STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255321	A. BUILDING _____ B. WING _____	05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HATTIESBURG HEALTH & REHAB CENTER	514 BAY STREET HATTIESBURG, MS 39401

(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 recertification survey, and complaint survey (CI MS #18153) from 5/15/18 through 5/24/18. During the survey the SA determined the complaint regarding an injury duing tranfer with a lift was substaniated, with no deficiencies cited. The SA also determined the facility was not in compliance with the Medicare and Medicaid requirements for participation. The SA cited regulatory deficiences at F656, and F686. The facility census at the time of the survey was 171, and the facility was certified for 184.	F 000		
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	F 657		7/2/18

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

Electronically Signed | 07/05/2018

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F 657	Continued From page 1 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 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review , facility policy review, and staff interview, the facility failed to revise pressure wound care plan to address reporting missing, soiled, or dislodged wound dressings for one (1) of 34 care plans reviewed, Residents #89. Findings include: A review of the facility's policy titled "Goals and Objectives, Care Plans" dated April 2011, goals and objectives are reviewed and/or revised when the desired outcome has not been achieved. Resident #89 Review of Resident #89 Care Plan revealed a Problem/Need, dated 3/29/18, for the potential for skin breakdown or pressure ulcers due to decreased mobility, and incontinent of bowel and bladder. Actual Staff III to coccyx. Review of the Approaches revealed no intervention to address missing, soiled, or dislodged wound dressings. An observation, on 05/21/2018 at 11:07 AM, of Resident #89's wound care provided by Registered Nurse (RN) #3/Treatment (Tx) Nurse, revealed when the residents brief was removed by RN #3, Resident #89 did not have a dressing on the wound identified as a stage three (3) sacral pressure ulcer.	F 657	1) On 5/24/2018, Resident #89's care plan for wound care was revised to address missing, soiled. or dislodged wound dressing per MDS Nurse #1. 2) Nineteen residents with wound dressing care plans have the potential to be affected by this deficient practice. On 6/28/18, MDS Nurse #1 performed 100% wound care plans audit. 12 of 33 wound care plans required revisions and were revised on 6/28/2018 per MDS Nurse #1. 3) On 6/28/2018, an in-service began per Staff Development Nurse for all nursing staff on the importance of care plans for wounds to address reporting of missing, soiled or dislodged wound dressings immediately. 4) The facility MDS Nurse #1 will audit 10 resident's care plan for wound care per week X 4 months to ensure compliance with care plans addressing the reporting of missing, soiled and dislodged dressings. Any issues found will be addressed immediately. These audits will be documented on a "Wound Care Plan Log". The QA Committee will evaluate "Wound Care Plan Log" every month X 4 months and make any recommendations needed to correct negative findings.	

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F 657	Continued From page 2 During an interview, on 05/21/2018 at 11:12 AM, with RN #3/Tx Nurse Nurse, she confirmed the dressing for the sacral wound was missing. RN #3 stated no one had reported to her that the dressing had come off. RN #3 also stated she would have expected someone to report the missing dressing as soon as it came off. During an interview, on 05/21/2018 11:13 AM, with RN #4/ Dementia Care Unit Manager, she stated the dressing has been known to come off during perineal care and during bathing. RN #4 also stated the Certified Nursing Assistants (CNAs) are trained to report to a nurse if at any time a dressing is missing or comes off during care. RN #4 confirmed that when a dressing comes off, it should be reported as soon as possible to prevent possible infection. RN #4 stated that the CNAs should know the importance of reporting when any dressing comes off. During an interview, on 05/21/2018 at 11:35 AM, with CNA #3, it was revealed the dressing on Resident # 89's sacral wound had come off during the bathing task. CNA #3 stated that she was providing care, at 5:30 AM on 05/21/2018, and noticed the dressing was dislodged. CNA #3 stated that it came off when she removed the brief. CNA#3 also stated that it was her intention to report it to the treatment nurse or another nurse, but she got busy and forgot. An interview, on 05/23/2018 3:10 PM, with Registered Nurse (RN) #6/Minimum Data Set (MDS) Coordinator, confirmed reporting a missing, dislodged, or soiled dressing should be a part of the resident's care plan. RN #6 stated the Certified Nursing Assistants (CNAs) should be	F 657		

