(a)<br><br>The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ... | K 000 | | |
| K 321 SS=F | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9.<br>When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4.<br>Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler<br>Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet) | K 321 | | 11/22/19 |

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| K 321 | Continued From page 1<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, the facility failed to properly protect hazardous areas 19.3.2.1. This deficiency affected two (2) of three (3) smoke compartments and all 47 residents in the facility on the day of survey<br><br>Findings include:<br><br>During the building inspection on October 29, 2019 at 10:40 AM, observation revealed the damage walls in the following rooms of the facility:<br><br>1. Boiler Room<br>2. Maintenance Office<br>3. Hopper Room<br>4. Mechanical Room<br>5. Milk Storage Room<br><br>These rooms were not smoke tight and were incapable of resisting the passage of smoke throughout the facility. | K 321 | Preparation and submission of this plan of correction by Natchez Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal law.<br><br>K321:<br><br>1. On 10/31/2019, the damaged walls in the Boiler Room, Maintenance Office, Hopper Room, Mechanical Room, and Milk Storage Room were repaired by removing the grills and exhaust fans, installing Type X, 5/8 sheet rock, and sealing with fire rated caulk by Maintenance Director.<br><br>2. On 10/31/2019, the Maintenance Director performed a complete inspection of the facility to ensure there were no other damaged walls that would allow the passage of smoke throughout the facility; no other issues were noted.<br><br>3. On 11/15/2019, an in-service was conducted by the Regional Maintenance Director with the facility Maintenance Director and Administrator on the requirements and processes of identifying, correcting, and preventing | |

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| K 321 | Continued From page 2 | K 321 | damage to walls that would allow passage of smoke throughout the facility.<br><br>4. Effective 11/15/2019, the facility Maintenance Director will perform a weekly inspection of the fire walls to ensure there are no penetrations. This inspection will be conducted weekly for four (4) weeks then monthly thereafter. A report of audit findings will be submitted by the facility Maintenance Director to the Quality Assurance Performance Improvement committee monthly for three (3) months for further review and recommendations. The Administrator is responsible for monitoring and compliance. | |

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| E 000 | Initial Comments<br><br>**********<br><br>Survey conducted on 10/29/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements.<br><br>No deficiencies were cited. | E 000 | | |

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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.