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	255050	A. BUILDING _____ B. WING _____	10/31/2018

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JEFFERSON DAVIS COMMUNITY HOSPITAL ECF	1320 WINFIELD STREET PRENTISS, MS 39474

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 10/29/18 to 10/31/18. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited The the regulatory deficiency F 641, F 644, F 656, and F 690. At the time of survey, the census was 42 , 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, facility policy review, and staff interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded for falls for one (1) of 12 Resident MDS assessments reviewed, Resident #25 Findings Include: Review of the policy documentation on facility letterhead, provided by the facility, dated 10/31/2018, no signature, revealed the facility followed the Resident Assessment Instrument (RAI) for Minimum Data Set (MDS) coding. Review of Resident #25's Quarterly MDS with an Assessment Reference Date (ARD) of 09/27/2018, revealed Section J1800 coded that	F 641	1. The Minimum Data Set (MDS) for Resident #25 was updated and transmitted on 11-16-18 by the MDS Nurse to reflect the fall which occurred on 8-18-18. 2. All residents have the potential to be affected by this deficient practice. 3. An in-service was provided to the Staff Development Nurse, Director of Nursing (DON), MDS Nurse, Social Services Coordinator, Medicare Nurse, Activities Coordinator, and Wound Care Nurse by the Nurse Consultant on 11-16-18 regarding accurate and specific MDS documentation. The MDS Nurse will review all nurses' notes, incident reports,	11/26/18

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

Electronically Signed | 11/20/2018

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 641	Continued From page 1 no falls, with or without injury, had occurred. Resident #25 had a prior MDS assessment, with an ARD of 07/03/2018, where no falls were coded. Review of a Resident Incident Report, dated 08/17/2018, signed by the Administrator, revealed Resident #25 had a fall with head injury on 08/16/2018. Review of Departmental Notes, dated 08/16/2018 at 1:14 PM, revealed that Resident #25 fell when attempting to go to the bathroom unassisted. During an interview with the Director of Nursing (DON), on 10/30/2018 at 02:15 PM, the DON confirmed that Resident #25 had a fall with head injury on 08/16/2018. An interview with Licensed Practical Nurse (LPN) #1/MDS Coordinator, on 10/31/2018 at 10:40 AM, confirmed that Resident #25's MDS Assessment on 09/27/2018 had been miscoded relating to Resident #25's fall on 08/16/2018. LPN #1 stated that there was nursing documentation on Resident #25's fall with a major injury after the 07/27/2018 MDS assessment and before the 09/27/2018 MDS assessment. LPN #1 stated she agreed that Section J1800 of the 09/27/2018 MDS assessment should have been coded "Yes" indicating Resident #25 indeed had a fall on 08/16/2018. During an interview on 10/31/2018 at 11:08 AM, the Director of Nursing (DON) confirmed that Resident #25's 09/27/2018 MDS assessment had been miscoded, because of Resident #25's fall on 08/16/2018.	F 641	and care plans prior to the completion of Section J of the MDS. Falls will be discussed in daily Department Head meetings as well as weekly Quality Assurance Performance Improvement(QAPI) meetings. 4. The DON and Staff Development Nurse conducted a 100% audit of all MDS Section J on 11-16-18. This audit identified one additional resident with unreported falls. The MDS for this identified resident was updated and transmitted by the MDS Nurse on 11-16-18. Audits will continue by the DON and Staff Development Nurse on all current MDS weekly x 4 weeks. Ongoing monthly audits will be completed and reviewed for effectiveness by the DON and Staff Development Nurse. Any deficient practices will be corrected immediately. Findings will be reviewed in the weekly QAPI meeting and recommendations will be made as needed.	

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F 644	Continued From page 2	F 644		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to refer a resident to the appropriate state designated authority for level 2 Pre-Admission Screening Resident Review (PASSR) evaluation and determination for one (1) of three (3) residents reviewed for PASSR, Resident # 4 Findings Include: A record review of the resident's Physician's orders revealed Resident #4 was ordered Haldol 1 milligram (mg) by mouth (po) twice daily (BID) for Psychosis, dated 8/18/2018, which was a new diagnosis and medication. The PASSR, upon	F 644	1. A Pre-Admission Screening and Annual Resident Review (PASARR) change in status request form on Resident #4 was completed by the Minimum Data Set (MDS) Nurse and submitted to Ascend on 11-6-18. A notice of a negative Level 1 screen outcome was received by the facility on 11/13/18. 2. All residents have the potential to be affected by this deficient practice. 3. An in-service was provided to the Staff Development Nurse, Director of Nursing(DON), MDS Nurse, Social	11/26/18

