STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255247	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN HEALTH AND REHABILITATION	103 CUNNINGHAM DRIVE RIPLEY, MS 38663

(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 from 1/28/2020 to 1/30/2020. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid regulations of participation and cited deficiencies at F656 and F690. The census at the time of the survey was 49, and the facility was licensed for 60 beds.	F 000		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		2/28/20

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

Electronically Signed | 02/27/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255247	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN HEALTH AND REHABILITATION	103 CUNNINGHAM DRIVE RIPLEY, MS 38663

(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 657	Continued From page 1 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review, the facility failed to revise the care plans for residents with an indwelling catheter, to include catheter strap use, for three (3) of four (4) care plans reviewed, Resident #1, #16, and #33. Findings include: Review of the facility's "Comprehensive Care Plan" policy, dated March 2019, revealed: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with residents rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the residents comprehensive assessment. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly Minimum Data Set (MDS) assessment. Resident #1 A record review of Resident #1's foley catheter care plan, revealed, the interventions failed to address securing the catheter to prevent complications. During an observation of Resident #1's catheter care, on 01/30/2020 at 8:08 AM, Certified Nursing Assistant (CNA) #1 revealed Resident #1 did not have a catheter strap in place to secure the Foley catheter to prevent possible trauma. CNA #1 stated that she didn't think any of the residents	F 657	Resident #1,#16,and #33 was immediately evaluated on 1/30/2020 by Registered Nurse with no adverse reaction noted or trauma to area of catheter insertion noted. Catheter leg straps were purchase and applied on 1/30/2020 according to facility policy. Minimum Data Set Nurse Care planed each resident with the catheter leg scrap according to facility policy and procedure. An in-service was immediately conducted by the Nurse Educator on 1/30/2020 with all certified nurse aide, License Practical Nurse, all Registered Nurses, Treatment Nurse Director of Nursing, Minimum Data Set Nurse, Medical Record Nurse, Unit Manager, and Social Service on the incontinent Management Standard on indwelling catheter care according to the facility's policy and procedure. An in-service was conducted by the Nurse Educator on 2/20/2020 with the Minimum Data Set Nurse on Comprehensive Care Plan policy located in the facility's Resident Centered Care Plan Standard. " The facility has determined that all residents who reside in the facility with an order for a catheter have the potential to be affected by this deficient practice. After reviewing all residents who have an order for a indwelling catheter on 2/3/2020, five out of fifty residents have the potential to be affected by this deficient practice of failure to revise the care plans for residents with an indwelling	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255247	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN HEALTH AND REHABILITATION	103 CUNNINGHAM DRIVE RIPLEY, MS 38663

(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 657	Continued From page 2 with catheters, had a catheter strap in place. On 01/30/2020 at 10:00 AM, during an interview with the Director of Nursing (DON), she confirmed Resident #1's care plan for a foley catheter did not address securing the catheter tubing, and it should be on the care plan. Resident #16 During an interview and observation of catheter care, on 01/29/2020 at 11:30 AM, Resident #16 was noted without a catheter leg strap to secure the tubing. CNA #2 stated they didn't use the leg straps often. On 01/30/2020 at 9:55 AM, during an interview and review of Resident #16's foley catheter care plan related to Urinary Retention, the DON revealed the facility's catheter care policy stated a leg strap was needed to prevent trauma. The DON stated the leg straps needed to be used and care planned. The DON confirmed the facility failed to include an intervention for the use of a catheter strap for Resident #16. Resident #33 Record review of Resident #33's foley catheter care plan, revealed, the interventions failed to address securing the catheter to prevent complications. On 01/30/2020 at 9:11 AM, during an observation with Registered Nurse (RN) #2, she confirmed Resident #33's catheter tubing was not secured to her leg. During an interview, on 01/30/2020 at 9:25 AM, RN #2 confirmed Resident #33's catheter care plan did not address the placement of a device to	F 657	catheter, to include catheter leg strap for securing the catheter. " All Certified Nurse Aide, Registered Nurses and License Practical Nurses have been in-service on the policy and procedure of "indwelling catheter care" by the Nurse Educator on 1/30/2020.The in-service training included all resident with an indwelling catheter will have a leg strap to secure it to the resident to ensure compliance with the facility's policy and procedure. " The nursing management staff which consists of Director of Nursing, Unit Manager, and RN Supervisor, will conduct random observation rounds weekly for 30 day starting on 2/10/20 and then monthly for three months to ensure that all catheter leg strap are applied and in place in accordance with the policy and procedure of indwelling catheter care policy in the facility's incontinent management standard. Any concerns noted will be immediately corrected by the nursing management staff and reviewed by the rest of the Interdisciplinary team and Quality Assurance committee which consist of Administrator, Director of Nursing, Unit Manager, Dietary Manager, Nurse Educator, Medical Records Nurse, Social Service Director, Activity Director and Medical Director to ensure compliance with indwelling catheter care is maintain. QA committee will make necessary recommendation as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255247	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN HEALTH AND REHABILITATION	103 CUNNINGHAM DRIVE RIPLEY, MS 38663

(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 657	Continued From page 3 secure her catheter. On 01/30/20 at 10:00 AM, during an interview with the DON, she confirmed Resident #33's care plan for a foley catheter did not address securing the catheter tubing. The DON stated it should be addressed on the care plan.	F 657		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690		2/28/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255247	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN HEALTH AND REHABILITATION	103 CUNNINGHAM DRIVE RIPLEY, MS 38663

