STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A156	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 at the facility from 10/30/17 to 11/2/17. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiency F 157, F279, F280, F 282, F322, F 323, F363, F371, and F 526. At the time of survey, the census was 97, and the facility held a license for 120 beds.	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (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, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 157		11/25/17

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

Electronically Signed | 11/21/2017

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 157	Continued From page 1 (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). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to notify the physician of refusal of the use of a hand roll for one (1) of 20 residents records reviewed, Resident #12. Findings include: A facility policy titled, "Range of Motion Exercises", undated, revealed to notify the physician of any condition changes.	F 157	This Plan of Correction is submitted under Federal and State Regulations and status applicable to Long Term Care Providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the scope and severity regarding any of the deficiencies are cited correctly. Rather, it	

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F 157	Continued From page 2 A review of physician orders, for Resident #12, revealed an order dated 09/29/17, for "Comfy air hand roll to right hand, remove for hygiene only. Encourage use. Check every two (2) hours for proper positioning and signs and symptoms of redness/edema." A review of Resident #12's Medication Administration Record (MAR) for the months of September, October, and November 2017, revealed the order for "Comfy Air Hand Roll to Right Hand" documented by initials that were circled (signifying the service was not provided). In an observation on 10/30/17 at 11:20 AM, Resident #12 was lying in bed with his contracted right hand on top of the covers. Resident #12 did not have a hand roll in his right hand. An observation on 10/31/17 at 3:45 PM, revealed Resident #12 did not have a hand roll in his hand during incontinent care. The Certified Nursing Assistants (CNA) did not apply the hand roll at any time during the care. In an interview, on 10/31/17 at 3:50 PM, CNA #1 confirmed Resident #12 did not have a hand roll in his right hand, and she said the resident would not leave it on. In an interview, on 11/2/17 at 11:05 PM, Registered Nurse (RN) #3 said Occupational Therapy (OT) was working on finding something that would work for Resident #12. RN #3 said she was unsure if the physician was aware that Resident #12 did not use the hand roll. In an interview, on 11/2/17 at 12:10 PM, RN #2 confirmed the circled initials on the MAR meant	F 157	is submitted as confirmation of our ongoing effort to comply with all State and Federal regulatory requirements. 1) On 11/3/2017, the facility notified the physician of Resident #12's refusal to use the hand roll. 2) The facility recognizes that all Residents with an order to use a hand roll had the potential to have been affected by this alleged deficient practice. 3) Nursing Supervisors will do audits on all residents with physician orders to have hand rolls. The Nursing Supervisor will audit to see if the hand rolls are applied in accordance to the physicians order. Also, if the resident is refusing to use the hand roll, they will verify that the physician has been contacted regarding such refusal. These audits will be performed 5 days a week for 3 weeks and 3 days a week for 2 weeks. The nursing supervisor will also verify the notification of the physician on any resident who refuses to use a hand roll on future orders. These audits will be given to the Quality Assurance Performance Improvement (QAPI) Committee. 4) The results of the audits will be brought to the Quality Assurance Performance Improvement Committee and corrective action will be monitored and evaluated by the Committee at least quarterly and more often as necessary. If any revisions of the plan of correction are	

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F 157	Continued From page 3 refusal or not done. RN #2 said the CNA's and the nurses were responsible for the hand roll after Occupational Therapy (OT) completed the training on the application of the hand roll. In an interview, on 11/2/17 at 12:30 PM, The OT said she was aware of Resident #12 refusing to wear the hand roll. OT said the resident had pulled away and fought with staff while applying the roll. In an interview, on 11/2/17 at 3:30 PM, the Nurse Practitioner (NP) said he had not been called about Resident #12 refusing to wear the hand roll. The NP said he would put the hand roll in Resident #12's right hand every time he would visit him. A review of the facility's face sheet revealed the facility admitted Resident #12 on 5/29/15, with a re-admit date of 08/01/17. Resident #12's diagnoses included Alzheimer's and Right Hand Contracture. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/22/17, revealed staff assessed Resident 12 with severely impaired cognition.	F 157	needed, the revisions will be developed and approved by the QAPI Committee to ensure the plan of correction is achieved and sustained.	
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.	F 279		11/30/17

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F 279	Continued From page 4	F 279		

483.21
(b) Comprehensive Care Plans

(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 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.

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F 279	Continued From page 5 (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 develop a care plan related to the safe transport of an oxygen tank on a rolling walker for one (1) of 20 care plans reviewed, Unsampled Resident E Findings Include: Unsampled Resident E A review of the facility's, "Care Plan Policy", dated 02/23/17, revealed that the care plan is to include identified needs, problems, and potential problems with appropriate interventions to promote the resident's highest level of safety, function, health, and daily living. Review of the care plan, for Unsampled Resident E, revealed that there was an identified need relating to an unsteady gait, updated 10/3/17, with an intervention to set up for ambulation using a rolling walker and supervision. A care plan, updated 10/23/17, revealed a problem related to an altered respiratory health status with an intervention to include a need for oxygen at three	F 279	1) On 11/3/2017, an employee of the Maintenance Department placed a safety strap on the oxygen tank and secured it to the rolling walker of Unsampled Resident E. On 11/3/2017,the Assistant Director of Nursing updated the care plan of Unsampled Resident E to reflect the oxygen tank is to be secured to the rolling walker with a safety strap when in use. 2) The facility recognizes that all Residents who ambulate with a rolling walker and an oxygen tank had the potential to have be affected by this alleged deficient practice. 3) Education was provided by the Director of Nursing on 11/27/17, including to ensure any resident ambulating with a rolling walker that requires continuous oxygen is care planned to have the oxygen tank secured to the rolling walker when in use. The Nurse Supervisor will monitor Unsampled Resident E, 3 days a week for 3 weeks and then 2 days a week for 2 weeks to ensure that Unsampled	

