

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

PRINTED: 11/21/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/19/2019
NAME OF PROVIDER OR SUPPLIER LAKEVIEW NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 16411 ROBINSON ROAD GULFPORT, MS 39503		
(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 CI MS #16219 & CI MS #16237 The State Agency conducted an annual recertification along with a complaint survey for MS #16219 and MS #16237 from 9/16/2019 to 9/19/2019. 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 #16219 for pressure ulcer neglect and MS #16237 for death prevention (facility followed code status) with no citations related to the complaint. The SA cited F565, F577, F640, F757, and F880 during the survey.	F 000			
F 565 SS=D	The census was 97 and the facility held a license for 105 beds. Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon	F 565			10/17/19

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

TITLE

(X6) DATE

Electronically Signed

10/17/2019

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 565	Continued From page 1 the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, resident interview, and review of the facility policy, the facility failed to resolve a grievance concerning a missing item for one (1) of 21 sampled residents, Resident #61. Findings include: Review of the facility policy entitled "Resident and Family Grievance" dated 8/6/2019 revealed, "Prompt efforts to resolve include facility acknowledgment of a complaint/grievance and activity working toward resolution of that complaint/grievance 12) The facility will make prompt efforts to resolve a grievance. " During an interview on 9/17/2019 at 2:00 PM, Resident #61 reported she had been missing her green bedspread for a month. She stated she reported to housekeeping at that time the blanket	F 565	* Resident #61's bedspread has been located in laundry by laundry personnel on 10/09/19. No in-service was held as it is standard procedure to look for lost clothing and bedding in laundry. ** All residents have the potential to be affected by this same deficient practice. *** All grievances will be brought to the morning department head meeting, Monday - Friday for review with the proper department. The Social Service Director (Grievance Officer) or appropriate department head will resolve the grievance and the Grievance Officer will provide the resident or responsible party with the written results within 7-14 days. **** Quality Assurance (QA) will review all		

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F 565	Continued From page 2 went missing. In an interview on 09/19/19 at 8:30 AM, Social Worker #1 stated Resident #61's family member had told her about the missing bedspread, but she could not remember when she had told her. Later that day Social Worker #1 provided a grievance written on 9/17/2019. In an interview, 09/19/19 09:45 AM, the Administrator stated when a resident brings up a concern in the Resident Council meeting, the Activity Director brings it up in the morning meeting. The Social worker then looks for the missing items and if she finds the item, she does not always write a grievance. In an interview on 09/19/19 at 10:15 AM, Certified Nursing Assistant #1 stated Resident #1 had a green blanket that had been missing over a week and a half.	F 565	grievances twice monthly for three months to ensure a timely resolution and will bring their findings to the monthly Quality Assurance meeting for review and recommendation.		
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.	F 577		10/17/19	

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F 577	Continued From page 3 (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on resident interviews, observations, and facility statement/policy, the facility failed to ensure residents were aware of the location and availability of the most recent survey results, this affected four (4) of five (5) residents who attended the Resident Council group meeting, who complained they were unaware of the location of the survey results. Findings include: Review of the facility statement/policy, dated 9/19/19, revealed the facility posts the location of the State Survey Book on the bulletin board in the front hallway. During the Resident Council meeting on 9/17/2019 at 2:00 PM, four (4) of five (5) residents complained they were unaware of the location of the survey results. On 09/19/19 at 8:30 AM, interview with Social Worker #1 revealed she did not know where the survey results were posted in the facility. The survey results were observed on 9/19/2019	F 577	* The four of five residents were informed by the Activity Director on 09/17/19 of the locations of the most recent survey results. ** All residents have the potential to be affected by this same deficient practice. *** Signs have been placed in the front hallway bulletin board, the 500 hall bulletin board and in the Activity Room stating the location of our most recent survey results. Survey results are located in binders labeled "State Survey Book". Survey books are located both in the Activity Room and the sitting room at the end of the 300 hall. Both rooms are open 24 hours a day, seven days per week. The location of the survey results books will be announced to the residents by the Activity Director each month during the Resident Council meeting and noted in the meeting minutes. The first meeting with this announcement made was held on 10/15/19.		

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F 577	Continued From page 4 at 8:35 AM, posted in the far corner of the activity room, which is not always readily accessible (such as a lobby or other area frequented by most residents, visitors or other individuals) where individuals wishing to examine survey results do not have to ask to see them. The notice was posted on the board "Located in our activity Department you will find a copy of our most recent State Board of Health Survey Results", with a lot of other information. This was not in the front hallway.	F 577	**** Quality Assurance nurse will review the Resident Council minutes once per month for three months to ensure that the announcement was made and will bring their findings to the monthly Quality Assurance meeting for review and recommendations.		
F 640 SS=E	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		10/17/19	

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F 640	Continued From page 5 §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 transmit the Minimum Data Set (MDS) in a timely manner for four (4) of four (4) residents reviewed for MDS transmission, of 24 sampled residents reviewed, Residents #1, #3, #6, and #7. Findings Include: Review of a signed statement on facility letterhead, dated 9/19/19, and signed by the Administrator, revealed the facility followed the Resident Assessment Instrument (RAI) Manual guidelines for submitting the MDS.	F 640	* Assessments for Residents #1, #3, #6 and #7 have been submitted by Minimum Data Set(MDS) nurses. ** All residents have the potential to be affected by this same deficient practice. *** MDS will run an Assessment Summary Report once weekly beginning 09/23/19 to look for any outstanding MDS assessments that have not been transmitted. Any assessments not transmitted listed on the report will be transmitted.		

