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	255145	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD REHABILITATION AND HEALTHCARE	501 SOUTH LOCUST STREET MCCOMB, MS 39648

(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 7/31/18 through 08/03/18. During the survey the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements for participation. The SA cited deficiencies at F550, F583, F656, F657, F658, F690, F692, and F693. The facility was licensed for 140 beds and had a census of 131 at the time of survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		9/25/18

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

Electronically Signed | 09/25/2018

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 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident, staff, and family interview, record review and facility policy review, the facility failed to ensure Resident #99 was treated with dignity and respect for one (1) of 26 residents reviewed. (Resident #99) A review of the facility's policies and procedures with a subject of "Resident Rights", dated 11/30/14, revealed the residents have the right to be treated with dignity and respect. An observation and interview on 07/31/18 at 08:31 AM with Resident #99 revealed the resident had a continuous feeding tube delivering Resident #99 stated that she did not like having the tube and she wanted to eat by mouth. Resident #99 stated she could swallow and wanted to eat. An observation and interview on 08/01/18 at 12:00 PM with Resident #99 revealed the resident	F 550	F550 1. Root Cause Analysis was completed 9/17/18 by Quality Assurance Performance Improvement Committee and based on results Resident #99 was offered and accepted a different room assignment that will maintain Residents rights and dignity. 2. A Quality Review was conducted on 9/18/18 by Director of Nursing of current Residents on NPO status to ensure Residents were not in a position to watch other Residents eat food. Eight Residents could have been affected by this practice. Follow up based on findings. 3. Clinical Educator provided re-education for current facility on 9/18/18 regarding this regulation with emphasis on ensuring Residents with "nothing by mouth" (NPO)	

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F 550	Continued From page 2 sitting up in bed with her feeding pump providing feeding at 45cc/hr. The resident's roommate was observed to have a lunch tray and the roommate was eating her lunch. Resident #99 stated "I wish I could eat. That lady there (pointing to roommate) eats all the time." The resident's tone became more exasperated as she stated "I have to sit and watch her eat. It be smelling so good. She eats three times a day!" The resident stated she could eat but staff wouldn't let her and say she can't swallow. The resident stated her roommate always eats in the room and no one pulls her curtain to block her view. The resident stated it made her feel like no one listens to her. A review of the resident's care plan revealed there were no interventions addressing the resident's desire to eat or interventions to keep resident from having to watch her roommate eat meals. An interview on 08/01/18 at 12:14 PM with LPN # 7, who was familiar with Resident #99 since her admission to the facility revealed the resident had been wanting to eat since she was admitted. LPN #7 stated the resident's roommate eats in the room and it was probably hard for the resident to smell the food and watch her eat. An interview on 08/02/18 at 10:16 AM with the RN Unit Manager revealed she was unaware of any interventions in place to keep Resident #99 from having to smell or watch her roommate eat but would expect staff would pull the curtain if the resident wanted them to. An interview on 08/02/18 at 10:20 AM with Resident #99's husband revealed his wife had been wanting to eat so badly and he brought food	F 550	status are not in a position to watch other Residents eat. Newly hired employees to receive education on this regulation in orientation. Resident's rights and dignity ensured by not placing Residents with orders for NPO in a position of watching other Residents eat. 4.Social Worker or Unit Nurse Manager to conduct a Quality Improvement Monitoring of room assignments weekly for 4 weeks then monthly and as needed to ensure room assignments are appropriate to ensure Residents rights and dignity are maintained. Findings to be reviewed at monthly Quality Assurance Performance Improvement Committee Meeting. Monitoring schedule modified based on findings. Root Cause Analysis will be used by the Committee and updates made to the Performance Improvement Project (PIP) as indicated by findings.	

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F 550	Continued From page 3 to her several times sneaking it in. He stated he got caught and was told he couldn't bring food to her because she may choke so he stopped bringing it. An interview with the Dietician, on 08/03/18 at 10:09 AM revealed #99 The dietician stated it would be awful if the resident wanted to eat to be watching her roommate or other people eat in front of her. The dietician stated she would expect staff to encourage the resident's roommate to eat her meals in the dining room or at least pull the curtain in the room so the resident did not have to watch her eat.	F 550		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		9/25/18

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F 583	Continued From page 4 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to provide privacy during wound care for one (1) of three (3) wound care observations. Resident #19 Findings Include: A review of the facility's policy titled, "Privacy Policy", dated 11/30/2014, revealed it is the policy of the facility to give all residents the opportunity for privacy. During an observation, on 08/01/18 at 10:07 AM, of wound care provided for Resident #19 by Registered Nurse (RN) #5, the RN left the room to get measurement strips, and did not pull the resident's curtain or close the door to the resident's room. Resident #19 was turned on her left side with her buttocks exposed and visible from the hallway. RN #5 returned to the room, and continued wound care. RN #5 left the room again in order to get a long Q-tip. RN #5 did not pull the resident's curtain or close the door to the resident's room. The resident was still on her left side with her buttocks exposed, and visible from	F 583	F 583 1. Root Cause Analysis was complete by Quality Assurance Performance Improvement (QAPI) Committee and based on findings RN #5 was reeducated 8/17/18 by Clinical Educator on providing full privacy by pulling privacy curtain and closing door completely when providing Resident care. Resident was not aware that the privacy curtain was not pulled. 2. Quality Review Observation of current Licensed Nurses and Certified Nursing Assistants (CNA) was completed on 9/17/18 by Director of Nursing to ensure competency of providing full privacy curtain and closing door completely when providing Resident care. Follow up based on findings. 3. Re-education was initiated for current nurses and CNA's 8/13/18 by Clinical Educator on this regulation with emphasis on providing visual privacy during	

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F 583	Continued From page 5 the hallway. An interview, on 08/03/18 at 1:17 PM, with RN #5 confirmed she had forgotten to close the door and curtain when she left the room. RN #5 also confirmed the resident's buttocks were exposed. RN #5 stated this would not happen again. An interview, on 08/03/18 at 2:00 PM, with the Director of Nurses (DON), revealed RN #5 failed to follow the facility Privacy Policy by not closing the door and curtain while providing wound care to Resident #19.	F 583	Resident care. 4. Director of Nursing or Assist and Director of nursing to conduct random Quality Improvement Monitoring of two Licensed Nurses four x weekly for one month, then weekly x four weeks then monthly to ensure Resident privacy is maintained during Resident care. Findings to be reviewed at monthly QAPI Committee Meeting Monitoring schedule modified based on findings. Root Cause Analysis will be used by the Committee and updates made to the Performance improvement Project (PIP) as indicated by findings.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		9/25/18

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F 656	Continued From page 6 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to implement the care plan related to wound care for Resident #5, incontinent care for Resident #25, nutrition for Residents #22, #26, and #129, and enteral tube feeding for Resident #99, for six (6) of 26 resident care plans reviewed. Findings include: A review of the facility's policy and procedures regarding, "Plans of Care", dated 11/30/14, revealed the facility's procedure included to develop a comprehensive plan of care for each resident that included measurable objectives and timetables to meet the resident's medical,	F 656	F 656 1. Root Cause Ananlysis was completed by Quality Assurance Performance Improvement Committee and based on findings. Resident #5's physician was notified 9/19 by Director of Nursing of omissions for wound care and application of vaginal cream. Resident #22, #26 and #129 was re-weighed to verify weights and reported to physician 9/4/18. Identified staff; Certified Nurses Aide (CNA) #2, Registered Nurse (RN) #3,CNA #4 and Licensed Practical Nurse (LPN) #4 were re-educated on this regulation	