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F 644	Continued From page 3 admission, noted the resident did not have behaviors or mental illness. Resident #4 was not taking psychotropic medication upon admission. During an Interview on 10/31/2108 at 10:50 AM, Licensed Practical Nurse (LPN) #1 stated that she's responsible for the PASSR. LPN #1 stated that all newly diagnosed residents with mental or intellectual disorders should be sent to the appropriate agency (Agency Named) to decide whether a level 2 should be done, however, she was unable to get to it at this time. She stated she will take care of the PASSR for Resident #4 as soon as possible (ASAP). LPN #1 stated that the facility does not have a policy on PASSRs, but it is part of her job duty to make sure they are done correctly and timely. A review of the facility's face sheet revealed the facility admitted Resident #4 on 08/24/2017, with diagnoses which included Unspecified Psychosis, Depression and Auditory Hallucinations.	F 644	Services Coordinator, Medicare Nurse, Activities Coordinator, and Wound Care Nurse by the Nurse Consultant on 11-16-18 regarding the coordination of the PASARR evaluation and the determination process. All residents receive a PASARR evaluation prior to admission. PASARR change in status forms will be submitted as indicated. 4. All medication orders will be reviewed in the daily Department Head meeting. The Psych Nurse Practitioner will continue to round on residents monthly for medication, diagnosis, and treatment needs. All recommendations from the Psych Nurse Practitioner will be given to the DON. PASARR change in status forms will be submitted as indicated by the MDS nurse. Any deficient practices will be corrected immediately. Findings will be reviewed in the weekly Quality Assurance Performance Improvement(QAPI) meeting and recommendations will be made as needed.	
F 656 SS=D	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	F 656		11/26/18

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F 656	Continued From page 4 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 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, record review, facility policy review, and staff interview, the facility failed to develop a comprehensive care plan to include interventions of a catheter securing device to prevent tension and trauma; and failed to implement the care plan of providing catheter	F 656	1. The care plan for Resident #30 was updated by the Staff Development Nurse on 10-31-18 to reflect the need to utilize a securing device to prevent tension and trauma as well as providing appropriate catheter care to avoid infection.	

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F 656	Continued From page 5 care in a manner to help prevent infection for one (1) of four (4) care plans reviewed, Resident #30. Findings include: Review of the facility policy, "Care Plans, Comprehensive Person-Centered", revised December 2016, revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Review of the facility policy, "Perineal Care", revised October 2010, revealed that the facility policy, if a resident had a catheter, was to gently wash the juncture of the tubing from the Urethra down the catheter about three (3) inches. The facility policy also noted that the catheter tubing should be held to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter. Review of the facility policy, "Catheter Care, Urinary", revised September 2014, revealed the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. The policy also included documentation to ensure that the catheter remains secure with a leg strap to reduce friction aandmovement at the insertion site. Record review revealed Resident #30's care plan, with an on-set date of 10/8/18, revealed a potential for complications related to an indwelling urinary catheter. Interventions included to keep	F 656	2. All residents with a Foley catheter have the potential to be affected. 3. Any resident admitted with or receiving a Foley catheter after admission, will have a bowel and bladder assessment as well as a comprehensive care plan that outlines the need for a securing device to prevent tension and trauma as well as steps to provide appropriate catheter care to avoid infection. The bowel and bladder assessment will be performed by the Registered Nurse (RN) Supervisor and the comprehensive care plan will be completed by the Minimum Data Set (MDS) Nurse. Ongoing audits of these areas will be performed by the Director of Nursing (DON) upon admission and orders for Foley catheter to assure compliance. 4. A 100% audit was conducted on Foley catheter residents for care plans and placement of securing device on 11-16-18 by Staff Development Nurse. Residents admitted with or receiving Foley catheter after admission, will have their catheter care plan and orders reviewed the following day in the daily Department Head meeting. Any deficient practices will be corrected immediately. Findings will be reviewed in the weekly Quality Assurance Performance Improvement(QAPI)meeting and recommendations will be made as needed.	

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F 656	Continued From page 6	F 656		

the catheter and drainage bag lower than the bladder at all times and to provide catheter care with soap and water every shift. The care plan did not address the use of a securing device (leg strap).

Review of Resident #30's face sheet revealed that she was admitted on 9/27/18, with a diagnoses of Hypoglycemia, Metabolic Encephalopathy, and Urinary Tract Infection.

Observation on 10/31/18 at 10:36 AM, revealed Certified Nursing Assistant (CNA) #1 provided catheter care for Resident #30, along with assistance of CNA #2. Both CNA's were observed to wash hands prior to providing catheter care. Observation revealed there was no leg band to secure the catheter tubing to prevent the catheter from pulling at the Urethra. CNA #2 held the catheter bag above the Resident's bladder and was holding the catheter at the junction of where it meets the bag tubing, instead of securing it at the Urethra. Then, CNA #1 wiped toward the Urethra, instead of away from it.

On 10/31/18 at 12:00 PM, interview with CNA#1 revealed that she knew that she wiped incorrectly when she cleaned Resident #30's Foley catheter. The CNA reported she was not sure about a catheter strap, today was her first day to take care of the resident.