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F 279	Continued From page 6 (3) liters using a nasal canula on a continuous basis. There was no care plan for the resident to ambulate with a rolling walker and have oxygen supplied continuously in a safe manner. Review of Unsampled Resident E's physician orders, dated October 2017, revealed Unsampled Resident E had a signed order for oxygen (O2) to infuse at three (3) liters using a nasal canula on a continuous basis. Unsampled Resident E also has an order stating Resident may ambulate throughout the facility with a Rollator and supervision. During an interview on 11/2/17 at 3:20 PM, Licensed Practical Nurse (LPN) #5, the Minimum Data Set (MDS) Coordinator for the facility, confirmed that the care plan needed to combine the resident's need for continuous oxygen and the resident's need to ambulate throughout the facility with a rolling walker in a safe manner. LPN #5 stated that the Care Plan Coordinator for the facility was not at work today, and that she was trying to keep the care plans updated in her absence. During an interview on 11/2/17 at 3:35 PM, the Director of Nursing (DON), confirmed that the care plan should reflect a need for Unsampled Resident E to ambulate using a rolling walker with the safe transportation of oxygen. A review of the face sheet revealed the facility admitted Unsampled Resident E on 08/13/15, with a diagnosis to include Chronic Obstructive Pulmonary Disease and Essential Hypertension. A review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date	F 279	Resident E is using the rolling walker with the oxygen tank secured with a safety strap while ambulating. The Care Plan Coordinator, 1 time monthly for 3 months, will review the care plan of any resident who ambulates with a rolling walker and has oxygen supplied continuously to ensure it is care planned appropriately. The audits will be given to the QAPI Committee for review. 4) The results of the audits will be brought to the Quality Assurance Performance Improvement Committee and corrective action will be monitored and evaluated by the Committee at least quarterly and more often as necessary. If any revisions of the plan of correction are needed, the revisions will be developed and approved by the QAPI Committee to ensure the plan of correction is achieved and sustained.	

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F 279	Continued From page 7 (ARD) of 09/22/17, revealed the Resident's Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment.	F 279		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative.	F 280		11/30/17

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F 280	Continued From page 8 (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (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	F 280		

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F 280	Continued From page 9 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, staff interview, record review and facility policy review, the facility failed to revise the care plan related to the resident's refusal of a hand roll for one (1) of 20 care plans reviewed, Resident #12. Findings include: A facility, "Care Plan Policy", revised date 02/23/17, revealed the total care plan is updated by nursing as any changes occur in the resident's status and care. A review of Resident #12's comprehensive care plan, initiated 8/1/17, revealed he had an Activity of Daily Living (ADL) deficit and contracture. A Comfy Air hand roll was listed as an intervention for contracture of right upper extremity. Resident #12 did not have a problem or concern listed for refusal of care or hand rolls included on his care plan. A review of physician orders for Resident #12 revealed an order dated 09/29/17, for a Comfy air hand roll to the right hand, remove for hygiene only. Encourage use. Check every two (2) hours for proper positioning and signs and symptoms of redness/edema. A review of Resident #12's Medication Administration Record (MAR) for the months of	F 280	1) On 11/3/2017, the Care Plan was updated by the Staff Development Coordinator to reflect Resident #12's refusal of the use of a hand roll. 2) The facility recognizes that all Residents that have a Physician's order for a hand roll had the potential to have been affected by this alleged deficient practice. 3) Education was provided to the Care Plan Nurse by the Director of Nursing on 11/27/17, including to ensure the refusal to use equipment (example: hand rolls) is included in the Care Plan. Three times weekly for 3 weeks, then 2 times weekly for 2 weeks the Care Plan Coordinator will review the care plan of each Resident with a physician order for a hand roll to ensure any refusal to have the hand roll placed is appropriately care planned. 4) The results of the audits will be brought to the Quality Assurance Performance Improvement Committee and corrective action will be monitored and evaluated by the Committee at least quarterly and more often as necessary. If any revisions of the plan of correction are needed, the revisions will be developed	

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F 280	Continued From page 10 September, October, and November 2017, revealed documentation for the Comfy Air Hand Roll to the Right Hand every shift with initials that were circled, which indicated the procedure wasn't done. An observation on 10/30/17 at 11:20 AM, and again on 10/31/17 AM, revealed Resident #12 did not have a hand roll in his right hand. In an interview, on 10/31/17 at 3:50 PM, CNA #1 confirmed Resident #12 did not have a hand roll in his right hand, and said the resident would remove the roll himself and not leave it in his hand. During an interview, on 11/2/17 at 10:35 AM, Licensed Practical Nurse (LPN) #5, Minimum Data Set (MDS) nurse, said the Care Plan Nurse was not available but she worked with her. LPN #5 confirmed the care plan did not address Resident #12 refusing to wear the hand roll. LPN #5 said she checked the MAR for refusal when she completed an MDS. LPN #5 said the new orders or changes in the care plan would be done by the floor nurses, at the time of the change. In an interview, on 11/2/17 at 11:05 AM, Registered Nurse (RN) #3, Charge Nurse, said if any changes or problems occurred, the provider was notified and orders written. RN #3 said she would write the changes on the care plan and give a copy to the Care Plan Nurse to make changes in the computer. RN #3 confirmed the MAR showed the resident refused care by the nurse circling the initials. RN #3 confirmed the refusal was not addressed in the care plan. A review of the facility's face sheet revealed the	F 280	and approved by the QAPI Committee to ensure the plan of correction is achieved and sustained.	