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F 656	Continued From page 7 nursing, mental, and psychosocial needs. Review of the facility's policy titled, "Weighing the Resident", with a revision date of 09/05/17, revealed: When there is a significant variance from the previous recorded weight the scale should be re-balanced and the resident re-weighed and a licensed nurse to validate. Review of the facility's policy titled, " Aspects of Care", with an effective date of 11/30/14, revealed: C. Rehabilitation Care: Rehabilitation services will be provided to ensure attaining and maintaining the optimal level of function of the residents. These services may be provided by licensed P.T. (Physical Therapist), O.T. (Occupational Therapist), S.T. (Speech Therapist), PTA (Physical Therapist Assistant), COTA (Certified Occupational Therapist Assistant), or TA (Therapy Assistant), and under the guidance of the Rehab Manager. Services include screening, evaluation, and treatments for inpatients with a variety of neurological, orthopedic and medical diagnoses. Documentation is ongoing and all inclusive of care given. Resident #5 Review of Resident #5's Care Plan, no date, revealed Focus Categories for redness to the perineal and vaginal areas, and pain/discomfort to the right foot/feet. The Target Date was 8/14/18. The Goal stated the resident will have intact skin, free of redness, blisters, or discoloration through next review. The Approaches and Interventions included: Monitor pain characteristics every shift and as needed, administer treatment as ordered and monitor for	F 656	8/13/18 by Assistant Director of Nursing emphasizing completing re-weight, notifying physician of significant weight change and recording significant weight results. CNA #1 was re-educated 8/3/18 by Director of Clinical Services on competency of providing perineal care in manner to prevent spread of infection. Resident #99's Care Plan was revised 8/27/18 by Director of Nursing to include interventions to identify Residents desire to eat; efforts by staff to prevent Resident from watching others eat and restore Residents eating skills. 2. Quality Review conducted 8/15/18 by Assistant Director of Nursing of current Residents weights to ensure appropriate re-weights are obtained, notification of physician of significant weight change and consistent documentation of weights. Follow up based on finding. Quality Review conducted 9/20 by Director of Nursing of current Residents TAR(treatment administration record) to ensure physician orders are followed regarding wound care and application of vaginal creams. Quality Review of Care Plans completed for Residents with physician orders for "nothing by mouth" (NPO) to ensure interventions reflect Resident choice related to being able to watch other Residents eat.	

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F 656	Continued From page 8 effectiveness, and notify nurse of any new areas of skin breakdown: redness, blisters, or bruises. An interview, on 08/02/18 at 10:55 AM, with Resident #5, revealed the nurse did not change the bandage on Resident #5's right foot. Resident #5 stated the staff often forgets to change her bandage. Resident #5 also reported she has not had her vaginal cream after her last visit to the doctor. Resident #5 stated it wasn't given every night last month. An observation at this time revealed the date on the bandage on Resident #5's right foot was 7/31/2018. Review of Resident #5's Physician's Orders revealed: 7/27/18 Clean area (top) of right foot with soap and water, apply dry gauze as needed, and daily until healed. 7/27/18 Premarin Vaginal Cream, insert one fourth (1/4) applicator full to vagina at bedtime for seven (7) nights and then use periodically as needed. Review of Resident #5's Treatment Administration Record (TAR), for July 2018, revealed the treatment to clean the right foot with soap and water, and apply a clean gauze as needed and daily was scheduled to be done on the 7 PM to 7 AM shift and PRN (as needed). The treatment was not initialed by staff on 7/29/18. The Premarin Vaginal Cream was scheduled for 8 PM and PRN, from 7/27/18 thru 8/3/18. There were no staff initials from 7/27/18 thru 7/31/18. An interview, on 08/03/18 at 2:34 PM, with the Director of Nursing (DON) revealed the nurses did not follow the Comprehensive Care Plan by not changing the residents bandage according to the orders, and by not applying the cream	F 656	3. Re-education was conducted with current Licensed Nurses and CNA's 9/18/18 by Clinical Educator on this regulation with emphasis on re-weights notification of physician of significant weight changes and consistent documentation of weights. Re-education was conducted 8/13 by Clinical Educator with emphasis on following physician orders with current Licensed Nurses and CNA's. Newly hired Licensed Nurses and CNA's to receive education in orientation. Residents with five or more pound weight change to be re-weighed by CNA with verified significant weight changes reported to physician by Unit Nurse Manager. Weights will be recorded consistently and reviewed during morning clinical meeting. Perineal Care will be provided in a manner to prevent the spread of infection. 4. Quality Improvement Monitoring to be conducted by the Director of Nursing or Assistant Director of Nursing weekly x 4 weeks when every two weeks x four weeks then monthly to ensure appropriate re-weights are obtained, consistent weights are documented and physician is notified of significant weight change. Quality Improvement Monitoring to be conducted by Unit Manager or Assistant Director of Nursing in morning clinical	

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F 656	Continued From page 9 according to the doctor's orders. A review of the Face Sheet revealed the facility admitted Resident #5, on 09/08/2016, with diagnoses which included Hypertension, Cellulitis of the Right Lower Limb, and Diabetes Mellitus With Right Foot Ulcer. A review of Resident #5's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/26/2018, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. Resident #22 Review of Resident #22's Care Plan revealed the Focus Category, with a Target Date of 8/30/18, for Nutrition/Hydration for the resident's risk of imbalaned nutriton. The Approaches and Interventions included: Weight per protocol. Notify Physician of weight fluctuations of five pound increase or decrease. An interview, on 07/31/18 at 12:34 PM, revealed Resident #22 stated he thinks he is losing weight. On 7/31/18 at 12:54 PM, and observation revealed Resident #22's lunch tray was tray in front of him on the overbed table. The tray was covered, and the resident stated he was not going to eat. Review of Resident #22's Weight History revealed the following weights: 02/01/18 (Admission) - 173,20 pounds (#), 02/12/18 - No weight, 03/06/18 - 209.8#, 04/04/18 - 145.60#, 04/18/18 - 114,00#, 05/04/18 - 140.20, 05/23/18 - 143.20, 06/08/18 - 130.8#, 06/15/18 - 102.60,	F 656	meeting to ensure physician orders for wound care and vaginal cream are followed and documented on MAR with no omissions. Quality Review to be conducted Staffing coordinator or Unit Manager with a random sample of two CNAs, two x weekly for four weeks then weekly for two weeks then monthly to ensure perineal care is provided in a manner to prevent the spread of infection.	

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F 656	Continued From page 10 06/27/18 - 133.40#, 07/02/18 - 133.40#, 07/17/18 - 130.00#. Review of the weights revealed there was weight losses and/or gains of five(5)# or more, and no re-weight documented. Review of Resident #22's Physician Orders revealed orders for a No Added Salt/ No Concentrated Sweets (NAS/NCS) Mechanical soft diet The physician also ordered Ensure with meals, and four (4) ounces (oz) med pass three times a day (TID). The record review indicated the Registered Dietician (RD) had tried multiple interventions such as supplements and appetite stimulants in the past. Review of a printed record of weights received from Medical Records revealed, on 7/2/18 the resident had a weight of 133.4#, and on 7/17/18 the resident had a weight of 130#, which would calculate to be an 8% weight loss in three months, and a 29% weight loss since admission. On 8/2/18 at 9:34 AM, an interview with Certified Nurse Assistant (CNA) #2 revealed she had been doing the monthly weights since July. CNA #2 reported the resident's primary CNA for the day recorded the weekly weights. CNA #2 stated if there was a reweight needed, she would do it. When asked about the weight discrepancies of 5 pounds or greater, CNA #2 reported the resident should be reweighed. CNA #2 reported when she weighed residents she did not have a copy of the last weight to know if there was a weight gain or loss. CNA #2 reported she turns the weights in to the Director of Nurses (DON) office when she completed them. CNA #2 stated the list of re-weights are left on each unit for her each week, and they come from the DON. CNA #2 reported she does not report any weight losses	F 656		

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F 656	Continued From page 11 to anyone, that she just weighs them and turns in the list to the DON. On 8/2/18 at 10:45 AM, Registered Nurse (RN) #3/Unit Manager reported the facility's scales had just been recalibrated, and CNA #4 was put in charge of weights. RN #3 reported the Assistant Director of Nursing (ADON) was in charge of the weights, and she brought a list each week of weights with any discrepancies to the unit for the CNA to re weigh the residents. RN #3 verified it is expected that the Physician be notified if there is a five (5)# discrepancy in the weight. RN #3 reported they had been having trouble with the scales and had recently had them calibrated, and the facility had implemented a Performance Improvement Plan (PIP) on the accuracy of the weights. RN #3 reported there is a committee that meets each week on the residents who are at risk or losing weight, and the DON keeps up with this information. On 8/2/18 at 4:21 PM, the DON revealed the Restorative Aide has been placed in charge of monthly and weekly weights since July. The DON reported they have put a weekly weight review meeting in place. The DON reported she would expect that the unit manager would report a five (5)# weight gain/loss to the physician, and document it in the nurses notes. The DON reported if there is a discrepancy in weight identified in the weekly weight meetings, then they are placed on weekly weights until they are stabilized. On 8/3/18 at 10:54 AM, an interview revealed DON reported that Maintenance calibrates the scales.	F 656		

