STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual re-certification survey at the facility from 1/6/2020 to 1/9/2020. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation and cited F-558, F-583, F-641 and F-645. The census at the time of the survey was 103, and the facility was certified for 120 beds.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and the facility policy review, the facility failed to accommodate Resident #87's needs in creating an individualized, home-like environment, as evidenced by not providing him access to his room and bathroom for one (1) of four (4) days of observations. Findings include Review of the facility's policy titled, "Resident Rights", no date, revealed residents will be treated with consideration, respect, and full recognition of his dignity, and individuality, including privacy in treatment and in care for his personal needs.	F 558	Preparation and Submission of this plan of correction by Picayune Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of the truths of the facts alleged or the correctness of the conclusion set forth on this statement of deficiencies. The plan of correction is prepared and submitted solely pursuant the requirement under state and federal laws. 1. On 01/06/2020 Maintenance Director repositioned the bed in Resident #87's room to allow door to open. On 1/8/2020 Maintenance Director arranged furniture in the room of Resident #87 in such a way	2/21/20

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

Electronically Signed | 02/21/2020

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F 558	Continued From page 1 During the initial tour of the facility, on 1/6/2020 at 10:26 AM, an observation revealed Resident #87 was in a wheel chair, trying to propel himself into his room. The door to the resident's room would only open approximately eight (8) inches due to the door was being blocked by the end of the "D" bed that was positioned closest to the room door. During an interview, on 1/6/2020 at 10:28 AM, Resident #87 confirmed he was having a problem not being able to get back into his room. Resident #87 stated, "It happens all the time." Resident #87 also revealed he can't always get to his bed or go to the bathroom when he needs to, because when the Certified Nursing Assistants (CNAs) go in to check on or help his roommate, they forget to move the bed back, so that it doesn't block the door. During an interview, on 1/6/2020 at 11:31 AM, CNA #2 stated the resident in the "D" bed or the bed next to the door has a low bed, and for it to be moved back in place, it must be in the lowest position. CNA #2 stated that forgetting to re-position the "D" bed after providing care, has happened, but she was not sure how many times. CNA #2 stated she thinks Resident #87 pushes on the bed when he goes in and out of the room and this causes the door to be blocked. During a follow-up interview, on 1/8/2020 at 9:36 AM, Resident #87 stated he was continuing to have a problem with the door being blocked. Resident #87 stated the previous night, he was again unable to go back into his room, because they had not put his roommate's bed back. Resident #87 stated he had to wait until he could get someone's attention to move his roommate's	F 558	that bed will not block entrance of door nor impede door opening. 2. On 01/06/20 room observations were completed by Maintenance Director to ensure residents had access to rooms and bathrooms; no other issues identified. 3. On 01/10/2020 an in-service was initiated to facility staff by the Staff Development Coordinator to ensure residents have access to rooms and bathrooms. 4. Effective 01/13/2020, the Maintenance Director will conduct weekly rounds to observe for any impediments to Resident rooms or bathrooms for four(4) weeks then monthly for three(3) then monthly for and quarterly thereafter. A report of findings will be submitted by the Maintenance Director to the Quality Assurance Performance Improvement Committee monthly for three (3)months for review and recommendations. The Administrator is responsible for ongoing compliance.	

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F 558	Continued From page 2 bed before he could go into his room. Review of the Face Sheet revealed Resident #87 was admitted by the facility, on 4/14/2018, with diagnoses to include Cerebral Infarction and Hemiplegia and Hemiparesis following unspecified Cerebrovascular Disease affecting the left (L) dominant side. Review of the Resident's most recent Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/12/2019, revealed Resident #87 has a Brief Interview Mental Status (BIMS) score of fifteen (15), indicating intact cognition.	F 558		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other	F 583		2/21/20

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F 583	Continued From page 3 than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, the facility failed to provide privacy for Resident #34, during an invasive procedure, for one (1) of three (3) resident blood draw observations. Findings include: Review of the facility's policy titled, "Resident Rights", no date, revealed residents will be treated with consideration, respect, and full recognition of his dignity, and individuality, including privacy in treatment and in care for his personal needs. During an observation, on 1/6/2020 at 10:06 AM, it was revealed Resident #34 was sitting in his wheel chair next to his bed having his blood drawn, by the Phlebotomist, with the privacy curtain open. Resident #34's roommate was on his side of the room, but able to view the Phlebotomist perform the blood draw on Resident #34.	F 583	1. On 01/06/2020 The Phlebotomist from contracted laboratory provider was in-serviced on Infection Control, Privacy, Blood Draws, and Residents Rights completed by the Director of Nursing. On 01/06/2020 Resident #34 was assessed for any distress by Social Services Director with no negative outcomes. 2. On 01/10/2020 observational rounds were completed by Director of Nursing to ensure Residents were being treated with consideration, respect, and dignity; no other issues identified. 3. On 01/10/2020 staff and contract employees were in-serviced on Privacy and Residents Rights by Staff Development Coordinator to ensure privacy for residents. On 01/10/2020 facility staff were in-serviced by Staff Development Coordinator on Infection Control, Privacy, Blood Draws, and Residents Rights.	