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F 280	Continued From page 11 facility admitted Resident #12 on 5/29/15 with a re-admit date of 08/01/17. Resident #12's diagnoses included Alzheimer's and Right Hand Contracture. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/22/17, revealed staff assessed Resident 12 with severely impaired cognition.	F 280		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and facility policy review, the facility failed to follow the care plan for feeding tube medications for (1) of (20) care plans reviewed Resident#12. Findings Include: Review of the facility's care plan policy dated, 2/23/2017, revealed a Comprehensive Care Plan included measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs shall be developed for each resident. Interventions are included to promote the resident's highest level of function, health and	F 282	1) On 11/4/2017, LPN #4 was provided with education regarding administering medication via an Enteral Tube. This education was provided by the Assistant Director of Nursing. 2) The facility recognizes that all Residents with PEG Tubes had the potential to be affected by this alleged deficient practice. 3) On 11/21/17 all Nursing Staff were provided education by the Staff Development Coordinator on the policy and procedures titled "Medication	11/30/17

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F 282	Continued From page 12 daily living. Review of the "Medication Administration; Enteral Tubes" policy, revised 9/25/15, revealed flushing the tube after each individual medication is given is required unless there is a physician's order due to fluid restrictions. Administering medications separately aids in avoiding interactions and clumping. Review of Resident #12's current Comprehensive Care Plans, initiated 8/1/17, and updated 10/9/17, revealed the resident had a Percutaneous Endoscopic Gastrostomy (PEG) tube and Cardiovasular Health issues and medication would be given as ordered through 12/1/17, with the medications listed on the care plans. Observation of medication pass (medpass), on 10/31/17 at 8:00 AM, revealed Licensed Practical Nurse (LPN #4) mixed Vasotec and Coreg, Cerovite and Keppra, Zoloft and Trilafon, Plavix and Sardil, Bacid and Lipitor together in medication cups, two (2) medications per cup. LPN #4 poured the mixed medications into resident #12's feeding tube and flushed with 10 cubic (cc) of water after each mixed medication. During an interview on 10/31/17 at 4:00 PM, LPN #4 confirmed she failed to administer each medication separately and flush the tube between each medication. LPN #4 said she combined the medication because of the quantity of meds. During an interview, on 11/2/17 at 12:25 PM, LPN #5 confirmed LPN #4 failed to follow the Comprehensive Care Plan for administering medications as ordered through the PEG tube for Resident #12, by mixing the medications and not	F 282	Administration: Enteral Tubes". On 11/27/17 The Staff Development Coordinator will monitor nurses administering medication to Residents with PEG Tubes, 3 times a week for 3 weeks and then 2 times a week for 2 weeks to ensure the Comprehensive Care Plan for administering medications are followed correctly. 4) The results of the audits will be brought to the Quality Assurance Performance Improvement Committee and corrective action will be monitored and evaluated by the Committee at least quarterly and more often as necessary. If any revisions of the plan of correction are needed, the revisions will be developed and approved by the QAPI Committee to ensure the plan of correction is achieved and sustained.	

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F 282	Continued From page 13 flushing between each medication. LPN #5 said the nurse is expected to give medication per professional standards, policy and care plan. Review of the facility's face sheet revealed, the facility readmitted the resident on 08/01/17. Resident #12's diagnoses included Alzheimer Disease, Hypertension, Hyperlipidemia, Depression, Chronic Obstructive Pulmonary Disease and Kidney Disease. Review of the Minimum Data Set, with an Assessment Reference Date of 09/22/17, revealed staff assessed Resident 12 with severe cognitive impairment.	F 282		
F 322 SS=D	NG TREATMENT/SERVICES - RESTORE EATING SKILLS CFR(s): 483.25(g)(4)(5) (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 ensure that a resident- (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 (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,	F 322		11/30/17

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F 322	Continued From page 14 vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview and facility policy review, the facility failed to administer each medication separately and flush the Percutaneous Endoscopic Gastrostomy (PEG) tube between each medication administration for one (1) of three (3) residents observed with feeding tubes, Resident#12. Findings Include: Review of the Facility's policy on Medication Administration - General Guidelines", dated 09/25/15, revealed administering the medication separately (via feeding tube) aids in avoiding interactions and clumping. The medication cup is rinsed with water to ensure the entire dose of medication has been administered. The enteral tubing is flushed with at least 5 milliliters (ml)of water between medication administrations. Review of Mosbey's Pocket Guide to Nursing Skills and Procedures, Perry and Potter, eighth edition, page 334, revealed under the oral medications through Gastric Tubes: To administer more than one (1) medication, give each separately, and flush between medications with 15 to 30 ml of water. The rationale included: Allows for accurate identification of medication if the medication is spilled, and in addition, some medications may be incompatible. It maintains patency of the tube. Review of Resident 12's Physician's Orders, dated October 2017, revealed to check for	F 322	1) On 11/4/2017, LPN #4 was provided with education regarding the policy "Medication Administration, Enteral Tubes." The Education was provided by the Assistant Director of Nursing. 2) The facility recognizes that all Residents with a PEG Tube had the potential to have been affected by the alleged deficient practice. 3) On 11/21/17, All Nursing Staff were provided education by the Staff Development Nurse on the policy and procedure titled "Medication Administration: Enteral Tubes". On 11/27/17, the Staff Development Coordinator will begin monitoring nurses administering medication to Residents with PEG Tubes, 3 times a week for 3 weeks and then 2 times a week for 2 weeks to ensure the administration of the medications are performed correctly. The audits will be given to the QAPI Committee for review. 4) The results of the audits will be brought to the Quality Assurance Performance Improvement Committee and corrective action will be monitored and evaluated by the Committee at least quarterly and more often as necessary. If any revisions of the plan of correction are needed, the revisions will be developed and approved by the QAPI Committee to	

