STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255174	A. BUILDING _____ B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINGING RIVER HEALTH AND REHABILITATION CENTER	3401 MAIN STREET MOSS POINT, MS 39563

(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 recertification survey from 11/12/19 through 11/14/19. During the survey, the SA determined the facility was not in compliance with the Medicare and Medicaid Requirements of participation. The SA cited deficiencies at F550, F585, F623, F625, F637, F656, F658, F690, and F850. The facility was licensed for 160 beds and had a census of 100 at the time of survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		12/27/19

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

Electronically Signed | 12/06/2019

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 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to assist two (2) of three (3) residents to vote in the general election. Resident #92 and Resident #3. Findings include: Review of the facility policy, "Voting and Community/ Citizenship Activities", dated 11/2017, revealed the Center will encourage and assist, where appropriate and reasonable, the resident to participate in the resident's community and citizenship activities of choice (i.e., voting ...). Resident #92 On 11/14/19 at 10:00 AM, interview with Resident #92 revealed he did not get to vote in the Governor's election on 11/5/19. Resident #92 stated she would have voted, if taken to vote. The facility admitted Resident #92 on 5/29/1998, and her most recent Brief Interview for Mental Status	F 550	Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged in the statement of deficiencies. This Plan of Correction is prepared solely as a matter of compliance with the Federal and State law. 1) The General Election on 11/5/2019 is in the past, so Center is unable to correct for the Governor□'s election for Residents #92 and #3. The Admissions Coordinator contacted the Election Commission Department of the County on 12/3/19 to determine election dates for 2020. Starting 1/1/2020, lists will be made by Social Services quarterly to determine who wishes to vote in person and who wishes to vote via absentee ballot. Starting 1/1/2020, this process will be updated and reviewed by Social Services	

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F 550	Continued From page 2 (BIMS), dated 10/18/19, revealed a score of 15, which indicated Resident #92 had no cognitive impairment. Resident #3 On 11/14/19 at 10:55 AM, interview with Resident #3 revealed she did not get to vote in the recent 11/5/19 general election. Resident #3 stated, "No, and I like to vote. Usually they drive us to vote." The facility admitted Resident #3 on 9/11/2014. Review of the most recent BIMS assessment, dated 10/17/19, revealed Resident #3 scored 15, which indicated no cognitive impairment. On 11/14/19 at 10:09 AM, in a phone interview, Social Worker #1 stated she did not know if the residents got to vote, because she had been out on sick leave since October 18, 2019. On 11/14/19 at 11:54 and 11:58 AM, interview with Administrator revealed he was not sure if the residents got to vote on 11/5/2019, for the Governor's election. The Administrator confirmed he was responsible since the Social Worker was on medical leave.	F 550	prior to any General Election. Starting 12/02/2019 and continuing until 12/18/2019, residents will be polled by the Activities Director to ask about interest in voting. All interested residents will receive assistance with registering to vote by the Activities Director by 12/20/2019. 2) Residents will be polled no later than 12/18/19 by Activities Director to ask about their interest in voting to determine potential to be affected by this issue. All interested residents will receive assistance with registering to vote by 12/20/2019. The next General Election, these residents will be taken to the voting location by our transportation as directed by the Activities Director and/or assisted with absentee ballots. 3) The Administrator and Admissions Coordinator will be assigned as formal backups beginning 12/1/2019 for the assistance of residents to exercise their right to vote. The administrator, Admissions Coordinator, and Social Services Director were in-serviced by the Nurse Consultant on 12/6/2019 on center policy regarding resident voting rights/activities. 4) Starting 12/20/2019, the Administrator and Admissions Coordinator will review new admissions each quarter to determine interest in voting. If a resident is interested, he/she will be added to the list of voters. Any resident who is not registered to vote, will receive assistance by the Activity Director in registering to	

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F 550	Continued From page 3	F 550	vote. When an election is scheduled, residents interested in voting will be asked by the Activity Director if they wish to vote via absentee ballot or by onsite voting with transportation provided on Election Day. Starting 1/1/2020, the system will be audited by the Administrator quarterly to ensure voting rights have been upheld per resident wishes. Results of these audits will be brought by the Administrator to the Quality Assurance Performance Improvement (QAPI) meeting quarterly with recommendations as needed to ensure continued compliance.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		12/27/19

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F 585	Continued From page 4 §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being	F 585		

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F 585	Continued From page 5 investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to resolve grievances for one (1) of 21 Residents interviewed for grievances, Resident #65. Findings Include:	F 585	1) Resident #65□s missing money was replaced by the Administrator on November 14, 2019 with her receipt signed to show paid. Resident #65 was satisfied with this resolution. 2) An audit was started and completed on	