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F 656	Continued From page 12 On 8/3/18 at 9:45 AM, an interview with Licensed Practical Nurse (LPN)#2 revealed weight loss is discussed in the Interdisciplinary Team (IDT) meeting weekly if there is a discrepancy. The LPN reported it could be four to five days from the time the weight is done until the time of the meeting before the discrepancy is noticed. LPN #2 reported the CNA does not have a copy of the last weight when they are weighing residents to be able to notify the nurse if there is a discrepancy. On 8/3/18 at 10:22 AM, an interview with the Registered Dietician (RD) revealed, "the scales have been messed up since I have been here". The RD reported she has been working here since February. The RD reported they have a weekly weight meeting, and look at the residents with weight loss or significant weight changes, but "it doesn't seem to be getting any better." The RD reported, "every week they have a plan to fix the scales and the next week it seems that there are more and more discrepancies with the scales, and they never seem to get corrected." The RD reported it is hard for her to make an accurate assessment for the residents due to inaccurate weights, and she is afraid there will be a negative outcome. The RD stated she is concerned that she may order/recommend a supplement/diet that could possibly have a negative affect for a resident. On 08/03/18 at 12:29 PM, an interview with the Maintenance Director revealed he calibrates the scales monthly. He reported he does not have a log e records the results each time he calibrates it. He reported he has not had any training and hasn't looked at a policy, but knows that there is one. He reported he uses a 50 pound weight the	F 656		

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F 656	Continued From page 13	F 656		

manufacture sent him to calibrate the scales with, and has pictures on his phone dated to prove when he did it, and the scale is calibrated correctly. He reported he has witnessed a few CNAs using the scales, and from what he saw they subtracted the weight that was written on the side of the wheelchair from what the scales said, and did not weigh the wheelchair separately. He reported the stand up scales is probably five to six years old, and the wheelchair scale and lift scales are older than that, but he is not sure how old they are.

Review of the Face Sheet revealed Resident #22 was admitted by the facility, on 02/01/18, with the included diagnoese, Diabetes Type Two, Schizophrenia, Major Depression, and Generalized Edema.

Resident #25

Review of the Care Plan revealed a Focus Category for Elimination, and with a Target Date of 08/18/18. Resident #25 was care planned for urinary and bowel incontinence. The Approaches and Interventions included:
Resident/family/caregiver teaching should include Good Hygiene practices: Females to wipe and cleanse from front to back. Obtain and monitor lab/diagnostic work as ordered. Report results to Medical Doctor (MD) and follow up as indicated.

An observation, on 08/02/18 at 9:00 AM, revealed Resident #25's Care Plan was not followed. Resident #25's incontinent care was provided by Certified Nursing Assistant (CAN) #1 and assisted by CNA #2. CNA #1 wiped the resident's buttocks area from back to front, instead of from front to back to prevent the possible spread of infection

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F 656	Continued From page 14 and/or contamination. CNA #1 wiped the area three (3) times as she was cleaning the resident. During an interview, on 08/02/2018 at 9:25 AM, CNA #1 revealed she had wiped Resident #25's bottom from back to front. CNA #1 stated, "I knew it didn't feel right, like I was doing it wrong." CNA #1 stated wiping the wrong way could cause the resident to get an infection. During an interview, on 08/02/2018 at 9:30 AM, CNA #2 confirmed CNA #1 had wiped the resident's bottom from back to front three times during her care. CNA #2 stated wiping the wrong way could cause the resident to get an infection. During an interview, with Licensed Practical Nurse (LPN) #1, on 08/02/18 at 9:35 AM, she stated not cleaned and wiped correctly from front to back, it could cause the resident to get a urinary tract infection. During an interview, on 8/2/18 at 2:50 PM, the Director of Nurses (DON), stated when providing incontinent care, the resident should be wiped from front to back to decrease the risk of an infection. An interview, on 08/03/2018 at 10:50 AM, with RN #1/Staff Development Nurse, revealed the CNA staff is given a Skills Check-Off during the new hire orientation, and at least annually. RN #1 stated she does random skills checks for the CNA staff for various reasons throughout the year. RN #1 stated CNA #1 was given the Perineal Care Skills Check-Off in December of 2017. RN #1 stated CNA #1 had asked for a refresher in-service on perineal care the morning of 08/02/2018.	F 656		

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F 656	Continued From page 15 Review of Resident #25's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/08/2018, and the 60 Day MDS with an ARD of 03/14/2018, revealed a Basic Interview for Mental Status (BIMS) score of 99, which indicated the facility was not able to complete the interview. Further review of the MDS revealed Resident #25 was always incontinent of bowel and bladder. Resident #26 Review of the Care Plan revealed the Focus Category, dated 04/05/18, for actual weight loss due to the resident has the potential for imbalanced nutrition. Approaches and Interventions included: Notify the physician if there are persistent symptoms of diarrhea, nausea/vomiting that is unresolved in 36-48 hours. Weight (specify time of day and frequency) as scheduled. Obtain and monitor lab/diagnostic work as ordered. Report results to Medical Director and follow up as indicated. Follow Registered Dietician's recommendation. A review of Resident #26's Weight Record revealed an admission weight, on 2/02/2018, of 148.4# (pounds). Further review of the Weight Record revealed the following weights: 2/20/2018- 149.7#, 2/27/2018-155.8#, 3/5/2018-156.2#, 4/4/2018-144#, 6/15/2018-146.2#, 7/10/2018-129.2#, 7/17/2018-137.2#. Resident #26 had a 7.30 % wt loss in 5 months. These weights document a greater than or less than five (5)# weight loss or gain, and no indication of a re-weigh to validate an accurate weight. Interview, on 08/02/2018 at 4:21 PM, with the	F 656		

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F 656	Continued From page 16 Director Of Nurses (DON) revealed Restorative had been placed in charge of monthly and weekly weights since July. The DON reported they have put weekly weight review meetings in place. The DON reported that she expected the Unit Managers to report a five pound (5 lb) weight gain/loss to the physician, and document it in the Nurses Notes. The DON reported if there is a discrepancy with the weights in the weekly weight meetings those residents are placed on weekly weights until they are stabilized. The DON confirmed the facility failed to have a consistent weight procedure, and the facility also failed to follow the Comprehensive Care Plan by inconsistent weights being recorded. A review of the Face Sheet revealed the facility admitted Resident #26, on 02/02/2018, with diagnoses which included Alzheimer's Disease, Depression, Schizophrenia and Hypertension. A review of Resident #26's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/09/2018, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 99, which indicated the facility was unable to complete the interview. Resident #99 A review of Resident #99's Care Plan revealed a Focus Category for Nutrition/Hydration, with a Target Date of 10/30/18, for potential fluid and nutritional imbalance related to an enteral tube feeding. Review of the Approaches/Interventions revealed a ST consult, dated 11/17/17, to address oral pharyngeal dysphagia per MBS (Modified Barium Swallowing) test, resident is to have one meal a day given by ST only. PEG (Percutaneous	F 656		

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F 656	Continued From page 17 Endoscopic Gastrostomy) tube feeding to resume during other meals. The Approach was discontinued on 11/30/17. The care plan had an intervention for the resident to be evaluated by speech therapy but did not state to follow therapy recommendations. There were no individualized interventions addressing the resident's desire to eat, or interventions to keep the resident from having to watch her roommate eat meals. An observation and interview, on 08/01/18 at 12:00 PM, with Resident #99 revealed the resident was sitting up in bed with a continuous feeding pump infusing at 45 cubic centimeters (cc)/hr. The resident's roommate was observed to have a lunch tray, and the roommate was eating her lunch. Resident #99 stated, "I wish I could eat. That lady there (pointing to roommate) eats all the time." The resident's tone became more exasperated as she stated, "I have to sit and watch her eat. It be smelling so good. She eats three times a day!" The resident stated she could eat, but staff wouldn't let her, and says she can't swallow. The resident stated her roommate always eats in the room, and no one pulls her curtain to block her view. An interview, on 08/02/18 at 10:16 AM, with the Registered Nurse (RN) Unit Manager revealed she was unaware of any efforts to restore eating skills for the resident as she was new to the unit. The unit manager stated she was unaware of any interventions in place to keep Resident #99 from having to smell or watch her roommate eat, but she would expect staff would pull the curtain if the resident wanted them to. An interview, on 08/03/18 at 2:40 PM, with the	F 656		