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F 583	Continued From page 4 During an interview, on 1/6/2020 at 10:16 AM, Resident #34 stated that he wanted the curtain pulled between him and his roommate while he was getting his blood drawn. Resident #34 stated he would have appreciated having privacy. During an interview, on 1/8/2020 at 1:55 PM, the Assistant Director of Nursing (ADON), revealed the facility had called the Phlebotomist back to the facility and provided an in-service on Resident Rights, specifically about performing blood draws in a resident's room. The ADON stated the Phlebotomist signed and dated the form titled, "Inservice Training." Review of the facility's "Inservice Training" documentation, dated 1/6/2020, revealed that an in-service on the topics of Infection Control, Privacy, Blood Draws, and Resident Rights was provided by Registered Nurse (RN) #1, and received by the Phlebotomist serving the facility on 1/6/2020. Review of the Face Sheet revealed Resident #34 was admitted by the facility, on 5/13/2019, with diagnoses to include Spinal Stenosis, Lumbar region and Muscle Weakness, Review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/03/2019, revealed Resident #34 had a Brief Interview Mental Status (BIMS) score of fifteen (15), indicating intact cognition.	F 583	4. Effective 01/13/2020 Administrator, Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator will conduct weekly rounds to observe for privacy, infection control, blood draws and Resident Rights being maintained for four (4) weeks then monthly for three (3) months and quarterly thereafter. A report of the findings will be submitted by the director of nursing to the Quality Assurance Performance Committee monthly for three (3) months for review and recommendations. The Administrator is responsible for ongoing monitoring and compliance.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		2/21/20

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F 641	Continued From page 5 resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to document accurate information on the Admission Minimum Data Set (MDS) for Resident #28, for one (1) of 21 MDSs reviewed. Findings include: Review of the facility's policy titled, "Resident Assessment Instrument", revised September 2010, revealed all persons who have completed any portions of the MDS Resident Assessment Form must sign such document attesting to the accuracy of such information. Review of the Admission Minimum Data Set (MDS), under Preadmission Screening and Resident Review, Section A1500, revealed the question, "Is the resident currently considered by the state level II process to have serious mental illness and/or intellectual disability or a related condition?" and "No" was answered. Under Active Diagnoses, Section I , the diagnoses that were checked included Schizophrenia, Non-Alzheimer's Dementia, and Depression. Review of the Medical Diagnosis from admission, on 10/23/19, for Resident #28 revealed diagnoses included Schizophrenia, Depression, Parkinson's Disease and Dementia with Behavioral Disturbance. On 01/09/2020 at 11:57 AM, in an interview with the Minimum Data Set (MDS) Nurse/Registered Nurse (RN) #1, she confirmed the Admission MDS for Resident # 28 revealed under section	F 641	1. On 02/17/2020 Minimum Data Set (MDS) assessment for Resident #28 with Assessment Reference Date (ARD) 10/30/2019 was reviewed for accuracy related to coding of A1500 by the MDS nurse. Per resident Assessment Instrument (RAI) manual, A1500 is coded as yes when the Level II has been completed. No modification was indicated. 02/18/2020 facility received notification for Ascend that no level II is required for resident #28. 2. On 02/17/2020 An audit of MDS assessments submitted for the last ninety (90) days was completed by Assessment Nurse to determine accuracy of assessment related to coding of A1500; no other issues identified. 3. On 01/13/2020 an in-service was conducted by the Regional Case Mix Registered Nurse(RN) with the MDS Nurses on the requirements to accurately code MDS assessment in accordance to the Resident Assessment Instrument (RAI) Manual. 4. Effective 02/17/2020, the Director of Nursing will conduct weekly audits for four (4) weeks then monthly for three (3) months and quarterly thereafter on MDS assessments to review accuracy of coding. A report of audit findings will be submitted by the Director of Nursing to the Quality Assurance Performance	