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F 585	Continued From page 6 Review of the facility policy " Investigating Grievances", dated April 2018, revealed the facility will investigate all grievances filed and make a prompt effort to resolve all complaints/grievances. The department Director of the involved employee or practice will be notified of the nature of the grievance and that an investigation is underway. The resident, or person acting on behalf of the resident, will be verbally informed of the findings of the investigation, as well as any corrective actions recommended, within a reasonable time of filing of the grievance. Resident #65 Review of the September 2019 Grievance Log, revealed a grievance filed on 9/25/19, and closed on 9/30/19 for Resident #65. Review of the facility's investigation form for the grievance, revealed Resident #65 reported missing money and a credit card holder from the pouch of her wheel chair, to the Social Worker, either on 9/21/19 or 9/22/19. The investigation revealed the resident's wheelchair was removed from her room for cleaning on the 11-7 shift. There was no documented evidence the resident was made aware of the results and/or that the grievance was resolved to the satisfaction of the resident. There was no documented evidence the resident's money was refunded. Interview on 11/13/19 at 12:00 PM, with Resident #65, revealed the Certified Nursing Assistants (CNAs) on night shift removed her wheelchair to wash it a couple of times and did not inform her. Resident #65 also stated when her wheelchair was returned, the money pouch did not have her	F 585	12/06/19 of grievances for the past 3 months, by Administrator, to ensure follow up was completed for each grievance to determine if any other resident had the potential to be affected by this issue; no other issues were found unresolved by this audit. 3) The Administrator and Admissions Coordinator were assigned as formal backups on 12/1/2019 for the handling and resolution of formal grievances via in-service; these designees, along with the Social Services Director, were in-serviced by the Nurse Consultant on 12/6/2019 on Center policy regarding grievances and, before closing out an open grievance, the Administrator (or Director of Nursing in the absence of the Administrator) will personally follow-up with the resident/person filing grievance to ensure a satisfactory resolution and notate this meeting on the grievance form. In-addition, all second (3p-11p) and third-shift (11p-7a) CNAs will be in-serviced to inform cognitive residents of scheduled wheelchair-cleaning days. 4) Starting 12/20/2019, a monthly audit will be performed by the Administrator on all filed grievances, times four months, to ensure compliance with this plan of correction. Results of these audits will be brought by the Administrator to the Quality Assurance Performance Improvement (QAPI) meeting quarterly with recommendations as needed to ensure continued compliance.	

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F 585	Continued From page 7 $20.00 in it. Resident #65 stated she reported the missing money to the Social Worker and the Administrator. Resident #65 said she was not told the outcome of the investigation and no one offered to give her money back. Telephone interview on 11/14/19 at 12:17 PM, with the Social Worker, revealed the grievance for Resident #65's missing money was turned over to the Risk Manager to resolve. The Social Worker said the Administrator and the Risk Manager was responsible for that grievance. Interview on 11/14/19 at 12:30 PM, with The Administrator, confirmed facility staff removed the wheelchair on night shift to clean it and did not wake the resident up and let her know the wheelchair was going to be washed. The Administrator said the staff will be in-serviced to let cognitive residents know when their wheelchairs will be removed for cleaning purposes. The Administrator said he thought the Risk Manager had given the resident her money. The Administrator did not have a receipt. The Administrator presented a receipt dated November 14, 2019 for $20.00 to Resident #65. Review of Resident #65's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/20/2019, revealed Resident #65 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had no cognitive impairment.	F 585		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a	F 623		12/27/19

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F 623	Continued From page 8 resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.	F 623		

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F 623	Continued From page 9 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon	F 623		

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F 623	Continued From page 10 as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to notify the resident/Responsible Party, and Ombudsman, in writing, of hospital transfers, including the reasons for transfer, for two (2) of five (5) residents reviewed for hospitalization, Resident #20 and Resident #32. Findings include: Review of the Facility Policy, "Documentation of Transfers/Discharges", dated November 2001, revealed: When a resident is transferred or discharged, his or her medical records shall be documented as to the reasons why such action was taken. Documentation from the care planning team concerning all transfers or discharges must include, as a minimum, and as they may apply: A. The reason for the transfer. B. That an appropriate notice was provided to the resident/representative. Resident #32 Review of Resident #32's medical record	F 623	1) Transfer notices for Residents #20 and #32 were sent to the Resident/Responsible Party and Ombudsman in writing on 12/06/19 by the Staff Development Coordinator 2) Starting 12/1/2019 through 12/13/2019, an audit of the prior two months of hospital transfers was completed by the Staff Developer; any resident who was transferred to the hospital without a transfer notice had a notice sent by the Staff Developer to the Resident/Responsible Party and Ombudsman in writing. 3) On 12/1/2019, the Administrator and Admissions Coordinator were assigned as formal backups for the provision of Transfer/Discharge Notices via in-service; these designees were in-serviced by the Nurse Consultant on 12/6/2019 on Center policy regarding Notice of Bed Holds Before/Upon Transfer requirements. The	