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F 656	Continued From page 18 Director Of Nurses (DON) revealed Resident # 99's care plan for tube feeding did not include interventions to restore Resident #99's eating skills, or individualized interventions to identify the resident's desire to eat or to make efforts to prevent the resident from having to watch others eat in her presence. The DON confirmed the care plan included an intervention for speech therapy to evaluate the resident, and this had been implemented, however, the DON stated she would think the facility should follow through with any recommendations made by the speech therapist, and this had not been done, so the care plan had not been followed. Review of Resident #99's ST Discharge Summary, dated 11/22/17, for services dated 11/17/17 to 11/20/17, revealed the Summary of Skilled Services Provided: Skilled interventions addressed the reporting period include assess and modify positioning to enhance swallow function including sitting at 90 degree angle while consuming meal and sitting at 90 degree angle 20 minutes after meal is finished. Patient has made little to no progress with skilled intervention. Discharge Recommendations: Recommend continued Speech Therapy services upon discharge to improve swallowing function following recent Modified Barium Swallow Study, which suggests the patient needs a pureed diet with honey thickened liquids. Patient also needs language intervention to target receptive language to improve following one step directions. Further review of the ST Discharge Summary revealed, on 11/20/17, Resident #99 was discharged due to change in medical status, and required skilled ST services to address swallowing deficits.	F 656		

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F 656	Continued From page 19 Review of Resident #99's Physician's Orders revealed an order, dated 11/21/17 to send the resident to the Emergency Room (ER) for evaluation of related to (r/t) an elevated temperature, and on 11/22/17, and order for Resident #99's admission to the hospital. An order, dated 11/23/17, revealed Resident #99 was admitted back to the nursing home on antibiotics for Pneumonia. There were no orders for therapy evaluations, but there was an order for Glucerna 1.5 at 55 cc/hr per the PEG tube. Review of the Face Sheet revealed Resident #99 was admitted by the facility on 10/06/17, and readmitted on 11/23/17. Diagnoses included, Hemiplegia and Hemiparesis Following a Cerebrovascular Disease, Idiopathic Epilepsy and Epileptic Syndromes With Seizures, and Persistent Mood Disorder. Resident #129 Review of Resident #129's current Care Plan revealed a Focus Category for Nutrition and Hydration. The Approaches and Interventions included to weigh the resident per protocol, and notify the Physician of a five pound weight increase or decrease. On 07/31/18 at 12:47 PM, an observation revealed Resident # 129 was feeding herself with no difficulty. Resident appeared well nourished. Resident stated "the food is very good." A review of the resident's weights revealed a 15# weight gain from 5/4/2018 to 6/15/2018, then a 16# weight loss from 6/15/2018 to 7/2/2018. Review of the weight record revealed no	F 656		

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F 656	Continued From page 20 re-weights were documented to ensure the care plan was followed to weigh the resident per protocol, and notify the physician of the five pound weight gain or loss. Review of the Face Sheet revealed Resident #129 by the facility, on 12/27/17, with diagnoses including Cognitive Communication Deficit, Chronic Obstructive Pulmonary Disease (COPD), and Dememtia Without Behavior Distrubance.	F 656		
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	F 657		9/25/18

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F 657	Continued From page 21 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to revise the care plan related to a fall for Resident #56, for one (1) of 26 resident care plans reviewed. Findings include: Review of the facility's policy titled, " Plans of Care", with a revision date of 09/25/2017, revealed: Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions after the completion of each Minimum Data Set (MDS) assessment (except discharge assessments), and as needed. The Interdisciplinary Team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental, and psychosocial well being. A review of Resident #56's Care Plan revealed the Focus Category, dated 06/19/18, for Falls secondary to balance and medication regimen, along with lack of coordination, generalized muscle weakness, and abnormalities of gait and positioning, and blindness to the left eye. The Approaches/Interventions included Occupational Therapy to screen for positioning in wheelchair, dated 07/23/18. The Care Plan did not address the fall incident. Review of Resident #56's Interdisciplinary Progress Notes revealed the resident had a fall	F 657	1. Root Cause Analysis completed by Quality Assurance Performance Improvement (QAPI) Committee based on finding Resident #56's Care Plan was revised 8/3/18 by Director of Nursing to include the 7/23/18 incident of fall to include interventions. 2. Quality Review of Care plans was conducted 8/13/18 by Director of Nursing of current Residents with incidence of falls in last 30 days to ensure Care Plans included incidence of falls with interventions with no negative findings. 3. Re-education was conducted 9/19/18 by Clinical Educator with current Nurses on this regulation with emphasis on ensuring Care Plans are updated with incidence of falls to include interventions. Newly hired employees to receive education in orientation. Interdisciplinary Team to review incident of falls in morning meeting and care plan will be updated to include interventions. 4. Quality Improvement Review to be conducted by Minimum Data Set Nurse or Unit Manager in morning meeting to ensure Care Plans are updated with incidence of falls to include interventions. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule	

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F 657	Continued From page 22 on 07/23/2018 at 9:30 AM. The nursing documentation revealed Resident #56 was sitting in her wheelchair outside the facility waiting to be loaded on the facility van. A staff member was present at the time, but was facing away from the resident. When the staff member turned around, Resident #56 had fell forward out of her wheelchair onto the ground. A small laceration and a hematoma was noted to the resident's left eye. Resident #56's Primary Physician (PP) was notified, and gave an order to send Resident #56 to the Emergency Room for an evaluation. Attempts to notify the Responsible Party (RP) were made without success until the RP arrived at the facility at 2:40 PM. During an interview, on 08/01/2018 at 9:30 AM, Resident #56, stated she only remembers leaning forward, and falling out of her wheelchair (w/c). Resident #56 stated she doesn't remember why she leaned forward. During an interview, on 08/03/2018 at 10:15 AM, Registered Nurse (RN) #2 confirmed Resident #56's fall, on 07/23/2018, was not included on the care plan. RN #2 stated she wasn't sure about how the care plan needed to be revised or updated. During an interview, on 08/03/2018 at 10:10 AM, the Director of Nursing (DON) confirmed Resident #56's care plan did not include an actual fall for 07/23/2018, nor a corresponding intervention. The DON stated she was not aware of whether or not Resident #56 was being seen by therapy. The DON confirmed an intervention needed to be on the care plan to clearly reflect what the facility was doing to attempt to prevent a fall.	F 657	modified based on findings. Root Cause Analysis will be used by the Committee and updates made to the Performance Improvement Project (PIP) as indicated by findings.	

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F 657	Continued From page 23 A review of the Face Sheet revealed Resident #56 was admitted by the facility, on 04/10/2018, with diagnoses to include Type Two Diabetes Mellitus and Lack of Coordination. A review of the Significant Change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/08/2018, revealed Resident # 56's Brief Interview of Mental Status (BIMS) score was 14, indicating intact cognition. Further review of the MDS revealed Resident #56 was coded for extensive assistance with transfers, and with two person assist.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview, and facility policy review, the facility failed to ensure Resident #5's Physician's Orders were followed for the care and treatment of a wound, and to obtain a follow-up Urinalysis with a Culture and Sensitiviey (UA with a C&S), for two of six (2 of 6) residents reviewed for wound care. Findings include: Review of the facility's policy titled, "Aspects of Care", with an effective date of 11/30/2014, revealed: Medical Care: Medical services will be	F 658	F658 1. Root Cause Analysis was completed by Quality Assurance Performance Improvement (QAPI) Committee and based on findings. Resident five's physician was notified 9/19/18 by Director of Nursing of omissions on Treatment Administration Record(TAR) for wound care and application of vaginal cream. Resident number twenty five's physician was notified by Unit Nurse Manager of order of Urinalysis with culture and sensitivity not being obtained.	9/25/18

