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	255264	A. BUILDING _____ B. WING _____	11/06/2019

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LONGWOOD COMM LIVING CENTER	200 LONG STREET/P. O. BOX 326 BOONEVILLE, MS 38829

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey along with a complaint survey, CI MS#16340, from 11/3/19 to 11/06/19. Concerns identified in the complaint were related to a facility reported incident of a resident's death after a fall. These concerns were not substantiated, and no deficiencies were cited related to the complaint. During the survey, the SA determined the facility was not in substantial compliance with requirements of participation in Medicare and Medicaid. The SA cited tags F656, F658, F693, and F759.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive 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	F 656		11/29/19

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

Electronically Signed | 11/29/2019

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 656	Continued From page 1 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to develop a Comprehensive Care Plan for Resident #37, one (1) of two (2) residents with a pressure sore, when the resident developed a pressure area of the left heel. Findings include: Review of the facility policy titled "Care Plan Committee," with no date, stated, "It is the policy of this facility that the Care Planning Committee/Team develop a comprehensive, person-centered care plan for each resident. Care plan will be modified as needed to reflect residents current status and needs." Review of the facility's "Resident Assessment," policy, dated June 1, 2000, revealed: Information	F 656	Resident number thirty- seven (#37) had a physical assessment and wound assessment performed on 11/05/2019 11:03 am by the Registered Nurse Supervisor with no negative findings noted related to no care plan initiated for wounds. The care plan was reviewed and revised to reflect current plan of care for Resident number thirty-seven (#37) on 11/05/2019 by Minimum Data Set Registered Nurse. An audit of care plans for current residents was initiated on 11/08/2019 and completed on 11/20/2019 by the Minimum Data Set Registered Nurse and Minimum Data Set Licensed Practical Nurse. Forty-two (42) residents were reviewed with forty-two (42) requiring revisions and/or updates to the care plan to reflect the current plan of care for the	

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F 656	Continued From page 2 derived from the comprehensive assessment enables the staff to plan care that allows the resident to reach his/her highest practicable level of functioning and may include: Special treatment or procedures, for example, treatment for pressure sores. Review of the facility's "Care Plan Comprehensive", undated, revealed a care plan is developed for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs. The care plan is developed within seven (7) days of the completion of the resident's assessment or within 21 days after the resident's admission, whichever comes first. Care plans are revised as changes in the resident's condition dictates. Review of Resident #37's care plan revealed that she did not have a care plan related to pressure area of the left heel which developed on 10/04/19. Review of a Transfer/Discharge Form and a Medical Diagnosis list (10/30/19), revealed resident #37 had a pressure ulcer to the left heel, stage 2. Review of the Significant Change (SC) Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/10/19, revealed the Care Area Assessment Summary (CAA) with a look back date of 10/04/19 to 10/10/19, indicated that a care plan for pressure ulcers should have been developed. The MDS noted a Stage 2 PU on admission, and an unstageable pressure ulcer on admission/readmission.	F 656	residents. Updates and revisions were completed by the Minimum Data Set Registered Nurse, Medical Records Nurse, Director of Nursing, and the Registered Nurse Supervisor by 11/29/2019. All Residents with wounds have the potential to be affected by this practice. An in-service for all nurses was initiated on 11/6/19 and completed on 11/11/19 by The Director of Nursing (DON) related to ensuring that all care plans are implemented and/or updated with any change of condition with a resident. All care plans will be checked for any residents with a change in condition, new order, and/or readmission/admission to the facility by the Director of Nursing during clinical meetings Monday through Friday and the Registered Nurse Supervisor on Saturday and Sunday with the Director of Nursing reviewing weekend changes on Monday. Any revisions or implementations of care plans will be completed at the time of the review daily by the Director of Nursing or the Registered Nurse Supervisor. The Director of Nursing will audit three (3) resident□s care plans weekly times six (6) weeks to ensure that all care plans are complete and accurate related to the resident□s current plan of care. Any found to be incomplete will be corrected by the Director of Nursing at that time. Findings will be reported to the Quality Assurance and Performance Committee monthly and	