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F 322	Continued From page 15 placement of the feeding tube by aspiration/auscultation (hearing) before and after administering flushes or medications. There was no order for flushing between medications or administering each medication separately via the feeding tube. Observation of the medication pass, on 10/31/17 at 8:00 AM, revealed Licensed Practical Nurse (LPN #4) mixed Vasotec and Coreg together, Cerovite and Keppra together, Zoloft and Trilafon together, Plavix and Sardil together, and Bacid and Lipitor together in medication cups. LPN #4 poured the mixed medications into resident #12's feeding tube and flushed with 10 cubic centimeters (cc) of water after each mixed medication. LPN #4 did not administer each medication separately. During an interview on 10/31/17 at 4:00 PM, LPN #4 confirmed she failed to administer each medication separately and flush the tube between each medication for Resident #12. LPN #4 said she combined the medication because of the quantity of meds. LPN #4 said she is not familiar with facility policy on giving meds via tube and she had not talked to pharmacy about interactions of medications. During an interview on 11/1/17 at 9:00 AM, the Pharmacy Consultant stated he did not review Resident #12's feeding tube medications for interactions. The Pharmacist said the best practice is to give the medications one (1) at a time and flush after each medication. The Pharmacist also said that if Resident #12 coughed and the medication came out of the tube, the nurse would not know what medication the Resident lost.	F 322	ensure the plan of correction is achieved and sustained.	

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F 322	Continued From page 16 In an interview, on 11/1/17 at 11:12 AM, LPN #1 said that the medication administered through the tube should be crushed and placed into individual cups. The tube should be flushed after each individual medication. During an interview, on 11/1/17 at 11:35 AM, LPN #3 said that the medication should be crushed and place into individual cups and the tube should be flushed after each individual medication. In an interview, on 11/1/17 at 12:10 PM, the Director of Nursing (DON) confirmed LPN #4 failed to correctly administer medication via feeding tube by not administering the medication individually and flush after each medication. The DON said the nurse should have called pharmacy and checked to see if any of the medications interacted with each other before combining them. The DON said the nurse's train each other when they are first hired. Review of the facility's face sheet revealed the facility readmitted the resident on 08/01/17. Resident #12's diagnoses included Alzheimer Disease, Hypertension, Hyperlipidemia, Depression, Chronic Obstructive Pulmonary Disease and Kidney Disease. Review of the Minimum Data Set, with an Assessment Reference Date of 09/22/17, revealed staff assessed Resident 12 with severely impaired cognition.	F 322		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3)	F 323		11/25/17

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F 323	Continued From page 17 (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based upon observation, record review, and staff interview the facility failed to secure an oxygen (O2) tank on a rolling walker to prevent accidents or to ensure other cognitively impaired residents did not tamper with the oxygen tank and accidentally drop the tank, for one (1) of 10 residents with continuous oxygen, Unsampled Resident #E, Findings include: No policy was provided by the facility for securing	F 323	1) On 11/3/2017, an employee of the Maintenance Department placed a safety strap on the oxygen tank and secured it to the rolling walker of Unsampled Resident E. 2) The facility recognizes that all Residents who ambulate with a rolling walker and an oxygen tank had the potential to have been affected by this alleged deficient practice.	

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F 323	Continued From page 18 oxygen tanks. An observation, on 10/30/17 at 4:30 PM, revealed Unsampled Resident #F was handling a rolling walker with an unsecured small O2 tank in the buggy part of the walker. Unsampled Resident #F leaned down and attempted to pick up the oxygen tubing that was hanging down to the floor from the unsecured O2 tank sitting on the rolling walker in the hallway of Nursing Station #2. Observation on 10/30/17 at 4:45 PM and 5:00 PM, revealed an unsecured O2 tank sitting on the seat of a rolling walker in the hallway outside of room 207. The oxygen tubing was connected and hanging to the floor. The rolling walker was identified, by Licensed Practical Nurse (LPN) #4, as belonging to Unsampled Resident #E. During an observation on 11/01/17 at 11:30 AM, Unsampled Resident #E ambulated with a rolling walker in the hallway of Nursing Station # 2. An unsecured O2 tank sat in the basket of the rolling walker. During an interview, on 10/30/17 at 5:00 PM, LPN #4, confirmed that there was an O2 tank sitting on the seat of a rolling walker in the hallway. LPN #4 stated that she was not sure who put it there, but that happened all the time. LPN #4 stated that Unsampled Resident E used the rolling walker, carrying the O2 tank, while ambulating to activities and other areas of in the facility. LPN #4 stated that the O 2 tank was never secured that she was aware of. LPN #4 stated, "That's the way we always do it." LPN #4 stated she would try to find a way to secure the O2 tank to keep it from falling. LPN #4 also stated that Unsampled Resident F wanders around the facility in a wheel	F 323	3) The Nursing Supervisor will monitor Unsampled Resident E, 3 days a week for 3 weeks and then 2 days a week for 2 weeks to ensure that Unsampled Resident E is using the rolling walker with the oxygen tank secured with a safety strap while ambulating. The audits will be given to the QAPI Committee for review. 4) The results of the audits will be brought to the Quality Assurance Performance Improvement Committee and corrective action will be monitored and evaluated by the Committee at least quarterly and more often as necessary. If any revisions of the plan of correction are needed, the revisions will be developed and approved by the QAPI Committee to ensure the plan of correction is achieved and sustained.	