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F 623	Continued From page 11 revealed there was no documented evidence the resident/representative or the Ombudsman was notified, in writing, of a hospital transfer for Resident #32, on 8/14/19. Review of the Physician Orders, dated 8/14/2019, revealed orders to send Resident #32 to the Emergency Room of the local hospital, related to "increased confusion, incontinent episodes, unlike behavior". On 11/13/19 at 2:11 PM, interview with the Director of Nursing revealed Resident #32 was transferred and admitted to the hospital on 8/14/19, and returned on 8/16/2019. On 11/14/19 at 10:56 AM, interview with the Administrator confirmed the facility did not mail a letter to the Responsible Party regarding Resident #32's hospital transfer on 8/14/2019. Resident #20 Review of Resident #20's medical record revealed there was no documented evidence the facility had provided the resident, Resident Representative and/or Ombudsman, of written transfer notices when the resident was sent to the hospital on five (5) different occasions. Review of the Minimum Data Set (MDS), with Assessment Reference Dates (ARDs) of 7/31/2019, 8/20/2019, 8/26/2019, 8/29/2019, and 9/5/2019, revealed they all documented acute hospital and/or unplanned discharge, with anticipation to return back to the facility. Interview on 11/14/19 at 11:54 AM, with the Administrator, confirmed the facility failed to send	F 623	Social Services Director hired in on 12/09/19 was also be in-serviced on this policy by the Nurse Consultant on 12/09/19. Additionally, all transfers to the hospital will be discussed in regular Morning Meeting (Monday-Friday) to ensure that a Transfer/Discharge notice has been created, signed and mailed/given to the Resident/Responsible Party and the resident□s name added to the monthly Ombudsman list. 4) Starting 12/20/2019, a monthly audit related to transfer/discharge notices to resident/responsible party and ombudsman will be performed by the Administrator on all residents transferred to the hospital, times four months, to ensure compliance with this plan of correction. Results of these audits will be brought by the Administrator to the Quality Assurance Performance Improvement (QAPI) meeting quarterly with recommendations as needed to ensure continued compliance.	

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F 623	Continued From page 12 the hospital transfer notices to the family and Ombudsman for Resident #20 and Resident #32. The Administrator stated it was the responsibility of the Social Worker to make sure the letters go out. The Administrator confirmed he was responsible for the duties of the Social Worker for the last four (4) weeks, because she was out on Family Medical Leave (FMLA). During a telephone interview, on 11/14/19 at 12:31 PM, the Social Worker confirmed she was responsible for the Ombudsman letter for resident transfers. The Social Worker said she was not responsible for sending out the hospital transfer letters to family/resident. The Social Worker said the facility had not decided who would be responsible for the hospital transfer letters.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	F 625		12/27/19

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F 625	Continued From page 13 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and policy review, the facility failed to provide a written bed hold notice to the resident and/or resident representative, at the time of transfer to an acute care setting, for three (3) of five (5) hospitalizations reviewed, Resident #20, Resident #32, and Resident #69. Findings include: Review of the facility's "Bed Hold Policy", dated 2/1/2005, revealed: The resident/responsible party/will be asked to sign a bed hold authorization. The authorization will be specific to the length of time the authorization is valid and the daily rate for the bed hold. A new bed hold authorization will be completed for each absence from the facility. Resident #20 Review of the Minimum Data Set (MDS) Assessments, for Resident #20, revealed Assessment Reference Dates (ARDs) of 9/5/2019, 8/29/2019, 8/26/2019, and 8/20/2019, when the resident was discharged to an acute care hospital, and 7/31/2019 for an unplanned discharge; all with anticipation to return back to	F 625	1) On 12/06/19, bed hold notices were sent to Resident/Representative for Residents #20, #32, and #69 by Staff Development Coordinator. 2) Between 12/02/2019 and 12/13/2019, an audit of the prior two months of hospital transfers was completed by the Staff Developer to ensure bed hold notices were sent; any resident who was transferred to the hospital without a bed hold notice had a notice sent to the Resident/Responsible Party in writing by the Staff Developer. 3) On 12/1/2019, the Administrator and Admissions Coordinator were assigned as formal backups for the provision of Bed Hold Policy Notices via in-service; these designees were in-serviced by the Nurse Consultant on 12/6/2019 on Center policy regarding Notice of Bed Holds Before/Upon Transfer requirements. The Social Services Director hired in on 12/09/19 was also be in-serviced on this policy by the Nurse Consultant on 12/09/19. Additionally, all transfers to the	