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F 640	Continued From page 6 Record Review of the Resident Assessment Instrument (RAI) Manual, used by the facility for policy requirements, revealed the 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, Annual assessment, Significant change in status assessment, Significant correction of prior full assessment, Significant correction of prior quarterly assessment, Quarterly review, A subset of items upon a resident's transfer, reentry, discharge, and death, Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. Resident #1 Record Review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 7/8/2019, revealed the MDS was not transmitted to Centers for Medicare & Medicaid Services (CMS) until 9/18/2019. Resident #7. Record Review of Resident #7's MDS, with an ARD of 8/1/2019, revealed the MDS was not transmitted to CMS until 9/18/2019. Resident #3 Review of Resident #3's yearly MDS, with the ARD date of 7/30/2019, revealed the MDS was not submitted to CMS until 9/17/19, and should have been completed and submitted by 7/30/19. Resident #6 Review of Resident #6's Quarterly MDS, with the ARD date of 8/9/2019, revealed the MDS was not	F 640	**** Quality Assurance (QA) nurse will monitor the Assessment Summary reports twice monthly for a period of three months to ensure timely submission. QA will bring their findings to the monthly QA meeting for review and recommendations.		

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F 640	Continued From page 7 transmitted to CMS until 9/19/2019, which is more than 14 days past the due date. During an interview on 09/19/19 at 05:10 PM, RN #1 confirmed the MDS's were late. The nurse said they printed out the assessment summary and noticed they had missed four (4) MDS's that had not been submitted. The nurse said she submitted the MDS's on 9/18/2019 for Residents #1, #7, #3 and #6.	F 640			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on Staff Interview, Record Review, and	F 757			10/17/19
			* Resident #48's medication was		

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F 757	Continued From page 8 Facility Policy Review, the facility failed to prevent the use of unnecessary medication for one (1) of seven (7) residents reviewed for unnecessary medications, Resident #48. Resident #48 was given medication for the diagnosis of Schizophrenia, after admission, with no prior history of this mental illness. Findings include: The facility's policy, "Use of Psychotropic Drugs", not dated, noted the indications for initiating, as well as the use of non-pharmacological approaches, will be determined by: The indications for use of any psychotropic drug will be documented in the medical record. 2.3 Pre-admission screening and other pre-admission data shall be utilized for determining indications for use of medications ordered upon admission to the facility. 2.4 For psychotropic drugs that are initiated after admission to the facility, documentation shall include the specific condition as diagnosed by the physician. 2.4.1 Psychotropic medications shall be initiated only after medical, physical, functional, psychosocial, and environmental causes have been identified and addressed. Review of current Physician's orders, revealed Resident #48 had orders for Seroquel 25 milligram (mg) at bedtime. In an interview on 9/19/19 at 12:48 PM, the Pharmacy Consultant stated Resident #48 did not have a diagnosis of Schizophrenia on admission orders, nor was she taking Seroquel 25 milligram (mg) daily at bedtime. In an interview on 09/19/19 at 1:33 PM, the	F 757	reviewed and discontinued on 09/25/19. ** All residents have the potential to be affected by this same deficient practice. *** The Admission Nurse will review the medication list for all new admissions to ensure the correct diagnosis is present for any psychotropic medications. No in-service was done. **** Quality Assurance (QA) nurse will monitor psychotropic medications by bringing new resident's charts to morning department head meeting Monday-Friday for review by the interdisciplinary team. Their findings will be brought to the monthly QA meeting for review and recommendations.		

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F 757	Continued From page 9 Director of Nursing (DON) stated she was not sure why a diagnosis of Schizophrenia was added after Resident #48 was admitted. In an interview on 09/19/19 at 2:41 PM, Licensed Practical Nurse (LPN) #1/ Minimum Data Set (MDS) Nurse, confirmed the Quarterly MDS on 6/24/19, does not list Schizophrenia as a diagnosis. She also confirmed Resident #48 did not have a baseline Care Plan to address the diagnosis of Schizophrenia, and if is listed as a diagnosis, there should be a care plan for it. In an interview on 09/19/19 at 2:51 PM, the Medical Director and Resident #48's Primary Care Physician (PCP) stated that he was unable to find where the initial diagnosis of Schizophrenia came from for Resident #48. The PCP stated on review the progress notes from two (2) separate hospital progress notes, revealed no diagnosis of Schizophrenia prior to admission. The PCP stated the progress notes from a local hospital on 1/14/19, also did not reveal a diagnosis of Schizophrenia. The PCP confirmed he wrote a diagnosis of "Labeled as Schizophrenic, but stated, "I did not necessarily agree with that." During an interview on 09/19/19 at 3:15 PM, the DON confirmed the Pre-Admission Screening Resident Review (PASRR) Level II, dated 7/17/19, revealed Resident # 48 did not have sufficient documentation to support a diagnosis of Schizophrenia or Mental Illness, and did not have evidence of the need for Seroquel. In an interview on 09/19/19 at 3:47 PM, Resident #48 stated she had never had a diagnosis of Schizophrenia. Resident #48 stated years ago	F 757			

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F 757	Continued From page 10 when she was having family problems, a doctor told her she was upset because all women are neurotic. Resident #48 denied ever having other psychiatric concerns prior to admission. A review of the Admission Physician Orders for Resident #48, dated 2/1/19, revealed no diagnosis that included Schizophrenia, and no orders for Seroquel. The facility admitted Resident #48 on 3/26/19, with the diagnoses which included: Acute Respiratory Failure with Hypoxia, Congestive Heart Failure, and Type 2 Diabetes Mellitus.	F 757			