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F 656	Continued From page 3 Interview with the Director of Nursing (DON), on 11/5/19 at 10:30 AM, revealed staff noticed a red spongy area to Resident #37's left heel on 10/04/19, and began painting the heel daily with betadine. The DON confirmed Resident #37 had no care plan related to Resident #37's left heel pressure ulcer, that developed on 10/4/19, or a care plan for the sacral pressure ulcer (that was present on admission, but had healed). Interview on 11/05/19 at 10:50 AM, with Registered Nurse (RN) #1/Minimum Data Set (MDS) Nurse, confirmed she had failed to develop a care plan on admission for Resident #37's sacrum pressure ulcer, and she failed to develop a care plan for the left heel pressure ulcer that developed on 10/04/19. She stated, "We had three (3) or four (4) admissions that week and to be honest I was just too busy and I didn't get it done; I must have forgotten to go back and add the care plan." RN #1 confirmed she failed to use the Care Area Assessment (CAA) triggers to develop a pressure ulcer care plan.	F 656	as needed for review, revision, and/or resolution.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and review of standards of practice for enteral tube placement, the facility failed to follow the professional standards of practice for	F 658	The Registered Nurse Supervisor performed gastric residual check for Resident number twenty-three (#23) Percutaneous Endoscopic Gastrostomy	11/29/19

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F 658	Continued From page 4 administration of medications via Percutaneous Endoscopic Gastrostomy (PEG) tube, for Resident #23; one (1) one (1) residents in the facility with a PEG tube. Findings include: Review of Nursing Skills and Procedures, Perry and Potter, Eighth Edition, revealed on page 333 #11, regarding enteral tubes: Check for gastric residual volume (GRV) to ensure proper tube placement. Observation on 11/04/19 at 8:48 AM, revealed Licensed Practical Nurse (LPN)#1 failed to check PEG tube placement prior to medication administration, by failure to check the gastric contents for Resident #23. Review of a physician's order, referring to the PEG tube, dated 07/18/19, revealed: "Check placement every shift and prior to medications." Interview with LPN #1 at 9:00 AM, in the hallway after leaving the resident's room, revealed she failed to check the resident's PEG tube placement and stated, "I forgot my stethoscope. I should have checked her gastric contents, but I forgot." LPN #1 confirmed that she was in-serviced to check PEG placement prior to medication administration. On 11/06/19 at 9:45 AM, interview with the Director of Nursing (DON) confirmed the nurses are in-serviced to check gastric contents prior to administering medications via a PEG tube. Record review revealed LPN #1 had signed an in-service, dated 05/07/19, titled "Medication	F 658	(PEG) tube on 11/4/2019 11:07 am with correct placement confirmed per auscultation and presence of gastric contents. Resident number twenty-three (#23) was physically assessed on 11/4/19 11:07 am by the Registered Nurse Supervisor for any negative effects related to Licensed Practical Nurse number one (#1) not checking Percutaneous Endoscopic Gastrostomy placement prior to medication administration and not flushing with water between medications with no negative findings noted. Licensed Practical Nurse number one (#1) was immediately in-serviced on 11/4/19 11:30 am by the Director of Nursing regarding checking Percutaneous Endoscopic Gastrostomy (PEG) placement by gastric residual prior to medication administration. Gastric residual was checked on all residents in the facility with a Percutaneous Endoscopic Gastrostomy (PEG) tube, one (1) resident, revealed no concerns, by The Director of Nursing (DON) on 11/4/19 11:15 am. Residents with Percutaneous Endoscopic Gastrostomy (PEG) tubes have the potential to be affected by this practice. An in-service for all nurses regarding checking gastric residual prior to administering any medications and/or enteral feedings was initiated on 11/6/19 and completed on 11/11/19 by The Director of Nursing (DON). The policy/procedure for checking gastric residual was reviewed on 11/8/19 8:00 am by The Regional Nurse Consultant for any	

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F 658	Continued From page 5 Administration Technique,". Documentation included: "Tube checked for placement."	F 658	needed revisions and/or updates with none noted. All nurses will follow the current policy for checking gastric residual. Nurses will be educated on the enteral tube policy upon hire and prior to working with any residents by the Registered Nurse supervisor. The Director of Nursing, or Registered Nurse Supervisor, or Licensed Practical Nurse Supervisor, will monitor medication administration per Percutaneous Endoscopic Gastrostomy (PEG) tube five (5) times per week for two (2) weeks, then three (3) for two (2) weeks, then one (1) for two weeks to ensure Percutaneous Endoscopic Gastrostomy (PEG) placement is checked prior to medication administration. Findings will be reported to the Quality Assurance and Performance Committee monthly and as needed for review, revision, and/or resolution.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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- §483.25(g)(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	F 693		11/29/19