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F 658	Continued From page 24 provided to all residents in a manner to achieve and maintain optimal standards of quality of care and professional services. Overall coordination of services will be provided by the facility medical director who will serve to coordinate medical care, and provide guidance and oversight regarding care policies. Clinical Care: Clinical Services will provide resident care twenty-fours per day under the direction of the Director of Clinical Services. The service is comprised of registered nurses, licensed practical nurses, and nurse aides. Clinical Services is responsible for the assessment and delivery of nursing needs, the administration of medications and treatments, activities of daily living, implementation of resident specific measures to prevent complications of immobility, psychosocial intervention, education, palliative care, and resident safety. The goal of the service is to assist the resident in attaining and maintaining maximum function to ensure quality of life. Review of the Mississippi Nursing Practice Law, with an effective date of July 1, 2010, revealed on pages three and four (3 & 4) of 26: 73-15-5 Definitions. (2) The practice of nursing by a registered nurse means the performance for compensation of services which requires substantial knowledge of biological, physical, behavioral, psychological, and sociological sciences, and of nursing theory as the basis for assessment, diagnosis, planning intervention, and evaluation in the promotion, maintenance of health; management of individual's responses, to illness, injury or infirmity; the restoration of optimum function; or the achievement of a dignified death. Nursing practice includes, but is not limited to, administration, teaching, counseling, delegation, and supervision of	F 658	Identified staff; Licensed Practical Nurse (LPN) #2,LPN #4, LPN#5 and LPN #6 were re-educated on this regulation 9/19/18 by Director of Nursing emphasizing following physician orders for wound care and application of vaginal cream. 2. Quality Review conducted 9/20/18 by Director of Nursing of current Residents Treatment Administration Record (TAR) to ensure physician orders are followed. Follow up based on findings. Quality Review conducted 9/20/18 by Director of Nursing of current Residents with orders of urinalysis with culture and sensitivity to ensure diagnostic obtained . Follow up based on findings. 3. RE-education was conducted with current Nurses 9/18/18 by Clinical Educator with emphasis on following physician orders regarding wound care, application of vaginal cream and obtaining urinalysis with culture and sensitivity. Newly hired Nurses to receive education in orientation. Nurses to follow physician orders for wound care and application of vaginal cream with documentation on TAR (treatment administration record) and obtaining urinalysis with culture and sensitivity with results on clinical record. 4. Quality Improvement Monitoring to be	

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F 658	Continued From page 25 nursing, and execution of the medical regimen, including the administration of medications, and treatments prescribed by any licensed or legally authorized physician, or dentist. (5) The practice of nursing by a licensed practical nurse means the performance for compensation of services requiring basic knowledge of the biological, physical, behavioral, psychological, and sociological sciences, and of nursing procedures which do not require the substantial skill, judgement, and knowledge required of a registered nurse. These services are performed under the direction of a registered nurse, or a licensed physician, or licensed dentist, and utilize standardized procedures in the observation, and care of the ill, injured, and infirm; in the maintenance of health; in action to safeguard life and health; and in the administration of medications, and treatments prescribed by any licensed physician, or licensed dentist authorized by state law to prescribe. Resident #5 An interview, on 08/02/18 at 10:55 AM, revealed Resident #5 stated the nurse did not change the bandage on her right foot. Resident #5 stated staff often forgets to change her bandage. Resident #5 said she has not had her vaginal cream after her last visit to the doctor. Resident #5 also stated it wasn't given every night last month. An observation at this time revealed the dressing on Resident #5's right foot was dated 07/31/18. Review of Resident #5's Physician's Orders revealed an order, dated 07/27/18, to clean the	F 658	conducted daily for four weeks, then two times weekly for two weeks then monthly by Unit Manager or Assistant Director of Nursing to ensure physician orders for wound care, vaginal cream application and obtaining urinalysis with culture and sensitivity are followed. Findings to be reviewed at monthly QAPI Committee Meeting Quality Review schedule will be modified based on findings. Root Cause Analysis (RCA) will be used by the Committee and updates made to the Performance Improvement Project (PIP) as indicated.	

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F 658	Continued From page 26 top of the right foot with soap and water, and apply dry gauze daily, and as needed (PRN). Further review of the orders revealed an order, dated 07/27/18, for Premarin Vaginal Cream, insert one fourth (1/4) application full in vagina at bedtime for seven (7) nights, and then use periodically as needed. Review of Resident #5's Treatment Administration Record (TAR), for July 2018, revealed the treatment to clean the right foot with soap and water, and apply a clean gauze as needed and daily was scheduled to be done on the 7 PM to 7 AM shift and PRN (as needed). The treatment was not initialed by staff on 7/29/18. The Premarin Vaginal Cream was scheduled for 8 PM and PRN, from 7/27/18 thru 8/3/18. There were no staff initials from 7/27/18 thru 7/31/18. During an interview, on 08/02/18 at 10:55 AM, with License Practical Nurse (LPN) #2/Floor Supervisor, LPN #2 stated the Treatment Nurse is responsible for the treatments daily. LPN #2 confirmed the Treatment Administration Record was not signed on 7/15/2018, 7/16/2018, 7/17/2018, 7/27/2018, 7/28/2018, 7/29/2018, 7/30/2018, and 7/31/2018. An interview, on 08/03/18 at 1:17 PM, with Registered Nurse (RN) #5/Treatment Nurse, revealed the nurses on the floor is still responsible for the treatments because she's still in orientation. On 08/03/18 at 1:20 PM, an interview with LPN #4 revealed she worked the night of 7/28/2018. LPN #4 said she didn't remember why the vaginal cream was not applied.	F 658		

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F 658	Continued From page 27 On, 8/3/2018 at 1:25 PM, an interview with LPN #5 revealed he worked the night of 7/29/2018. LPN #5 said Resident #5 did not feel comfortable with him inserting the cream. LPN #5 said the Nursing Supervisors apply the cream on the nights he worked. On 08/03/18 at 1:26 PM, an interview with LPN #6 revealed she worked the nights of July 25, 26, 27, and 30. LPN #6 stated Resident #5 was asked to turn the call light on after the CNAs did her last "Diaper change." Resident #5 did not turn on the call light, and LPN #6 said she forgot to apply the medication. An interview, on 08/03/18 at 2:34 PM, with The Director of Nursing (DON) revealed the nurses did not follow the facility policy by not changing the residents bandage according to the orders. The DON said the Treatment Nurse is still in orientation, and the floor nurses are responsible for the treatments. The DON also said the facility failed to follow the facilities policy by not applying the cream according to the doctor's orders. A review of the Face Sheet revealed the facility admitted Resident #5, on 09/08/2016, with diagnoses which included, Hypertension, Cellulitis Right Lower Limb, and Diabetes Mellitus With Right Foot Ulcer. A review of Resident #5's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/26/2018, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. Resident #25	F 658		

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F 658	Continued From page 28 Review of Resident #25's Physician's Orders revealed a Telephone Order, dated 5/18/18 to start Cipro 500 milligrams (mg) by mouth (PO) for 10 days for a Urinary Tract Infection. Repeat the Urinalysis with a Culture and Sensitivity (U/A, C&S) in 18 days. No lab was found in the residents chart. During an interview, on 8/2/18 at 2:50 PM, the Director of Nurses (DON), stated an order was written by the Physician, on 05/18/2018 for a follow-up UA with a C&S that was not done. The DON stated she was aware the order was written by the Physician, on 5/18/18, for Resident # 25 had not been followed. The DON stated the Physician had been notified, and the Physician gave an order to discontinue the order written on 5/18/2018 for a follow-up Urinalysis . The DON stated that any order written by the Physician is to be followed. Review of the Face Sheet revealed the facility admitted Resident #25, on 11/18/2009, with included diagnoses, Type Two Diabetes, Cognitive Communication Deficit, and Other Cerebrovascular Disease. Review of Resident #25's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/08/2018, and the 60 Day MDS with an ARD of 03/14/2018, revealed a Basic Interview for Mental Status (BIMS) score of 99, which indicated the facility was not able to complete the interview.	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		9/25/18

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F 690	Continued From page 29 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and facility policy review, the facility	F 690	1. Root Cause analysis was completed by Quality Assurance Performance	