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F 323	Continued From page 19	F 323		

chair, but that she has never noticed Unsampled Resident #F messing with that rolling walker or the O2 tubing that is connected to it, but that it was a possibility.

During an interview on 10/31/17 at 3:40 PM, Registered Nurse #2 confirmed that keeping an unsecured O2 tank on the rolling walker, that Unsampled Resident #E used to ambulate, was not a safe practice or intention of the facility. RN #2 stated that the facility did not have a policy on the use of O2 tanks related to the placement of an O2 tank in a resident's rolling walker used for ambulation.

During an interview, on 11/2/17 at 11:00 AM, Unsampled Resident #E confirmed that she used the rolling walker to ambulate to activities and other areas of the facility. Unsampled Resident #E confirmed that the O2 tank on the rolling walker was never secured when used. Unsampled Resident #E also stated that there was one (1) occasion, when she was coming in from outside, that the O2 tank fell off the rolling walker. Unsampled Resident #E stated that she kept the rolling walker in the hallway because she didn't really have a place in her room for storage.

During an interview, on 11/2/17 at 12:45 PM, the Director of Nursing (DON) confirmed that Unsampled Resident #E used an O2 tank on her rolling walker to ambulate inside the facility, and that she preferred to keep it parked in the hallway next to her room. The DON confirmed that the O2 tank needed to be secured to the rolling walker for safety purposes. The DON stated that she did not know the tank had not been secured.

A review of the face sheet revealed the facility

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F 323	Continued From page 20 admitted Unsampled Resident #E on 08/13/15, with diagnoses to include Chronic Obstructive Pulmonary Disease and Essential Hypertension. A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/22/17, revealed Unsampled Resident #E's Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. A review of the face sheet revealed the facility admitted Unsampled Resident #F on 01/29/13, with diagnoses to include Alzheimer's Disease and Delusional Disorder. A review of the Significant Change in Status MDS with an ARD of 08/04/17, revealed Unsampled Resident #F's BIMS score of 5, indicating severe cognitive impairment.	F 323		
F 363 SS=F	MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED CFR(s): 483.60(c)(1)-(7) (c) Menus and nutritional adequacy. Menus must- (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; (c)(2) Be prepared in advance; (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;	F 363		11/30/17

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F 363	Continued From page 21 (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident group interviews, staff interviews, record reviews, and the facility policy review, the facility failed to follow the menu for fried chicken and creamed spinach for one (1) of three (3) dietary observations. Findings Include: Review of the facility's policy, "(Name of Vendor), Inc. Standardized Recipes" effective 01/01/99, revealed, "1. Standardized recipes will be used to prepare each menu item. 2. Recipes will include the following information: A. Recipe Name, B. Number and Size of portions, C. List and quantity of ingredients, D. Cooking temperature and time, E. Preparation steps, F. Critical control points." Review of the Production Recipe, for 11/1/17 for Fried Chicken, revealed the ingredients and instructions for 44 pound fresh cut chicken, three (3) quart and ½ cup of all purpose flour, one (1) cup and two (2) tablespoons of cornstarch, ¼ cup and two (2) tablespoons of ground paprika, ¼ cup and two (2) tablespoons of garlic powder, two and ¾ teaspoon of poultry seasoning, one (1) and 1/3 teaspoon of ground thyme, one (1) and 1/3 tablespoon of ground black pepper and three (3)	F 363	1) Cook #2 was educated on the importance of following the recipes to include measuring ingredients. The education was provided on 11/1/17 by the Dietary Manager. 2) The facility recognizes that all Residents had the potential of being affected by this alleged deficient practice. 3) The Food Service Director will conduct observations of Cooks while preparing a meal on 8 meals for three weeks and then 5 meals for two weeks to ensure recipes are being followed to include measuring ingredients. The audits will be given to the QAPI Committee for review. 4) The results of the audits will be brought to the Quality Assurance Performance Improvement Committee and corrective action will be monitored and evaluated by the Committee at least quarterly and more often as necessary. If any revisions of the plan of correction are needed, the revisions will be developed and approved by the QAPI Committee to	

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F 363	Continued From page 22 quarts and ½ cup of buttermilk. Instructions included to combine flour, cornstarch, dry seasonings, salt and pepper. The chicken was to be dredged into the seasoned flour and then dipped into the buttermilk and then dredged again. The chicken was to then be placed on a rack and allowed to rest for 20 minutes. Observation on 11/1/17 at 10:25 AM, revealed a container of raw chicken which was being seasoned. Cook #2 picked up containers of lemon pepper, seasoned salt, and onion powder. Cook #2 shook each seasoning without measuring into a container of flour. Cook #2 placed the pieces of chicken which had been coated in the flour into the deep fryer. She did not dip the chicken into buttermilk before adding to the deep fryer. Cook #2 looked at the time on a battery operated wall clock. Interview on 11/1/17 at 10:30 AM, with Cook #2, revealed she did not measure the seasonings before adding to the flour. Cook #2 stated, "I guess I should have." Cook #2 also stated she had not dipped the chicken in the buttermilk. Stated she was just nervous. Interview on 11/1/17 at 10:30 AM, with Food Service Director #1, revealed they were out of paprika, garlic powder and black pepper. Food Service Director #1 stated she had been helping since last week due to the last manager had walked out. Review of the recipe for the creamed spinach revealed one (1) and ½ ounce of margarine, three (3) and 1/3 tablespoon of all purpose flour, one (1) and ¼ cup plus two (2) tablespoons of skim milk, one (1) tablespoon plus ¾ teaspoon of	F 363	ensure the plan of correction is achieved and sustained.	

