STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	A. BUILDING _____ B. WING _____	04/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUMPHREYS CO NURSING CENTER	500 CCC ROAD BELZONI, MS 39038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification survey along with a complaint, MS #00015738, at the facility from 4/2/19 through 4/4/19. During the survey, the SA did not substantiate the complaint, MS #00015738 for condition misdiagnosed, stage 3 pressure ulcer, poor nutritional state/weight loss, and abuse/neglect for improper incontinent care, and did not cite any deficiencies related to the complaint. The SA did determine the facility was not in compliance with Medicare and Medicaid requirements of participation and cited the regulatory deficiencies F 641 and F 761. At the time of the survey, the census was 54 and the facility held a license for 60 beds.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) assessment to include hospice services for one (1) of 27 resident MDS assessments reviewed for hospice. Resident #54. Findings include: Review of the facility's "MDS Charting Documentation Guidelines" policy, with a revision date 09/18, revealed: In order to have an accurate assessment of the resident, information	F 641	1. Resident #54 Minimum Data Set was modified by the Assessment Nurse to include hospice and remove the dialysis on 4/2/19. 2. Three (3) of 55 residents were identified by the Director of Nursing to have the potential to be affected by this deficient practice. Three (3) of the three (3) residents had their minimum data sets reviewed by the Assessment Nurse and Nurse Case Manager on 4/9/19 to ensure coding of hospice as ordered and none of the three (3) needed a modification of	4/25/19

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

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F 641	Continued From page 1 must be gathered on the resident while in the observation period for the MDS. This information must come from resident assessment and documented information in the resident's chart within the time frame set forth on the MDS. In order to assure that information is in the chart to validate information on the MDS, the Charting Documentation guidelines should be utilized. Review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/20/19, revealed Resident #54's Special Treatments, Procedures, and Programs was checked for dialysis. On 04/02/19 at 1:31 PM, an interview with Licensed Practical Nurse #3 revealed Resident #54 was not on dialysis. LPN #2 stated the resident is on Hospice, but not dialysis. On 04/02/19 at 1:46 PM, an interview with the Minimum Data Set Coordinator (MDS) Nurse revealed all MDSs scheduled for transmission are reviewed by the MDS Nurse, the Administrator, and the Director of Nurses (DON) on Fridays to ensure accuracy prior to transmission. The MDS Nurse Stated she had to have missed this one and didn't get it corrected. On 04/02/19 at 2:21 PM, an interview with the DON revealed during the transmittal meeting on Friday, the MDSs are checked to ensure accuracy. The DON stated the team failed to recognize that Dialysis was marked instead of Hospice.	F 641	their minimum data set for hospice coding after the initial modification. 3. An in-service was conducted on 4/4/2019 by the Director of Nursing on the policy/procedure on Resident Assessment revised 11/17 to include coding of hospice as ordered with one (1) of one (1) Assessment Nurses and one (1) of one (1) Nurse Case Managers. The Quality Assurance Committee reviewed the policy on Resident Assessment with revision date of 11/17 on 4/25/2019 and did not recommend any changes. 4. Correct coding of hospice on the resident minimum data set will be monitored beginning April 4, 2019 by the Director of Nursing, Medical Records Nurse, and/or Administrator to ensure compliance with facility policy/procedure related to coding of hospice on the resident minimum data set weekly for four weeks and monthly for two months and findings recorded on the transmission meeting form and maintained by the Director of Nursing. The Quality Assurance Committee will evaluate the monitoring completed by the Director of Nursing, Medical Records Nurse, and/or Administrator monthly for three months. Quality Assurance Committee will make recommendations as needed.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		4/25/19