(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 690	Continued From page 4 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to secure an indwelling catheter to prevent possible trauma or dislodgement, for three (3) of four (4) residents observed with a foley catheter, Resident #1, #16, and #33. Findings Include: Review of facility's "Incontinence Management - Indwelling Catheters" policy, dated 01/2020, revealed, to reduce tension on the catheter and in and out movement, the catheter will be secured with a catheter leg strap or other securing device. Backward and forward movement can introduce contaminants into the urinary tract. Resident #1 On 01/30/2020 at 8:08 AM, during an interview and observation of catheter care, with Certified Nursing Assistant (CNA) #1, revealed, Resident #1 did not have a catheter leg strap in place to secure the foley catheter. CNA #1 stated none of the residents with foley catheters have leg straps in place. On 01/30/2020 at 9:55 AM, an interview with the Director of Nursing (DON), revealed all residents with catheters should have a strap to secure it to prevent pulling and trauma. The DON stated they had not been using leg straps, because she	F 690	" Resident #1,#16,and #33 was immediately evaluated on 1/30/2020 by Registered Nurse with no adverse reaction noted or trauma to area of catheter insertion noted. Catheter leg straps were purchased and applied on 1/30/2020 according to facility policy. Minimum Data Set Nurse Care planned each resident with the catheter leg scrap according to facility policy and procedure. An in-service was immediately conducted by the Nurse Educator on 1/30/2020 with all certified nurse aide, License Practical Nurse #2, all Medication Nurses, all Registered Nurses, Treatment Nurse Director of Nursing, Minimum Data Set Nurse, Medical Record Nurse, Unit Manager, and Social Service on the incontinent Management Standard on indwelling catheter care according to the facility's policy and procedure. An in-service was conducted by the Nurse Educator on 2/20/2020 with the Minimum Data Set Nurse on Comprehensive Care Plan policy located in the facility's Resident Centered Care Plan Standard. " The facility has determined that all residents who reside in the facility with an order for a catheter have the potential to be affected by this deficient practice. After reviewing all residents who have an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255247	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN HEALTH AND REHABILITATION	103 CUNNINGHAM DRIVE RIPLEY, MS 38663

(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 690	Continued From page 5 wasn't aware that it was in the facility's policy. The DON stated they needed to do education for all staff. Resident #16 On 01/29/2020 at 11:30 AM, during an interview and observation of Resident #16's catheter care, Resident #16 was noted without a catheter leg strap in place, and the catheter tubing was not secured or anchored to prevent excessive tension. CNA #2 stated they didn't use the leg straps often. Licensed Practical Nurse (LPN) #1 stated the velcro leg straps would only hold for a couple of days, before the velcro wouldn't stick. LPN #1 revealed there was a need to secure the catheter to prevent trauma. An interview with the DON, on 01/30/2020 at 9:55 AM, revealed, she stated a catheter strap was needed to prevent trauma. The DON revealed the facility was not using leg straps to secure catheters. The DON stated residents with catheters should have leg straps. Resident #33 During an observation and interview, on 01/30/2020 at 9:11 AM, Registered Nurse (RN) #2, confirmed Resident #33's catheter tubing was not secured to her leg. RN #2 revealed not having the foley catheter tubing secured, could cause pain or trauma. RN #2 stated Resident #33 should have a "Stat Lock" or some other device to secure the catheter. During an interview, on 01/30/2020 at 9:55 AM, the DON stated all residents with catheters should have a strap to secure it, and to prevent pulling and trauma. The DON stated they had not been using leg straps, because she was not aware it was in their policy. She stated they	F 690	order for an indwelling catheter on 2/3/20, five out of fifty residents have the potential to be affected by this deficient practice of failure to secure catheter with a leg strap to prevent movement of the catheter. " All Certified Nurse Aide, Registered Nurses and License Practical Nurses have been in-service on the policy and procedure of "indwelling catheter care" by the Nurse Educator on 1/30/2020.The in-service training included that all resident with an indwelling catheter will have a leg strap to secure it to the resident to ensure compliance with the facility's policy and procedure. " The nursing management staff which consists of Director of Nursing, Unit Manager, and RN Supervisor, and will conduct random observation rounds weekly for 30 day on 2/10/20 and then monthly for three months to ensure that all catheter leg strap are applied and in place in accordance with the policy and procedure of indwelling catheter care policy in the facility's incontinent management standard. Any concerns noted will be immediately corrected by the nursing management staff and reviewed by the rest of the Interdisciplinary team and Quality Assurance committee which consist of Administrator, Director of Nursing, Unit Manager, Dietary Manager, Nurse Educator, Medical Records Nurse, Social Service Director, Activity Director and Medical Director to ensure compliance with indwelling catheter care is maintain. QA committee will make necessary recommendation as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255247	A. BUILDING _____ B. WING _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN HEALTH AND REHABILITATION	103 CUNNINGHAM DRIVE RIPLEY, MS 38663

(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 690	Continued From page 6 needed to do education for all staff.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255247	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/05/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN HEALTH AND REHABILITATION	**103 CUNNINGHAM DRIVE** **RIPLEY, MS 38663**

(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 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 | 02/27/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255247	A. BUILDING _____ B. WING _____	02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST HAVEN HEALTH AND REHABILITATION	103 CUNNINGHAM DRIVE RIPLEY, MS 38663

(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 * EMERGENCY PREPAREDNESS * Survey conducted on 2/5/20 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

Electronically Signed | 02/27/2020

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.