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F 363	Continued From page 23 gluten free low sodium chicken soup base and three (3) pounds and four (4) ounces of frozen chopped spinach. The instructions included to mix the margarine, milk, and flour and then the chicken base and cook until thickened. The spinach was to be drained and squeezed to remove excess liquid and then stirred into the sauce. Observation on 11/1/17 at 10:45 AM, revealed a large aluminum pot which contained a white creamy liquid with particles of green. The substance had the appearance and texture of a thin soup. Cook #2 stirred the liquid and said it was creamed spinach. Cook #2 stirred the liquid and then used a plastic disposable spoon to taste. Cook #2 stated, "It's too salty." Interview on 11/1/17 at 10:50 AM, with Food Service Director #1 revealed another cook had made the creamed spinach but he was already gone. She stated the recipe was not followed and they would remake the creamed spinach. In an interview on 11/1/17 at 10:50 AM, Cook #2 revealed they did not have a timer. Review of the facility menu, for 11/1/17, revealed Fried Chicken, Creamed Corn, Collard Greens, Lemon Cake with Glaze, Cornbread, Iced Tea, Margarine, Sugar Packet, Salt Packet and Pepper Packet. The Alternate Menu revealed Swiss steak, White Rice, and Creamed Spinach.	F 363		
F 371 SS=F	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or	F 371		11/30/17

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F 371	Continued From page 24 considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, facility policy review, and record review, the facility failed to cover and date food stored in the walk-in cooler and refrigerator, maintain consistent cleaning schedules and tray line temperatures records, failed to remove food particles from the stand mixer and a panini press for one (1) of three (3) kitchen observations and failed to deliver trays in a timely manner to maintain temperature for one (1) of three (3) dining observations for two (2) of seven (7) halls, specifically the 200 halls. Approximately one (1) and one-half (1/2) hours elapsed from the time the cart was delivered to the 200 hall until the last	F 371	1) On 10/31/17 the Dietary Manager removed the dried food particles from the stand mixer, and the panini sandwich press. The bowl of Shrimp, cooked spinach, 4 boxes of raw chicken, the three (3) pink colored pies, three packages of ground beef and the one carton of liquid eggs were discarded on 10/31/17 by the Dietary Manager. The package of ham and the package of turkey were discarded on 10/31/17 by the Dietary Manager. The crack in the sink was fixed and the standing water was cleaned by the Maintenance Director on 10/31/17. The	

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F 371	Continued From page 25 residents were served. Findings Include: Review of the facility's policy, "Program: Cleaning and Sanitizing", no date, revealed, "All food service departments must have an effective cleaning program that includes a cleaning schedule." "Sanitize Cleaning Schedule. The cleaning schedule must: Identify: the cleaning jobs in each area of the kitchen. Assign: cleaning responsibilities to each job position. Schedule: the time the cleaning is to be done and/or completed." "Preparing: TCS Food. When preparing TCS food-food requiring time and temperature control for safety-team members must protect food from cross-contamination and/or time/temperature abuse. Label and date. Label and date-mark prepared salad leftovers using the ingredient with the earliest discard date or seven (7) days after the earliest original preparation date of any TCS food." The facility did not provide a policy related to the delivery of food trays. Observation on 10/30/17, with the corporate chef on the initial kitchen tour at 10:35 AM, revealed dried food particles on the stand mixer. A panini sandwich press was covered and stored on the table underneath the stand mixer. There were food particles on the contact plates of the sandwich press. In an interview on, 10/30/17 at 10:35 AM, Dietary Personnel #6, stated the stand mixer had not been used this date, "No, that was yesterday." The Corporate Chef confirmed the unclean	F 371	two (2) containers of cut tomatoes and cucumbers were discarded by the Dietary Manager on 10/31/17. Starting on 11/06/17 the tray line temperature records will be consistently filled out correctly and monitored by the Dietary Manager. Starting on 11/06/17 the cleaning logs will be followed and filled out correctly and monitored by the Dietary Manger. Starting on 11/06/17 the Patient Tray Cart-Delivery Time Log will be completed for each meal period and this will be monitored by the Dietary Manager. 2) The facility recognizes that all Residents had the potential to have been affected by this alleged deficient practice. 3) The Company Resource Manager will do an in-service on checking for cleanliness of equipment, labeling and dating of stored food, and ensure trays are delivered on time this will be done on 11/25/17. The Dietary Manager will do rounds in the kitchen to check for cleanliness of equipment, labeling and dating of stored food, and ensure trays are delivered on time 5 days a week for 3 weeks, and then 3 days a week for 2 weeks. The results of the findings will be reported to the Quality Assurance Performance Improvement Team. The audits will be given to the QAPI Committee for review. 4) The results of the audits will be brought to the Quality Assurance Performance Improvement Committee and corrective action will be monitored	