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F 693	Continued From page 6 clinically indicated and consented to by the resident; and §483.25(g)(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, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to check for gastric contents to ensure proper placement and failed to flush water between each medication, to prevent complications, prior to medication administration via Percutaneous Endoscopic Gastrostomy (PEG) Tube. This affected one (1) of one (1) residents in the facility receiving medications via PEG tube. Resident #23. Findings include: Facility policy titled, "Enteral Tube Medication Administration," dated 08/09/13, revealed: Administer medication separately, flushing tube with five (5) milliliters (ml) of water after each dose. Equipment required: Medication Administration Record (MAR), prepare medications for administration as ordered. Review of Nursing Skills and Procedures, Perry and Potter, Eighth Edition, revealed on page 333 #11, to check for gastric residual volume (GRV) to ensure proper placement. On 11/04/19 at 8:48 AM, Licensed Practical	F 693	Registered Nurse Supervisor performed a placement check for Resident number twenty-three (#23) Percutaneous Endoscopic Gastrostomy (PEG) tube on 11/4/19 11:03 am with correct placement confirmed per auscultation and presence of gastric contents. Resident number twenty-three (#23) was physically assessed on 11/4/19 11:03 am by the Registered Nurse Supervisor for any negative effects related to Licensed Practical Nurse number (#1) one not checking Percutaneous Endoscopic Gastrostomy (PEG) placement prior to medication administration and not flushing with water between medications with no negative findings noted. Licensed Practical Nurse number one (#1) was immediately in-serviced on 11/4/19 11:30 am by the Director of Nursing regarding checking Percutaneous Endoscopic Gastrostomy (PEG) placement by gastric residual and water flushes between medications. Gastric residual was checked on all residents in the facility with a Percutaneous Endoscopic Gastrostomy (PEG) tube, one (1) resident, revealed no	

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F 693	Continued From page 7 Nurse (LPN) #1 failed to check gastric contents to ensure proper PEG tube placement, prior to medication administration, for Resident #23. LPN #1 administered Potassium liquid in a syringe followed by a liquid Multivitamin with minerals and allowed both medications to mix and flow by gravity through the syringe into the PEG tube. She then flushed with 15 cubic centimeter (cc) of water and continued with the rest of the resident's medications, which were administered appropriately. Review of a physician's order, dated 07/18/19, noted, referring to the PEG tube, "Check placement every shift and prior to medications." During an interview on 11/6/19 at 9:00 AM, in the hallway after leaving the resident's room, LPN #1 confirmed she failed to check the resident's PEG tube placement and stated, "I forgot my stethoscope. I should have checked her gastric contents, but I forgot." LPN #1 confirmed she was in-serviced to check PEG placement prior to medication administration. LPN #1 confirmed she failed to give the liquid potassium separate from the liquid multivitamin; she should have given it separately and used a five (5) cubic centimeter (cc) water flush between the two (2) medications. On 11/06/19 at 9:45 AM, the Director of Nursing (DON) confirmed, per interview, that the nurses are in-serviced to check gastric contents prior to administering medications via PEG tube. The DON confirmed the nurses are in-serviced not to mix medications; they should give medications separately with five (5) cc of water between each medication. Record review revealed LPN #1 had been	F 693	concerns, by The Director of Nursing (DON) on 11/4/19 11:15 am. One (1) resident medication administration observed on 11/4/19 11:58 am by the Director of Nursing, revealed no concerns. Residents with Percutaneous Endoscopic Gastrostomy (PEG) tubes have the potential to be affected by this practice. An in-service for all nurses regarding checking gastric residual prior to administering any medications and/or enteral feedings and flushing with water between medications was initiated on 11/6/19 and completed on 11/11/19 by the Director of Nursing. The policy/procedure for checking gastric residual and medication administration per Percutaneous Endoscopic Gastrostomy (PEG) tube was reviewed on 11/8/19 8:00 am by The Regional Nurse Consultant for any needed revisions and/or updates with none noted. All nurses will follow the current policy for checking gastric residual and flushing with water between medications. All nurses will follow the current policy for checking gastric residual. All nurses will be educated on the medication administration policy and Enteral tube policy upon hire and prior to working with any residents by the Registered Nurse Supervisor. The Director of Nursing, or Registered Nurse Supervisor, or Licensed Practical Nurse Supervisor, will monitor medication administration per Percutaneous Endoscopic Gastrostomy (PEG) tube five	