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F 657	Continued From page 3 trained to report this to the nurses. RN #6 also stated the care plan department was working on all the care plans to make them better. RN #6 confirmed that reporting a missing, dislodged, or soiled dressing was not on Resident # 89's care plan. During an interview, on 05/24/2018 08:55 AM, with the Director of Nursing (DON), it was revealed reporting missing, dislodged, or soiled wound dressings should be a part of a resident's care plan objectives. The DON stated that this helps prevent the wound from getting worse. A review of the Face Sheet revealed Resident #89 was admitted by the facility, on 09/01/2015, with diagnoses to include Diabetes Mellitus and Dementia. Review of Resident # 89's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/29/2018, revealed the resident's Brief Interview of Mental Status (BIMS) score indicated severe impaired cognition	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		7/2/18

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F 686	Continued From page 4 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to promote the healing of pressure ulcers for one of five (1 of 5) residents reviewed with pressure ulcers, Resident #89. Findings include: A review of the facility's policy titled "Pressure Ulcers/Skin Breakdown-Clinical Protocol" undated revealed: The physician will authorize pertinent orders related to wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorbtive, etc.), and application of topical agents. The policy however did not address the events of dressings becoming dislodged, missing, or soiled. An observation, on 05/21/2018 at 11:07 AM, revealed Registered Nurse (RN) #3 removed Resident #89's brief to find there was no dressing on the wound identified as a stage three (3) sacral pressure ulcer. A review of the facility's wound care report titled, "Wound and Skin Status Report", dated 05/10/2018, revealed Resident #89 had a facility acquired pressure ulcer with an onset date of 04/20/2017. The facility's wound and skin report revealed treatments for a daily, and an as needed wound care with use of a Promogran dressing. A review of Resident # 89's May 2018 Physician	F 686	1) On 05/21/2018, CNA #3 received a 1:1 in-service per Staff Development Nurse on the immediate reporting of dislodged, soiled or missing wound dressing. On 5/21/2018, RN#3/Treatment Nurse completed the physician ordered treatment on Resident #89 and observed no negative findings. 2) Nineteen residents with wound dressings have the potential to be affected by this deficient practice. On 5/21/2018, all resident with wound dressings were observed for dislodgement, missing or soiled dressing per DON and no further wound dressings were identified to be missing, dislodged or soiled. 3) On 6/28/2018, the QA Committee which included Medical Director, Physician #2, Nurse Practitioner, DON, QA Nurse/Infection Control Nurse, Restorative, Corporate Representative and Administrator, reviewed and revised the facility policy and procedure titled "Pressure Ulcer/Skin Breakdown-Clinical Protocol" to include "The nursing staff will follow physician orders for treatment and care of the resident's wounds in accordance with standards of practice and prevention of infection. If wound dressing becomes dislodged, missing, or soiled, the nursing staff will take immediate appropriate actions to promote healing". On 6/28/2018, the QA committee	

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F 686	Continued From page 5 Orders, revealed an order, on 01/05/2018, for a wound care treatment related to a Stage Three (3) pressure ulcer to the coccyx. The treatment order stated the wound was to be cleansed with normal saline, pat dry, apply Promogran or equivalent to wound bed, cover with silicone border foam, and change daily and as needed. During an interview, on 05/21/2018 at 11:12 AM, with RN #3/Treatment Nurse, it was confirmed the dressing for the sacral wound was missing. RN #3 stated no one had reported to her the dressing had come off. RN #3 also stated she would have expected someone to report the missing dressing as soon as it came off. During an interview, on 05/21/2018 11:13 AM, with RN #4/Dementia Care Unit Manager, it was confirmed the dressing for the sacral wound was missing. RN #4 stated the dressing has been known to come off during perineal care and during bathing. RN #4 also stated that the Certified Nursing Assistants (CNAs) are trained to report to a nurse if at any time a dressing is missing or comes off during care. RN #4 stated when a dressing comes off, it should be reported as soon as possible to prevent possible infection. RN #4 stated the CNAs should know the importance of reporting when any dressing comes off, and that maybe an in service is needed to remind them about how important it is to report it. RN #4 also stated no one had reported to her Resident #89's wound dressing was missing, or that it had come off this morning. An interview, on 05/21/2018 at 11:35 AM, with CNA #3, revealed the dressing on Resident #89's sacral wound had come off during the bathing task. CNA #3 stated she was providing care at	F 686	reviewed and revised the facility's policy titled "Wound Care" to include "Dressings that become dislodged, missing, or soiled will be reported immediately to the appropriate staff for correction". On 6/28/2018, the Staff Development Nurse began an in-service for RNs, LPNs, CNAs, Hospice Staff, and Therapy Staff on reporting missing, dislodged or soiled dressing immediately and Policy changes. This in-service was completed on 7/1/18. 4) The facility's QA Nurse will observe 10 wound dressings for dislodgement, soiled or missing per week X 4 months and document on the "Wound Dressing Log". Any issues noted will be corrected immediately. The QA Committee will review and evaluate the "Wound Dressing Log" every month X 4 months and make any recommendations needed to correct negative findings.	