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F 371	Continued From page 26 sandwich press. Observation of the walk-in refrigerator and storage cooler, on 10/30/17 at 10:35 AM, revealed a large aluminum bowl which contained pink colored shrimp. The bowl was covered with plastic wrap but not dated. There was a bowl which contained what resembled cooked spinach, not dated, four (4) boxes of undated raw chicken, with no received or discard by date, three (3) pink colored pies with no dates, three (3) packages of ground beef which were undated, and one (1) carton of liquid eggs with no use by date. Interview with the Corporate Chef, on 10/30/17 at 10:35 AM, confirmed the foods were undated and would not be able to tell when the shrimp or spinach had been cooked. He further stated the foods should have been dated with received and use by dates. Observation in the kitchen, on 10/31/17 at 9:00 AM, revealed one (1) package of sliced ham in a plastic bag and one (1) package of sliced turkey in a plastic bag, both undated. Interview on 10/31/17 at 9:20 AM, with the Food Service Director, confirmed the undated sliced meats in plastic bags. Observation in the kitchen, on 10/31/17 at 9:25 AM, revealed standing water on the floor near the three (3) compartment sink. Dietary Cook #3 was present and stated the sink had been leaking "too long." Observation on 10/31/17 at 9:25 AM, of the two (2) compartment cooler, revealed two (2) containers of cut tomatoes and cucumbers with	F 371	and evaluated by the Committee at least quarterly and more often as necessary. If any revisions of the plan of correction are needed, the revisions will be developed and approved by the QAPI Committee to ensure the plan of correction is achieved and sustained.	

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no covering or dates. Cook #2 stated, when asked when the tomatoes and cucumbers had been prepared or when they were to be used, "That's a good question."

In an interview, on 10/31/17 at 9:50 AM, the facility Administrator revealed the facility was under contract with a food service and had been aware of some problems in the dietary department. Had recently had two (2) employees in the kitchen leave.

In an interview, on 11/1/17 at 3:15 PM, Registered Nurse #1, Quality Assurance Nurse, stated the kitchen concerns had not been brought to Quality Assurance.

In an interview, on 11/2/17 at 11:45 AM, the Registered Dietitian revealed she had just recently become aware of problems in the kitchen. She stated she expected food to be dated, labeled, and covered in the refrigerator and had observed for cleanliness. She stated there were forms to be used to record tray line temperatures and would have to retrain the kitchen staff if they were not following the recipes.

Review of the tray line temperature records dated 10/28/17-11/2/17 had not been consistently filled out. Review of the cleaning logs had not been documented as done. Handwritten statement from Maintenance Supervisor #1 revealed on 10/30/17 it had been reported that the triple sink in the kitchen was cracked and leaking and this was the first report of problems to maintenance. On 10/30/17 maintenance welded the crack in the sink and tested for further leaks. No work orders were produced to the surveyor.

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F 371	Continued From page 28 A review of a record titled "Patient Tray Cart-Delivery Time Log" was provided by the facility for three (3) of the days of survey with the dates of 10/30/17, 10/31/17, and 11/01/17 without the dinner meal included. An observation on 10/30/17 at 4:15 PM, revealed dinner meal trays were delivered to Station 2 in a large covered delivery cart. The meal trays were handed out to the resident's located in the dining room. Trays were left on the delivery cart with the doors closed. Residents were fed in the dining room and down the 200 hall while the trays remained on the delivery cart. An observation on 10/30/17 at 5:20 PM, revealed dinner meal trays were delivered down the 200 hall serving Unsampled Resident A and Unsampled Resident B in Room 220 and Unsampled Resident C. The tea and water glasses were noted to have melted ice in both cups. An observation on 10/30/17 at 5:30 PM, revealed dinner meal trays were delivered down 200 hall short hall to Unsampled Resident D in Room 232 and Resident #9 in Room 233. The tea and water glasses did not have any ice noted in the cups. This was approximately one (1) and one-half (1/2) hours after the cart was sent to the floor. An interview on 10/30/17 at 5:20 PM, with Unsampled Resident A and B, confirmed the trays were late for this meal, and the food on the tray was cold, which included chicken pot pie, green beans and soup that was served in a cup on the side of the plate. Unsampled Resident A said even the plate was cold the food was on.	F 371		

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F 371	Continued From page 29 Unsampled Resident B confirmed his pureed food was not warm. In an interview on 10/31/17 at 5:30 PM, Resident #9 said the food "tasted like crap" and wasn't cold or hot. Resident #9 requested another meal. In an interview on 10/31/17 at 5:30 PM, Unsampled Resident D said she was used to waiting to last for her meals. Unsampled Resident D said the food was usually cold and there was no use to ask for the staff to warm it. In an interview on 11/1/17 at 12:30 PM, Certified Nursing Assistant (CNA) #1 said she did not know how long the delivery cart would hold the food hot. She thought about an hour. CNA #1 said the trays were different every day on the cart, and they never knew whose tray would be on the carts. In an interview on 11/1/17 at 4:00 PM, the Director of Nursing (DON) said the facility did not have a policy/procedure for delivery of food trays. The DON said the expectation was to deliver the trays as soon as possible but no longer than 30 minutes. The DON said the training of the staff would not include the delivery timing of the trays but she expected it to be understood to deliver "as soon as possible." In an interview on 11/01/17 at 4:40 PM, the District Dietary Manager (DDM) said the common practice was to deliver the whole tray including liquids and dessert on the delivery cart. The DDM said the cart was not heated but used "Pellets" that the plate sits on and said it should hold the food above 140 degrees Fahrenheit. The DDM said she expected the food and the ice to	F 371		

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hold their temperatures if the delivery flow was continuous. The DDM said she was looking for the dining delivery sheets for the meals served at night.

In an interview on 11/02/17 at 10:00 AM, the DON said that the facility could not locate the sign in sheets for any of the dinners served on the dates of 10/30/17, 10/31/17, or 11/1/17.

A review of the manufacture recommendations of the pellets revealed the pellets would hold the temperature of food above 140 degrees Fahrenheit for 45 minutes.