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F 693	Continued From page 8 provided an in-service, dated 05/07/19, titled, "Medication Administration Technique," and the in-service noted, "Tube checked for placement."	F 693	(5) times per week for (2) two weeks, then three (3) for two (2) weeks, then one (1) for (2) two weeks to ensure Percutaneous Endoscopic Gastrostomy (PEG) placement is checked prior to medication administration and flushes are performed between medications. Findings will be reported to the Quality Assurance and Performance Committee monthly and as needed for review, revision, and/or resolution.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to ensure a medication error rate less than five (5) percent (%) as evidenced by failure to follow Physician orders for correct dosage of nasal spray; and, failure to administer medications separately via Percutaneous Endoscopic Gastrostomy (PEG) tube for Resident #23. Three (3) medication errors out of 44 opportunities during medication pass resulted in a medication error rate of 6.82 %. Findings include: Facility policy titled, "Enternal Tube Medication Administration," dated 08/09/13, revealed: Administer medication separately, flushing tube	F 759	Resident number twenty-three (#23) was physically assessed on 11/4/19 11:03 am by the Registered Nurse Supervisor for any negative effects related to Licensed Practical Nurse number one (#1) not flushing with water between medications and not administering the full dose of a nasal spray with no negative findings noted. Licensed Practical Nurse number (#1) one was immediately in-serviced on 11/4/19 11:30 am by The Director of Nursing (DON) regarding administering water flushes between medications and administering all medications as ordered. An in-service for all nurses regarding medication administration and following physician orders was initiated on 11/6/19	11/29/19

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F 759	Continued From page 9 with five (5) milliliters (ml) of water after each dose. Equipment required: Medication Administration Record (MAR), prepare medications for administration as ordered. Observation on 11/04/19 at 8:48 AM, revealed Licensed Practical Nurse (LPN) #1 administered medications to Resident #23 through a PEG tube. She placed Potassium liquid in a syringe followed by a liquid Multivitamin with minerals and allowed both medications to mix and flow by gravity through the syringe. She then flushed with 15 cubic centimeter (cc) of water and continued with the rest of the resident's medications. LPN #1 administered Flonase nasal spray to Resident #23 and gave one (1) puff to each nare. Review of a physician's order, dated 06/11/19, revealed: Flonase Suspension two (2) puffs in each nostril one (1) time a day. Interview with LPN #1 at 9:00 AM, in the hallway after leaving the resident's room, confirmed she failed to give the liquid potassium separate from the liquid multivitamin; she should have used a five (5) cubic centimeter (cc) water flush between the two (2) medications. LPN #1 confirmed she administered one (1) puff of Flonase nasal spray to each nare of Resident #23 instead of two (2) puffs per the physician's order. LPN #1 stated, "I always give her just one (1) puff, she doesn't want two (2) puffs." LPN #1 confirmed she had not notified the doctor to have the medication dosage re-evaluated or changed. Interview with the Director of Nursing (DON) on 11/06/19 at 9:45 AM, confirmed the nurses are in-serviced and they are not to mix medications; they should give medications separately with five	F 759	by the Director of Nursing and completed on 11/11/19. The Facility Pharmacy Consultant performed medication administration education on 11/22/2019, 9 am for nurses. All nurses will follow the current medication administration policy. All nurses will be educated on the medication administration policy upon hire and prior to working with any residents by the Registered Nurse Supervisor. One (1) resident medication administration per Percutaneous Endoscopic Gastrostomy (PEG) tube observed on 11/4/19 11:15 am by the Director of Nursing, revealed no concerns. Medication administration observed for (6) six residents on 11/07/2019 by the Director of Nursing, revealed no concerns. Residents with medications administered by the facility nursing staff have the potential to be affected by this practice. An in-service for all nurses regarding medication administration and following physician orders was initiated on 11/6/19 by the Director of Nursing and completed on 11/11/19. The Facility Pharmacy Consultant performed medication administration education on 11/22/2019, 9 am for nurses. All nurses will follow the current medication administration policy. All nurses will be educated on the medication administration policy upon hire and prior to working with any residents by the Registered Nurse Supervisor. The Director of Nursing, or Registered Nurse Supervisor, or Licensed Practical	

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(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 759	Continued From page 10 (5) cc of water between each medication.	F 759	Nurse Supervisor will monitor medications administration five (5) times per week for two (2) weeks, then three (3) times for two (2) weeks, then one (1) time for two (2) weeks to ensure proper medications administration as ordered. Findings will be reported to the Quality Assurance and Performance Committee monthly and as needed for review, revision, and/or resolution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255264	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/06/2019**

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LONGWOOD COMM LIVING CENTER	**200 LONG STREET/P. O. BOX 326** **BOONEVILLE, MS 38829**

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

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

Electronically Signed | 11/30/2019

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
	255264	A. BUILDING _____ B. WING _____	11/06/2019

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E 000	Initial Comments ********** Survey conducted on 11/06/19 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 | 11/30/2019

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