STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255332	A. BUILDING _____ B. WING _____	C 04/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLMES COUNTY LONG TERM CARE CENTER - DURANT	15481 BOWLING GREEN ROAD DURANT, MS 39063

(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 A standard recertification survey was conducted by Ascellon on behalf of the MS State Department of Health, from 4/8/19 - 4/11/19. In addition, Complaint Intake (CI) MS #15697 was investigated in conjunction with this standard survey. The complaint was unsubstantiated for the allegation regarding a lack of fall prevention measures and unsubstantiated for neglect related to the development of pressure ulcers. An associated deficiency, F580, was cited based on the complaint investigation. The standard survey revealed that the facility was not in substantial compliance with the requirements of participation in Medicare/Medicaid. The following deficiencies resulted from the facility's noncompliance related to the standard survey: F582, F604, F656, F684, and F812. The facility's census on 4/8/19, was 72 residents and the facility held a license for 80 beds.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580		5/28/19

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

Electronically Signed | 05/09/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, the facility failed to notify the representative of one of a change in condition for one (1) of 18 sampled residents, Resident #48.	F 580	1. Resident #48 was discharged to the hospital from the facility on 4/18/19. The Licensed Practical Nurse(LPN) assigned to Resident #48 that day notified the	

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F 580	Continued From page 2 Resident #48 returned to the facility post hospitalization with a deteriorated carbuncle (a carbuncle is a red, swollen, and painful cluster of boils that are connected to each other under the skin) wound; however, the resident's representative was not notified of the change. Findings include: Review of the facility document titled "Notification of Family/Resident Representative" policy, dated 10/16, documented it was the policy of the facility to notify the family or resident representative of all services provided by the facility. This included changes in a resident's condition or status. The family member or the representative will be notified of this change. Resident #48 was admitted to the facility on 6/15/17, with the following diagnoses Diabetes Mellitus, Hypertension, Non-Alzheimer's Dementia, unspecified Lack of Coordination, and unspecified Abnormalities of Gait and Mobility. Record review revealed the resident was returned to the facility from the hospital, on 12/19/19, with an open carbuncle to the sacral area. Review of the "Nurse's Note" dated 12/19/18 at 1:05 PM, documented the resident returned to the facility with an open carbuncle to the sacrum which measured four (4) centimeters (cm) by three and one-half (3.5) cm, with eschar in the center of the wound bed, and the tissue surrounding the eschar was noted to have slough. The note documented: Phoned representative and informed of new orders. Continued review of a nurse's note revealed the family was notified of new physician's orders, but	F 580	Resident Representative (RR). The LPN assigned to the resident will inform RR of any change in condition and document notification specific to the change in residents electronic health record. 2. All residents have the potential to be affected by this deficient practice. 3. An in-service was conducted by the Director of Nursing to educate licensed staff on notification and specific status change documentation in the resident's electronic health record as per policy on 4/16/19. The Director of Nursing, Medical Records Nurse or Minimum Data Set (MDS). Beginning 5/22/2019 the nurse will monitor for significant change on all hospital returns x three (3) months to ensure proper resident representative notification occurs. 4. The Director of Nursing or Registered Nurse (RN) Supervisor will report findings monthly to the Quality Assurance (QA) Committee x 3 months to ensure continued compliance. The QA Committee will make recommendations or changes as needed. 5. All corrective actions were completed on 5/28/2019.	

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F 580	Continued From page 3 not informed about the open wound on the resident's sacrum. Telephonic interview with Family Member #A on 4/9/19 at 9:00 AM, revealed on 1/24/19, a nurse had informed him she was unsure if the family had been notified of the pressure ulcer on 12/19/18, or not. He stated the family was unaware the resident had returned to the facility with an open wound. Interview with the LPN #1, Wound Care Nurse, on 4/10/19 at 10:00 AM, revealed Resident #16 had developed a carbuncle prior to hospitalization; however, when the resident returned, the carbuncle was completely opened. Telephonic interview on 4/11/19 at 10:58 AM, with Family Member #B, revealed the facility had not notified him of an open pressure ulcer on 12/19/18, when the resident had returned to the facility from the hospital. He stated he had only been informed the resident had returned to the facility. Interview on 4/11/19 3:45 PM, with the Director of Nursing (DON), revealed the next of kin should have been notified not only of the resident's return to the facility, but also about any new pressure ulcers which may have developed. She stated nurses were trained on notification during their orientation period to the facility. Interview with Registered Nurse (RN) #1 on 4/11/19 at 4:12 PM, revealed the nurse should always notify the resident's representative whenever a resident returned from the hospital and should inform them of any new wounds and/or treatments.	F 580		

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F 580	Continued From page 4 Interview on 4/11/19 at 4:04 PM, with Licensed Practical Nurse (LPN) #2, revealed the family representative should always be notified their loved one had returned to the facility and if a change in a wound had occurred upon readmission to the facility.	F 580		