A review of the manufacture recommendations of the delivery cart did not mention time frame for length of holding heat or cold on the cart.

A review of the facility's face sheet revealed the facility admitted Unsampled Resident A on 02/01/12. Unsampled Resident A's diagnoses included Diabetes Mellitus and Congestive Heart Failure.

The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/13/17, revealed Unsampled Resident A's Brief Interview for Mental Status (BIMS) was 6, which indicated severely impaired cognition.

A review of the facility's face sheet revealed the facility admitted Unsampled Resident B on 08/12/15. Unsampled Resident B's diagnoses included Diabetes Mellitus and Hypertension.

The MDS, with an ARD of 09/29/17, revealed Unsampled Resident A's BIMS was 13, which indicated intact cognition.

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F 371	Continued From page 31 A review of the facility's face sheet revealed the facility admitted Unsampled Resident D on 07/24/12. Unsampled Resident D's diagnoses included Iron Deficiency Anemia and Essential Hypertension. The MDS, with an ARD of 10/20/17, revealed Unsampled Resident C's BIMS was 15, which indicated intact cognition. A review of the facility's face sheet revealed the facility admitted Resident #9 on 09/28/17. Resident #9's diagnoses included Chronic Kidney Disease and Diabetes Mellitus. The MDS, with an ARD of 10/09/17, revealed Unsampled Resident A's BIMS was 11, which indicated moderately impaired cognition.	F 371		
F 526 SS=C	Hospice CFR(s): 483.70(o)(1)-(4) (o) Hospice services. (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.	F 526		11/25/17

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F 526	Continued From page 32 (2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following:	F 526		

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F 526	Continued From page 33 (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility	F 526		

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F 526	Continued From page 34 personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. (3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following:	F 526		

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F 526	Continued From page 35 (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient.	F 526		

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F 526	Continued From page 36 (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. (4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.20. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility policy review, the facility failed to designate a Hospice Coordinator, which affected seven (7) of seven (7) Hospice residents in the facility and one (1) of seven (7) residents reviewed for Hospice care, Resident #12. Findings include: A review of a facility policy entitled "Hospice", with a revised date of 02/23/17, revealed the facility would communicate with the Hospice of resident's choice but did not designate a coordinator for the service. A review of the facility staff list did not reveal any position of Hospice Coordinator. In an interview, on 10/31/17 at 2:15 PM,	F 526	1) On 11/6/2017, a Hospice Coordinator was designated for the facility. 2) The facility recognizes that all Residents on Hospice had the potential to have been affected by this alleged deficient practice. 3) The Director of Nursing will ensure that a staff member will be assigned as a Hospice Coordinator when the facility is housing a Resident receiving Hospice Services. 4) The position will be reviewed by the Quality Assurance Performance Improvement Committee to ensure someone is assigned to this position. This will be monitored and evaluated by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A156	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

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F 526	Continued From page 37 Registered Nurse (RN) #2, when asked about the Hospice Coordinator, said "What does that include?" RN #2 said the Charge Nurses notify the doctor when the family requested the Hospice service. In an interview on 11/02/17 at 9:40 AM, the Director of Nursing (DON) said she was not aware of the position of Hospice Coordinator. The DON said that she and the Charge Nurses handled all the Hospice orders and coordinating the care. The DON said no one currently had the position of Hospice Coordinator. A review of Resident #12's physician orders revealed an order for Hospice admission on 09/12/17. A review of the facility's face sheet revealed the facility admitted Resident #12 on 08/01/17. Resident #12's diagnoses included Alzheimer's and Right Hand Contracture. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/22/17, revealed staff assessed Resident 12 with severely impaired cognition.	F 526	the Committee at least quarterly and more often as necessary. If any revisions of the plan of correction are needed, the revisions will be developed and approved by the QAPI Committee to ensure the plan of correction is achieved and sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A156	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/01/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	**305 WEST MOODY STREET POPLARVILLE, MS 39470**

(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 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 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and testing, the facility failed to properly maintain door openings in smoke barrier walls as per NFPA 19.3.7.8. This condition affected three (3) of six (6) smoke compartments and 22 of 97 residents in the facility on the day of survey. Findings Include: On November 1, 2017 at 11:20 AM, observation revealed no automatic door closer on the smoke	K 374	FIRE SAFETY Received NOV 28 2017 MSDH-HFLC & CONSTRUCTION 11-28-17 Accepted By mail This Plan of Correction is submitted under Federal and State Regulations and status applicable to Long Term Care Providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the scope and severity regarding any of the	11/2/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/21/2017

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
	25A156	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/01/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	**305 WEST MOODY STREET** **POPLARVILLE, MS 39470**

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K 374	Continued From page 1 door separating the nursing home from the hospital. The administrator was made aware of the problem during the exit conference.	K 374	deficiencies are cited correctly. Rather, it is submitted as confirmation of our ongoing effort to comply with all State and Federal regulatory requirements. 1) On 11/2/2017, the Maintenance Director installed an automatic door closer on the smoke door separating the Nursing Home from the Hospital. 2) The facility recognizes that all Residents had the potential to have been affected by this alleged deficient practice. 3) The Maintenance Supervisor will check the smoke doors for automatic closures once a month or as needed. These audits will be given to the Quality Assurance Performance Improvement (QAPI) Committee. 4) The results of the audits will be brought to the Quality Assurance Performance Improvement Committee and corrective action will be monitored and evaluated by the Committee at least quarterly and more often as necessary. If any revisions of the plan of correction are needed, the revisions will be developed and approved by the QAPI Committee to ensure the plan of correction is achieved and sustained.	