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F 690	Continued From page 30 failed to provide Resident #25's incontinent care in a manner to prevent the possible spread of infection for one of three (1 of 3) incontinent care observations. Findings include: Review of the facility's policy titled, " Perineal Care", with a revision date of 09/05/2017, revealed the Procedure included, on female residents, wash from front to back, to avoid urethral or vaginal contamination. An observation, on 08/02/18 at 9:00 AM, revealed Resident #25's incontinent care was provided by Certified Nursing Assistant (CAN) #1 and assisted by CNA #2. CNA #1 wiped the resident's buttocks area from back to front, instead of from front to back to prevent the possible spread of infection and/or contamination. CNA #1 wiped the area three (3) times as she was cleaning the resident. During an interview, on 08/02/2018 at 9:25 AM, CNA #1 revealed she had wiped Resident #25's bottom from back to front. CNA #1 stated, "I knew it didn't feel right, like I was doing it wrong." CNA #1 stated wiping the wrong way could cause the resident to get an infection. During an interview, on 08/02/2018 at 9:30 AM, CNA #2 confirmed CNA #1 had wiped the resident's bottom from back to front three times during her care. CNA #2 stated wiping the wrong way could cause the resident to get an infection. During an interview, with Licensed Practical Nurse (LPN) #1, on 08/02/18 at 9:35 AM, she stated not cleaned and wiped correctly from front to back, it could cause the resident to get a	F 690	Improvement (QAPI) Committee and based on findings Certified Nurses Aide (CNA) #1 was re educated on 8/3/18 by Director of Clinical Services with emphasis providing perineal care in a manner to prevent spread of infection. Resident exhibited no negative outcome from perineal care provided. 2. Quality Review Observation of current CNAs was completed 9/10/18 by Clinical Educator to ensure competency of providing incontinent care in a manner to prevent the spread of infection. Follow up based on findings. 3. Re-education was conducted 8/13/18 by Clinical Educator with CNAs on this regulation with emphasis on providing incontinent care in a manner to prevent the spread of infection. Incontinent care to be provided in a manner to control the spread of infection. 4. Quality Improvement Monitoring to be conducted with a random sample of two CNAS, two x weekly for four weeks then weekly for two weeks then monthly to ensure incontinent care is provided in a manner to prevent the spread of infection by Assistant Director of Nursing or Director of Nursing. Findings to be reviewed at monthly QAPI Committee Meeting. Monitoring schedule modified based on findings. Root Cause Analysis to be used by the Committee and updates made to the Performance Improvement Project (PIP) as indicated by findings.	

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F 690	Continued From page 31 urinary tract infection. During an interview, on 8/2/18 at 2:50 PM, the Director of Nurses (DON), stated when providing incontinent care, the resident should be wiped from front to back to decrease the risk of an infection. An interview, on 08/03/2018 at 10:50 AM, with RN #1/Staff Development Nurse, revealed the CNA staff is given a Skills Check-Off during the new hire orientation, and at least annually. RN #1 stated she does random skills checks for the CNA staff for various reasons throughout the year. RN #1 stated CNA #1 was given the Perineal Care Skills Check-Off in December of 2017. RN #1 stated CNA #1 had asked for a refresher in-service on perineal care the morning of 08/02/2018. Review of Resident #25's Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/08/2018, and the 60 Day MDS with an ARD of 03/14/2018, revealed a Basic Interview for Mental Status (BIMS) score of 99, which indicated the facility was not able to complete the interview. Further review of the MDS revealed Resident #25 was always incontinent of bowel and bladder.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must	F 692		9/25/18

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F 692	Continued From page 32 ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and facility policy review, the facility failed to ensure accurate weight monitoring for Residents #22, #26, and #129. This concern was identified for three (3) of 12 residents reviewed for weight loss/gain. Findings include: Review of the facility's policy titled, "Weighing the Resident", with a revision date of 09/05/17, revealed: When there is a significant variance from the previous recorded weight the scale should be re-balanced and the resident re-weighed and a licensed nurse to validate. Resident # 22 An interview, on 07/31/18 at 12:34 PM, revealed Resident #22 stated he thinks he is losing weight. On 7/31/18 at 12:54 PM, and observation	F 692	1. Resident #129 was re-weighed to verify weights and reported to physician 8/6/18 by Assistant Director of Nursing. Identified staff, Certified Nurses Aid (CNA) #2, Registered Nurse (RN) #3, CNA #4 and Licensed Practical Nurse (LPN) #4 were re-educated on this regulation 8/13/18 by Director of Nursing emphasizing completing re-weights, notifying physician of significant weight change and recording significant weight results. 2. Quality Review conducted 8/15/18 by Assistant Director of Nursing of current Residents weights to ensure appropriate reweights are obtained, notification of physician of significant weight changes and consistent documentation of weights. Follow up based on findings.	

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F 692	Continued From page 33 revealed Resident #22's lunch tray was tray in front of him on the overbed table. The tray was covered, and the resident stated he was not going to eat. Review of Resident #22's Weight History revealed the following weights: 02/01/18 (Admission) - 173,20 pounds (#), 02/12/18 - No weight, 03/06/18 - 209.8#, 04/04/18 - 145.60#, 04/18/18 - 114,00#, 05/04/18 - 140.20, 05/23/18 - 143.20, 06/08/18 - 130.8#, 06/15/18 - 102.60, 06/27/18 - 133.40#, 07/02/18 - 133.40#, 07/17/18 - 130.00#. Review of the weights revealed there was weight losses and/or gains of five(5)# or more, and no re-weight documented. Review of Resident #22's Physician Orders revealed orders for a No Added Salt/ No Concentrated Sweets (NAS/NCS) Mechanical soft diet The physician also ordered Ensure with meals, and four (4) ounces (oz) med pass three times a day (TID). The record review indicated the Registered Dietician (RD) had tried multiple interventions such as supplements and appetite stimulants in the past. Review of a printed record of weights received from Medical Records revealed, on 7/2/18 the resident had a weight of 133.4#, and on 7/17/18 the resident had a weight of 130#, which would calculate to be an 8% weight loss in three months, and a 29% weight loss since admission. On 8/2/18 at 9:34 AM, an interview with Certified Nurse Assistant (CNA) #2 revealed she had been doing the monthly weights since July. CNA #2 reported the resident's primary CNA for the day recorded the weekly weights. CNA #2 stated if there was a reweight needed, she would do it.	F 692	3. Re-education was conducted with current Licensed Nurses and CNA 9/18/18 by Clinical Educator on this regulation with emphasis on re-weights notification of physician of significant weight changes and consistent documentation of weights. Newly hired licensed Nurses and CNA's to receive education in orientation. Residents with five or more pound weight change to be reweighed with verified significant weight changes reported to physician. Weights will be recorded consistently and reviewed during morning clinical meeting. 4. Quality Improvement Monitoring to be conducted by the Director of Nursing or Assistant Director of Nursing weekly x4 weeks then every two weeks times four weeks, then monthly to ensure appropriate re-weights are obtained, consistent weights are documented and physician is notified of significant weight change. Findings to reviewed at monthly QAPI Committee Meeting. Quality Review schedule will be modified based on findings. Root Cause Analysis (RCA) will be used by the Committee and updates made to the Performance Improvement Project (PIP) as indicated.	

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F 692	Continued From page 34 When asked about the weight discrepancies of 5 pounds or greater, CNA #2 reported the resident should be reweighed. CNA #2 reported when she weighed residents she did not have a copy of the last weight to know if there was a weight gain or loss. CNA #2 reported she turns the weights in to the Director of Nurses (DON) office when she completed them. CNA #2 stated the list of re-weights are left on each unit for her each week, and they come from the DON. CNA #2 reported she does not report any weight losses to anyone, that she just weighs them and turns in the list to the DON. On 8/2/18 at 10:45 AM, Registered Nurse (RN) #3/Unit Manager reported the facility's scales had just been recalibrated, and CNA #4 was put in charge of weights. RN #3 reported the Assistant Director of Nursing (ADON) was in charge of the weights, and she brought a list each week of weights with any discrepancies to the unit for the CNA to re weigh the residents. RN #3 verified it is expected that the Physician be notified if there is a five (5)# discrepancy in the weight. RN #3 reported they had been having trouble with the scales and had recently had them calibrated, and the facility had implemented a Performance Improvement Plan (PIP) on the accuracy of the weights. RN #3 reported there is a committee that meets each week on the residents who are at risk or losing weight, and the DON keeps up with this information. On 8/2/18 at 4:21 PM, the DON revealed the Restorative Aide has been placed in charge of monthly and weekly weights since July. The DON reported they have put a weekly weight review meeting in place. The DON reported she would expect that the unit manager would report a five	F 692		