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F 686	Continued From page 6 5:30 AM on 05/21/2018, and noticed the dressing was dislodged. CNA #3 stated it came off when she removed the brief. CNA #3 also stated it was her intention to report it to the treatment nurse or another nurse, but she got busy and forgot. An interview, on 05/23/2018 10:55 AM, with CNA #4 stated if a dressing for a wound is missing, soiled, or coming off, the CNA is to report it to nursing as soon as possible. CNA #4 stated if the dressing is missing, soiled, or coming off, the wound could get worse or get an infection. An interview, on 05/23/2018 at 11:15 AM, with Licensed Practical Nurse (LPN) #1, confirmed if a dressing was missing, soiled, or dislodged, the expectation would be that it is reported to a nurse as soon as possible. LPN #1 stated it should be reported so it can be redressed to prevent the wound from becoming contaminated, or get infected. During an interview, on 05/23/2018 at 2:05 PM, with the Director of Nursing (DON), it was confirmed when a wound dressing is missing, soiled, or coming off, the CNA is to report the status of the wound dressing to nursing as soon as possible. The DON stated when a wound is left uncovered, it is at risk for an infection. The DON also stated the "as needed" order covers the times that the dressing would need to be replaced, such as when the dressing is missing, soiled, or dislodged. The DON stated there was no actual facility policy that covers the reporting of missing, soiled, or dislodged dressing on wounds. A review of the Face Sheet revealed Resident #89 was admitted by the facility, on 09/01/2015, with diagnoses to include Diabetes Mellitus and	F 686		

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F 686	Continued From page 7 Dementia. A review of Resident # 89's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/29/2018, revealed a Brief Interview of Mental Status (BIMS) score indicating severe impaired cognition.	F 686		

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	255321	A. BUILDING **01 - BUILDING 0101** B. WING _____	**05/15/2018**

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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 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to properly arrange exit discharge in accordance to NFPA 101 sections 19.2.7 & 7.7.1. These deficiencies practice affected one (1) of eight (8) exits in the facility on day of survey. Findings include: On 5/16/18 at 11:00 AM, observation revealed the exit door located across from 'B' Wing Nurse Station did not release and open upon activation of the fire alarm and the sprinkler system. This locked exit door obstructs the means of egress leading to public way from the facility. The finding was acknowledged by the Administrator and Maintenance Supervisor verified this observation during the exit interview	K 271	1) On, 05/16/2018, the exit door located across from "B" Wing nursing station was immediately repaired by the maintenance supervisor to release and open upon activation of the fire alarm/sprinkler system. 2) 55 residents have the potential to be effected by this exit door malfunction. 3) On 5/16/2018, the maintenance supervisor and five maintenance workers were in-serviced on the necessity of the exit doors to release with the fire system activation. 4) The facility maintenance supervisor will monitor all exit doors for release with the activation of the fire alarm system three time per week X 4 months and document on the "Exit Door Release Log". Any	5/25/18

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K 271	Continued From page 1 on 5/16/18.	K 271	malfunction identified will be repaired immediately. The QA Committee will evaluate the log every month x 4 months.	

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E 000	Initial Comments Survey conducted on 5/15/18 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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