On 10/31/18 at 12:34 PM, interview with CNA #2 revealed Resident #30 had a leg strap on the day prior. The CNA reported that the resident should have a catheter strap on at all times to help prevent trauma from pulling. The CNA reported that she knew to hold the catheter at the closest

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F 656	Continued From page 7 point to the Urethra as possible and that CNA #1 should have wiped away from the Urethra, instead of toward it, while providing catheter care. On 10/31/18 at 11:27 AM, interview with the Director of Nursing (DON) revealed that she expected the resident to have a leg strap to secure the catheter. The DON stated that she expected the CNA to wipe the resident from front to back when providing perineal/catheter care and for staff to clean the catheter by wiping away from the Urethra. The DON reported that she expected the CNA to follow the care plan, which included providing care per the policy. Review of the staff education training, dated May 2018, on incontinent catheter and peri- care, revealed that staff was trained on assuring that the catheter must be below the bladder at all times to prevent urine from flowing back into the bladder. The training also revealed that the catheter should have a secure leg band on and the catheter should be cleaned from the insertion site to approximately four (4) inches outward.	F 656		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §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	F 690		11/26/18

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F 690	Continued From page 8 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, medical record review, policy review, and staff interview, the facility failed to provide catheter care in a manner that would prevent infection and/or trauma for one (1) of two (2) resident observations of perineal care, Resident #30. Findings include: Review of Resident #30's face sheet revealed the facility admitted the resident on 9/27/18, with diagnoses of Hypoglycemia, Metabolic Encephalopathy, and Urinary Tract Infection (UTI).	F 690	1. The Certified Nursing Assistant (CNA) #1 that was involved in the deficient practice of catheter care on Resident #30 was in-serviced by the Staff Development Nurse on the correct technique for catheter care with return demonstration on 10-31-18 with a positive outcome. 2. Any resident having a Foley catheter has the potential to be affected. 3. All CNAs have been in-serviced by the Director of Nursing (DON) and Staff Development Nurse on the policy and	

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F 690	Continued From page 9 Review of the facility policy, "Perineal Care", revised October 2010, revealed if a resident had a catheter, to gently wash the juncture of the tubing from the Urethra down the catheter about three (3) inches. The facility policy also noted that the catheter tubing should be held to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter. Review of the facility policy, "Catheter Care, Urinary", revised September 2014, revealed the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. The policy also included documentation to ensure that the catheter remained secure with a leg strap to reduce friction and movement at the insertion site. On 10/31/18 at 10:36 AM, observation of catheter care for Resident #30, revealed Certified Nursing Assistant (CNA) #1 provided catheter care, along with assistance of CNA #2. There was no leg strap or catheter securing device observed, to prevent the catheter from pulling at the Urethra. CNA #2 held the catheter bag above the resident's bladder and was holding the catheter at the junction of where it meets the bag tubing, instead of securing it at the Urethra. Then observed CNA #1 wiped toward the Urethra, or urinary Meatus, instead of away from it. On 10/31/18 at 11:27 AM, an interview with the Director of Nursing (DON) revealed that she expected Resident #30 to have a leg strap to secure the catheter. The DON stated that she	F 690	procedure for urinary catheter care with return demonstration with a completion date of 11-26-18. The Staff Development Nurse will assess skills on hire and annually thereafter. 4. The Staff Development Nurse will observe random observations of peri/catheter care weekly x 4 weeks. Any deficient practice will be corrected immediately. Findings will be review in the weekly Quality Assurance Performance Improvement (QAPI) meeting and recommendations will be made as needed. Nursing staff will be in-serviced on Peri/Catheter care twice a year and as needed by Staff Development Nurse.	

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F 690	Continued From page 10	F 690		

also expected the CNA to clean the catheter tubing by wiping away from the Urethra, instead of toward the Urethra/Urinary Meatus. The DON stated that she expected the CNA to follow their policy for catheter care.

On 10/31/18 at 12:00 PM, an interview with CNA #1 confirmed that she wiped incorrectly when she cleaned the Foley catheter for Resident #30. The CNA stated that she wasn't sure about the catheter securing device, because this was the first day she'd provided care for Resident #30.

On 10/31/18 at 12:34 PM, an interview with CNA #2 revealed that she had observed the resident to have a leg strap the day before and that the resident should have a catheter strap on at all times to keep from pulling. The CNA reported that she knew to hold the catheter at the closest point to the urethra as possible. The CNA reported that CNA #1 should have wiped the tubing away from the Urethra while providing catheter care.

Record review revealed that Resident #30 completed Intravenous (IV) Tobramycin, an antibiotic, on 10/16/18 for a UTI. The resident had a urinalysis with culture and sensitivity completed on 10/24/18, with no antibiotics prescribed for a UTI at this time.

An interview with the DON on 10/29/18 at 3:49 PM, revealed they are waiting on the culture and sensitivity for the Physician to decide if Resident #30 needed treatment with antibiotics.

Review of the staff education training, dated May 2018, on incontinent catheter and peri- care, revealed that staff was trained on assuring that

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F 690	Continued From page 11 the catheter must be below the bladder at all times to prevent urine from flowing back into the bladder. The training also revealed that the catheter should have a secure leg band, and should be cleaned from the insertion site to approximately four (4) inches outward.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255050	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/31/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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		

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

Electronically Signed | 11/20/2018

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
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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 10/31/18 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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