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F 692	Continued From page 35 (5)# weight gain/loss to the physician, and document it in the nurses notes. The DON reported if there is a discrepancy in weight identified in the weekly weight meetings, then they are placed on weekly weights until they are stabilized. On 8/3/18 at 10:54 AM, an interview revealed DON reported that Maintenance calibrates the scales. On 8/3/18 at 9:45 AM, an interview with Licensed Practical Nurse (LPN)#2 revealed weight loss is discussed in the Interdisciplinary Team (IDT) meeting weekly if there is a discrepancy. The LPN reported it could be four to five days from the time the weight is done until the time of the meeting before the discrepancy is noticed. LPN #2 reported the CNA does not have a copy of the last weight when they are weighing residents to be able to notify the nurse if there is a discrepancy. On 8/3/18 at 10:22 AM, an interview with the Registered Dietician (RD) revealed, "the scales have been messed up since I have been here". The RD reported she has been working here since February. The RD reported they have a weekly weight meeting, and look at the residents with weight loss or significant weight changes, but "it doesn't seem to be getting any better." The RD reported, "every week they have a plan to fix the scales and the next week it seems that there are more and more discrepancies with the scales, and they never seem to get corrected." The RD reported it is hard for her to make an accurate assessment for the residents due to inaccurate weights, and she is afraid there will be a negative outcome. The RD stated she is concerned that	F 692		

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F 692	Continued From page 36 she may order/recommend a supplement/diet that could possibly have a negative affect for a resident. On 08/03/18 at 12:29 PM, an interview with the Maintenance Director revealed he calibrates the scales monthly. He reported he does not have a log e records the results each time he calibrates it. He reported he has not had any training and hasn't looked at a policy, but knows that there is one. He reported he uses a 50 pound weight the manufacture sent him to calibrate the scales with, and has pictures on his phone dated to prove when he did it, and the scale is calibrated correctly. He reported he has witnessed a few CNAs using the scales, and from what he saw they subtracted the weight that was written on the side of the wheelchair from what the scales said, and did not weigh the wheelchair separately. He reported the stand up scales is probably five to six years old, and the wheelchair scale and lift scales are older than that, but he is not sure how old they are. Review of the Face Sheet revealed Resident #22 was admitted by the facility, on 02/01/18, with the included diagnoese, Diabetes Type Two, Schizophrenia, Major Depression, and Generalized Edema. Resident #26 A review of Resident #26's Weight Record revealed an admission weight, on 2/02/2018, of 148.4# (pounds). Further review of the Weight Record revealed the following weights: 2/20/2018- 149.7#, 2/27/2018-155.8#, 3/5/2018-156.2#, 4/4/2018-144#, 6/15/2018-146.2#, 7/10/2018-129.2#, 7/17/2018-137.2#. Resident	F 692		

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F 692	Continued From page 37 #26 had a 7.30 % wt loss in 5 months. These weights document a greater than or less than five (5)# weight loss or gain, and no indication of a re-weigh to validate an accurate weight. Interview, on 08/02/2018 at 4:21 PM, with the Director Of Nurses (DON) revealed Restorative had been placed in charge of monthly and weekly weights since July. The DON reported they have put weekly weight review meetings in place. The DON reported that she expected the Unit Managers to report a five pound (5 lb) weight gain/loss to the physician, and document it in the Nurses Notes. The DON reported if there is a discrepancy with the weights in the weekly weight meetings those residents are placed on weekly weights until they are stabilized. The DON confirmed the facility failed to have a consistent weight procedure, and the facility also failed to follow the Comprehensive Care Plan by inconsistent weights being recorded. A review of the Face Sheet revealed the facility admitted Resident #26, on 02/02/2018, with diagnoses which included Alzheimer's Disease, Depression, Schizophrenia and Hypertension. A review of Resident #26's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/09/2018, revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 99, which indicated the facility was unable to complete the interview. Review of the Face Sheet revealed Resident #26 was admitted by the facility, on 02/02/18. with the included diagnoses, Alzheimer's Disease, Psychosis, Major Depression, Gastro-Esophageal Reflux Disease (GERD), and Schizophrenia.	F 692		

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F 692	Continued From page 38 Resident #129 On 07/31/18 at 12:47 PM, an observation revealed Resident # 129 was feeding herself with no difficulty. Resident appeared well nourished. Resident stated "the food is very good." A review of the resident's weights revealed a 15# weight gain from 5/4/2018 to 6/15/2018, then a 16# weight loss from 6/15/2018 to 7/2/2018. Review of the weight record revealed no re-weights were documented. Review of the Face Sheet revealed Resident #129 was admitted by the facility, on 12/27/17, with diagnoses including Cognitive Communication Deficit, Chronic Obstructive Pulmonary Disease (COPD), and Dememtia Without Behavior Distrubance.	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and	F 693		9/25/18

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F 693	Continued From page 39 §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based observation, record review, staff and resident interview, and facility policy review, the facility failed to ensure Resident #99 received appropriate care and services to restore oral eating skills for one of four (1 of 4) residents reviewed with tube feedings. Findings include: Review of the facility's policy titled, "Aspects of Care", dated 11/30/14, revealed the facility would provide rehabilitation services to ensure attaining and maintain the optimal level of function of the residents. Services could have been provided by a licensed Speech Therapist and were to include screening, evaluations, and treatments. Documentation was to be ongoing and all inclusive of care given. A review of Resident # 99's Comprehensive Admission Minimum Data Set (MDS), dated 10/13/18, revealed the facility admitted the resident, on 10/06/17, with diagnoses including Aphasia, and Hemiplegia/Hemiparesis. The MDS revealed the resident was admitted to the facility with an enteral feeding tube. An observation and interview, on 07/31/18 at 8:31 AM, with Resident #99 revealed the resident had a continuous feeding tube delivering the	F 693	1. Root Cause Analysis was conducted by Quality Assurance Performance Improvement (QAPI) Committee and based on findings physician was notified of recommendations by therapy dated 11/17/17 for Resident #99 to advance in oral consumption. Therapy re screened Resident #99 8/9/18 for advancement in Diet. Physician orders were noted for a diagnostic barium swallow as recommended in therapy screen. Diagnostic barium swallow resulted 8/23/18 with results recommending "to remain on "nothing by mouth"(NPO) status " Additional recommendation were Resident could have pleasure feedings with Speech Language Pathology to treat 5 x a week for 4 weeks to complete pleasure feedings, strengthen swallow and decrease aspiration risk. Due to max potential being met orders noted 9/7/18 to discontinue Speech Language Pathology. Recommendations made for Resident #99 to remain NPO. 2. Quality Review conducted 9/20/18 by Director of Nursing of current Residents with NPO status to ensure recommendations for advancement in oral consumption have been communicate to	

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F 693	Continued From page 40 resident's nutrition. Resident #99 stated she did not like having the tube, it had come out before, and she wanted to eat by mouth. Resident #99 stated she could eat by mouth, but "they" say she can't swallow. Resident #99 stated she can swallow, and wants to eat. When asked for clarification on who told her she couldn't swallow, she said "them people here". An observation and interview, on 08/01/18 at 12:00 PM, with Resident #99 revealed the resident was sitting up in bed with her feeding pump providing the tube feeding at 45 cubic centimeters (cc)/hr. The resident's roommate was observed to have a lunch tray, and the roommate was eating her lunch. Resident #99 stated "I wish I could eat. That lady there (pointing to roommate) eats all the time." The resident's tone became more exasperated as she stated, "I have to sit and watch her eat. It be smelling so good. She eats three times a day!" The resident stated she could eat but staff wouldn't let her, and says she can't swallow. The resident stated her roommate always eats in the room, and no one pulls her curtain to block her view. The resident stated it made her feel like no one listens to her. An interview, on 08/01/18 at 12:14 PM, with Licensed Practical Nurse (LPN) #7, who was familiar with Resident #99 since her admission, revealed the resident has been wanting to eat since she was admitted to the facility. LPN #7 stated she thought there was an evaluation of the resident's ability to swallow done several months ago after the resident was hospitalized when her Percutaneous Endoscopic Gastrostomy (PEG) tube came out. LPN #7 stated she believed the resident was eating one meal a day, but because the resident talked a lot while eating the staff was	F 693	IDT and reported to physician. Follow up based on findings. 3. Director of Nursing has provided re-education 9/20/18 to Licensed Nurses on this regulation with emphasis following notifying physician of recommendations regarding advancement in oral consumption. Director of Rehabilitation and Director of Nursing provided re-education 9/20/18 for Licensed Nurses and therapy staff on process for communication /follow-up related to speech therapy recommendations. Newly hired employees to be educated in orientation. Speech Language Pathology recommendations to be communicated in morning meeting to Director of Nursing or Assistant Director of Nursing. Physician to be notified. 4. Quality Improvement Monitoring to be completed by Director of Nursing or Assistant Director of Nursing weekly x four weeks and then monthly to ensure recommendations for advancement in oral consumption for Residents with NPO status are communicated to physician. Findings to be reviewed at monthly QAPI Committee Meeting. Quality Review Schedule to be modified based on findings. Root Cause Analysis (RCA) will be used by the Committee and updates made to the Performance Improvement Project(PIP) as indicated.	