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F 761	Continued From page 2 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure the correct medication route was labeled on Resident #54's medication cards, for one (1) of 5 (five) residents observed for medication administration. Findings include: A review of the facility's "Administering Medications Through Nasogastric or Gastrostomy Tube" policy, with a latest revision date of 3/18,	F 761	1. Resident #54 medication cards were noted with a direction change sticker by the Licensed Practical Nurse on 4/4/19 and new medication cards with directions to administer meds per peg were ordered by the Director of Nursing on 4/4/19 and new meds for Resident #54 received 4/5/19 from pharmacy. 2. Eight (8) of 55 residents were identified by the Director of Nursing to have the potential to be affected by this deficient practice. Eight (8) of eight (8) residents	

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F 761	Continued From page 3 revealed: Upon the order of the attending physician, medication will be administered through nasogastric/gastrostomy tube when a patient is unable to swallow medications or has a nasogastric/gastrostomy tube for nourishment. Review of Resident #54's April 2019 physician's orders revealed: 11/23/18 Anastrozole 1 MG tablet. Give one tablet via PEG (Percutaneous Endoscopic Gastrostomy) tube everyday for Breast Cancer. 11/23/18 Uloric 40 MG tablet. Give one table via PEG tube everyday for End Stage Renal Disease. 11/23/18 Rosuvastatin Calcium (Crestor) 10 MG tablet. Give one tablet via PEG tube everyday at 6 PM for Hyperlipidemia. On 4/3/19 at 8:09 AM, an observation, during the medication pass, revealed Resident #54's medication card labels read Anastrozole 1 milligram (MG), give 1 tablet by mouth every day, and Uloric 40 MG tablet, give 1 tablet by mouth every day. On 4/3/19 at 8:10 AM, an interview with Licensed Practical Nurse (LPN) #1 revealed she stated, "That need [sic] another label on it (referring to Resident #54's medication cards)." On 4/03/19 at 1:13 PM, an observation revealed there was another one of Resident #54's medication cards with the wrong administration route, Rosuvastatin Calcium 10 MG (Crestor), give one by mouth at bedtime. There was a total of three (3) medication cards for Resident #54 to administer medications by mouth. On 4/03/19 at 1:25 PM, an interview with the	F 761	with gastrostomy tube medications were reviewed by the Director of Nursing on 4/4/2019 and all have correct labels on medications and/or direction change stickers. 3. An in-service was conducted on 4/4/2019 by the Director of Nursing on the policy/procedure on Administration of Medications revised 10/17 with in-servicing including checking right route of administration with seven (7) of eight (8) Licensed Practical Nurses and three (3) of four (4) Registered Nurses. The Quality Assurance Committee reviewed the policy on Administration of Medications with revision date of 10/17 on 4/25/2019 and did not recommend any changes. 4. Gastrostomy tube resident medication cards will be monitored beginning April 4, 2019 by the Director of Nursing, Medical Records Nurse, Treatment Nurse, Assessment Nurse, and/or Nurse Case Manager to ensure compliance with facility policy/procedure related to correct labeling of medication cards weekly for four weeks and monthly for two months and findings recorded on the medical record audit form and maintained by the Director of Nursing. The Quality Assurance Committee will evaluate the monitoring completed by the Director of Nursing, Medical Records Nurse, Treatment Nurse, Assessment Nurses, and/or Nurse Case Manager monthly for three months. The Quality Assurance Committee will make recommendations as needed.	

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F 761	Continued From page 4 Director of Nursing (DON), revealed our (referring to the facility's) medication cards should match our orders. The DON also stated, the resident could possibly not get her medication or possibly aspirate with the medication card label being different from the physician orders. The DON reported Resident #54 has a diet for pleasure ordered, and she (Resident #54) has the ability to swallow, but still holds the food/fluids in her mouth. A review of the facility's Face Sheet revealed the facility admitted Resident #54, on 12/23/16, with a diagnosis of Dysphagia. Review of the most recent comprehensive Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/26/18, revealed Resident #54 had a staff assessment of mental status that indicated both short and long term memory problems, and cognitive skills for daily decision making was severely impaired-never/rarely made decisions.	F 761		

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	255259	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/05/2019**

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HUMPHREYS CO NURSING CENTER	**500 CCC ROAD** **BELZONI, MS 39038**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 4/5/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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