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F 641	Continued From page 6 A1500 the question, "Is the resident currently considered by the state level II process to have serious mental illness and/or intellectual disability or a related condition?" and "No" was marked. She confirmed Section I revealed the diagnoses that included Schizophrenia, Non-Alzheimer's Dementia and Depression were checked. She confirmed the information was incorrect and should have been marked for serious mental illness because she has diagnoses of Schizophrenia and Depression. Review of the Admission Record revealed the facility admitted Resident #28, on 10/23/19, with the included diagnoses of Dementia with Behaviors, Parkinson's Disease, Depression and Schizophrenia.	F 641	Improvement Committee monthly for three (3) months for further review and recommendations. The Director Nursing is responsible for monitoring and compliance.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires	F 645		2/21/20

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F 645	Continued From page 7 specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section-	F 645		

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F 645	Continued From page 8 (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to complete the Level I Pre-Admission Screening Application for Long Term Care (PASARR) for Resident #28, for one (1) of 21 resident PASARRs reviewed. Findings include: Review of the facility's typed statement, signed and dated by the Administrator on 1/9/2020, revealed the facility follows the state regulations regarding the PASSAR. On 01/09/2020 at 11:01 AM, in an interview with the Director of Business Development/Licensed Practical Nurse (LPN) #1, she stated she was responsible for completing the Pre-Admission Screening Application for Long Term Care (PASSAR) on new admissions only and confirmed she marked "No" for Resident # 28 when asked if they have a diagnosis of Mental Illness and stated she has Schizophrenia. LPN #1 confirmed Resident # 28 has not had a Level II screening since admission and confirmed the Level I was not complete. LPN #1 stated, "It's plain as day, I messed up" and confirmed the Level I PASSAR screen was incomplete. Review of the Admission Record revealed the	F 645	1. On 01/09/2020 a significant change Level 1 Preadmission Screening Resident Review PASRR was completed and submitted to Ascend by the Risk Manager Registered Nurse for Resident #28 related to active diagnosis of Schizophrenia , Depression, Parkinson's and Dementia with Behavioral Disturbances. On 02/18/2020 facility received notification from Ascend that no Level II was required for Resident #28. 2. On 02/17/2020 Assessment Nurse and Director of Business Development, (Licensed Practical Nurse) completed an audit Preadmission Screening Resident Review of (PASRR's) Level I that were submitted in the last 90 days, checking that diagnosis were actually coded in relation to Major Mental diagnosis; no other issues identified. 3. On 01/10/2020 an in-service was conducted by the Regional Financial Specialist with Director of Business Development, LPN and billing office staff on the requirements to accurately code PASRR to capture major mental	

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F 645	Continued From page 9 facility admitted Resident #28, on 10/23/19, with the included diagnoses of Parkinson's Disease, Dementia with Behaviors, Depression and Schizophrenia.	F 645	diagnosis. 4. Effective 02/17/2020, the Director of Nursing will conduct weekly audits for four (4) weeks then monthly for three (3) months and quarterly thereafter on Preadmission Screening Resident Review (PASRR) assessments to review accuracy of coding. A report of audit findings will be submitted by the Director of Nursing to the Quality Assurance Performance Improvement Committee monthly for three (3) months for further review and recommendations. The Director of Nursing is responsible for monitoring and compliance.	

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	255141	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/07/2020**

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K 000	INITIAL COMMENTS 42 483.70(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 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to properly maintain exit egress as per NFPA 19 2.2.2.6. This deficiency practice affected four (4) of seven (7) exits and 45 of 105 residents in facility on day of survey. Findings include: On January 7, 2020 at 9:40 PM observation numerous large potholes and standing water obstructing driveway exit egress from the three (3) side exits and one (1) rear exit of the facility.	K 211	1. On January 31, 2020 a contact was signed to removed the existing concrete and replace with new concrete. Goal date of Completion is 03/10/2020. 2. On January 7, 2020 observations were done to ensure facility is maintaining egress. No other issues identified. 3. On January 7, 2020 in-service on Means of Egress - General NFPA 101 was conducted by Administrator with Maintenance. 4. Effective January 13, 2020, Maintenance Director or Assistant will make weekly observation rounds for (4) weeks then monthly for (3) months and	3/10/20

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

Electronically Signed | 02/21/2020

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K 211	Continued From page 1	K 211	quarterly thereafter. A report of findings will be submitted by the Director of Maintenance to the Quality Assurance Performance Improvement Committee monthly for three (3) months for review and recommendations. The Administrator is responsible for ongoing compliance.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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
E 000	Initial Comments ********** Survey conducted on 01/07/20 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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

Electronically Signed | 02/21/2020

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.