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afraid she would get choked, so efforts to have her eat were discontinued. LPN #7 stated she believed the resident could probably eat, had been caught eating when her husband snuck food into the room. LPN #7 stated the resident's roommate eats in the room, and it is probably hard for the resident to smell the food and watch her eat.

A review of the Physician's Orders for Resident #99 revealed an order, dated 10/09/17 for Speech Therapy to evaluate. On 10/10/17 there was an order to start an 1800 calorie mechanical soft diet, and consult speech therapy for a deglutination study. On 11/9/17 there was an order for a Barium Swallow study.

A review of the results of the Barium Swallow study, dated 11/17/17, revealed a diagnosis of Dysphagia. The report indicated the resident wanted to start eating again, and the resident had no documented dysphagia treatment. The report indicated the resident had no difficulty with controlled straw sips of nectar to honey thick liquids and recommendation was for honey thick liquids then downgrade to nectar as the resident improved in treatment. Additional recommendations included smooth pureed textures and Speech Therapy treatment for dysphagia therapy.

A review of the resident's record revealed no documentation of a speech evaluation prior to 11/17/17. A review of the Speech Therapy documentation for Resident #99 revealed an initial evaluation, dated 11/17/17, by the contracted Speech Therapist. The Speech Therapist assessed the resident's potential for achieving goals as good, and the evaluation listed

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F 693	Continued From page 42 treatment approaches of evaluating swallow function, and oral function therapy. The evaluation indicated the resident was on trials to upgrade to a diet of pureed with honey thick liquids. Therapy was to be provided five times a week for one week. The evaluation indicated the resident had not had therapy previously. There was a speech therapy discharge summary indicating the resident was discharged from therapy, on 11/20/17, due to discharge to the hospital. The discharge summary indicated the resident needed continued therapy. A review of the physician's orders revealed an order, dated 11/22/17, for the resident to be admitted to the hospital, and orders indicating a return to the facility on 11/23/17. There was no indication in the resident's medical chart that any speech therapy services were provided after the resident returned from the hospital. An interview, on 08/02/18 at 10:16 AM, with Registered Nurse (RN) #6/Unit Manager, revealed she was unaware of any efforts to restore eating skills for the resident as she was new to the unit. The unit manager stated she was unaware of any interventions in place to keep Resident #99 from having to smell or watch her roommate eat, but would expect staff would pull the curtain if the resident wanted them to. An interview, on 08/02/18 at 10:20 AM, with Resident #99's husband revealed he was told by the facility nurses the resident couldn't swallow. Resident #99's husband stated his wife had been wanting to eat so badly, and he brought food to her several times, sneaking it in. He stated he got caught, and was told he couldn't bring food to her because she may choke so he stopped	F 693		

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F 693	Continued From page 43 bringing it. He stated one of the nurses told him to call the doctor to see if she could eat, but he had not been able to catch up with the doctor. He was unaware of any efforts by the facility to assist the resident to restore eating skills. An interview, on 08/02/18 at 12:41 PM, with the Therapy Supervisor confirmed Resident #99 had received therapy services to restore eating skills in November of 2017. The Therapy Supervisor stated it appeared the Speech Therapist recommended to continue working with the resident, feeding her one meal daily. The therapist no longer worked at the facility, and there were no documented services provided after November. In April 2018 an Interdisciplinary Therapy Screen (IDTS) was completed by the current contracted Speech Therapist, and he recommended Speech Therapy services in an effort to restore eating skills. The Therapy Supervisor stated that when a recommendation was made for therapy on a resident with no viable billing source, she forwards a request to the Administrator of the facility for approval. If the facility approved the request, then therapy services would provide treatment for the length of time approved. The Therapy Supervisor stated she forwarded a request in April of 2018 to the facility Administrator for approval for Speech Therapy services to work with Resident #99 on restoring eating skills, but had not heard anything since the form was submitted. The Therapy Supervisor stated services could not be provided without approval for payment. Resident#99 did not have a pay source so the facility would have to pay for services. An interview, on 08/02/18 at 2:58 PM, with the current facility contracted Speech Therapist	F 693		

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revealed he completed an assessment for the need for speech therapy on Resident # 99 in April, 2018. The Speech Therapist stated he had not assessed Resident #99 prior to that date. The Speech Therapist's recollection was that nursing staff made a referral for evaluation of the resident to see if she had the potential to start eating by mouth. He stated his screening revealed the resident had potential to start eating to the extent to supplement or perhaps replace enteral feeding. A form requesting payment for providing Speech Therapy services was submitted by his supervisor to the Administrator in April, but he had not been informed of the decision made regarding the request.

A review of the "Notification of Intent to Provide Therapy Services", dated 4/12/18, indicated the current contracted Speech Therapist screened the resident, and assessed that the resident had potential for oral advancement sufficient to supplement or replace total nutrition/hydration enteral support. The notification indicated a recommendation for Speech Therapy to be provided three times a week for 30 days. The Notification had a hand written statement "Questionable due to non compliance. Family bringing in fried chicken, and items not clinically recommended."

An interview with the Dietician, on 08/03/18 at 10:09 AM, revealed #99 had not had any weight loss, and the tube feeding had been meeting her nutritional goals. The Dietician stated she would recommend the resident continue tube feeding unless she was evaluated by a Speech Therapist, and worked on her swallowing. The Dietician stated she was unaware the resident had been evaluated by the Speech Therapist or findings

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	255145	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD REHABILITATION AND HEALTHCARE	501 SOUTH LOCUST STREET MCCOMB, MS 39648

(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 693	Continued From page 45 that the resident was a candidate to restore eating skills. The Dietician stated she would expect the facility to provide those services. The Dietician stated it was awful if the resident could eat, and to be watching her roommate or other people eat in front of her. The Dietician stated she would expect staff to have the resident's roommate eat in the dining room ideally, or at least pull the curtain in the room. An interview, on 08/03/18 at 2:40 PM, with the DON, Corporate Nurse, and Administrator present regarding the facility's efforts to provide services to restore Resident #99's eating skills revealed the DON was unaware of the Speech Therapist's evaluation, and recommendation to provide therapy services. The Corporate Nurse stated there had obviously been a breakdown in communication between nursing and the therapy department. The Administrator stated she received the request for approval for speech therapy services, but did not forward it to the corporate office for approval because it was her understanding from nursing staff that the resident had been non-compliant with her recommended diet. The Administrator stated the husband had brought food to the resident when the resident was supposed to be on tube feedings only. The DON confirmed the care plan for tube feeding did not include interventions to restore Resident #99's eating skills. The DON confirmed the care plan did include interventions for Speech Therapy to evaluate the resident, and she would think the facility should follow any recommendations made by the Speech Therapist, and that had not been done, so the care plan had not been followed.	F 693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255145	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD REHABILITATION AND HEALTHCARE	**501 SOUTH LOCUST STREET** **MCCOMB, MS 39648**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility 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 352 SS=D	Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to ensure proper supervisory signals in accordance with NFPA 101 Chapter 9.7.2.1. This deficiency affected one (1) of nine (9) exits and 14 of 145 residents in the facility at the time of survey. Findings include: On August 3, 2018 at 11:00 AM, observation revealed the water shut off valve to the canopy near the Kitchen was not electronically monitored and supervised. The administrator was made aware of the problem during the exit conference.	K 352	On 8/27/18 two tamper switches were installed to the water shut off valve to the canopy outside near the entrance to the kitchen for electronic monitoring and supervision of the sprinkler head along the outside canopy from the kitchen to the laundry. All residents in the area of the one of nine exits in the facility could be impacted by the shut off valve to the canopy near the kitchen not being electronically monitored or supervised. On 8/27/18, Southern Sprinkler inspected the facility for required automatic sprinkler	9/25/18

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

Electronically Signed | 09/25/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255145	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARD REHABILITATION AND HEALTHCARE	**501 SOUTH LOCUST STREET** **MCCOMB, MS 39648**

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K 352	Continued From page 1	K 352	system supervisory attachments and determined all required supervisory attachments were installed in accordance with NFPA 72. Automatic Sprinkler System inspects and test the Sprinkler system supervisory attachments and their integrity yearly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255145	A. BUILDING _____ B. WING _____	08/03/2018

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E 000	Initial Comments Survey conducted on 8/3/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

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