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F 625	Continued From page 14 the facility. During an interview, on 11/14/19 at 11:54 AM, the Administrator confirmed the facility failed to send the written Bedhold letters to the resident/family. The Administrator said it was the responsibility of the Social Worker (SW) to make sure the letters go out. The Administrator stated he was, however, responsible for the duties of the SW for the last four (4) weeks, due to the SW had been out on Family Medical Leave. During a telephone interview, on 11/14/19 at 12:31 PM, the SW stated she was not responsible for sending out the bedhold letters or the hospital transfer letters. The SW stated the facility had not decided who would be responsible for the Bedhold and hospital transfers letters, that she was aware of. Resident #32 Review of the Physician Orders, dated 8/14/2019, revealed an order to send Resident #32 to the local Emergency Room (ER) for increased confusion, incontinent episodes, and unlike behavior. During an interview, on 11/13/19 at 2:11 PM, the Director of Nursing confirmed Resident #32 was admitted to hospital on 8/14/2019, and returned to the facility on 8/16/2019. On 11/14/19 at 10:56 AM, an interview with the Administrator revealed the facility did not provide a written bedhold notice to the resident and/or resident representative for Resident #32's hospital transfer/admission, on 8/14/19. Resident #69	F 625	hospital will be discussed in regular Morning Meeting (Monday-Friday) to ensure that a Bed Hold Notice has been created, signed and mailed/given to the Resident/Responsible Party. 4) Starting 12/20/2019, a monthly audit will be performed by the Administrator on all residents transferred to the hospital, times four months, to ensure compliance with the bed hold requirements. Results of these audits will be brought by the Administrator to the Quality Assurance Performance Improvement (QAPI) meeting quarterly with recommendations as needed to ensure continued compliance.	

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F 625	Continued From page 15 Review of the medical record revealed Resident #69 was transferred to the hospital on 9/13/2019, and was re-admitted to the Nursing Home on 9/14/2019. There was no evidence in chart of notification to the resident and/or resident representative, in writing, of the bed hold agreement. During an interview, on 11/13/19 at 4:14 PM, the Staff Development Nurse revealed they could not find the bed hold authorizations/notifications for Resident #69's hospital transfer on 9/13/19.	F 625		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) and initiate a significant change in status assessment (SCSA) MDS, related to hospice for three (3) of (26) resident Minimum Data Set (MDS) assessments reviewed, Resident #45, Resident #71, and Resident #76.	F 637	1) On 11/20/19, the Minimum Data Set (MDS) for Residents #45, #71 and #76 were audited and corrected for Hospice services (via modification request) for the dates of each original significant change going forward by the MDS Coordinator. 2) A full audit was started and completed	12/27/19

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F 637	Continued From page 16 Findings include: A review of the facility's policy, "Resident Assessment", dated November 2017, revealed a comprehensive assessment of a resident's needs shall be made following the guidelines set forth in the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual. (The RAI manual, October 2017, documents anytime a resident is admitted to Hospice, changes Hospice Services, or discharges from Hospice, a SC MDS must be initiated.) Resident #45 Review of the medical record revealed there was no Significant Change in Status Assessment (SCSA) MDS completed after Resident #45 was admitted to hospice services on 1/15/19. A review of the facility's Face Sheet revealed, Resident #45 was admitted on 11/14/18. Review of the Physician's Order Sheet, revealed Resident #45 had hand-written orders to admit to Hospice, dated 1/15/19, for a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). On 11/13/19 at 3:11 PM, an interview with Registered Nurse (RN) #1 confirmed Resident #45 did not have a SCSA MDS assessment completed after she was admitted to hospice services. Resident #71 Record review revealed the most recent quarterly MDS assessment, with an ARD of 10/1/19, and a SCSA MDS, with an ARD of 7/1/19, did not	F 637	on 11/13/19 by the MDS Coordinator to ensure no other MDS assessments were coded incorrectly with regards to hospice services; no other MDS assessments were found to be coded incorrectly. 3) On 12/6/19, the MDS nurses were in-serviced on facility policy regarding Resident Assessments to include hospice admissions/discharges by the Director of Nursing (DON). 4) The MDS Nurse will bring all new physician orders to regular (Monday □ Friday) standup meetings and on any new orders related to Hospice care, the significant change date will be set within fourteen (14) days. Starting 12/20/2019, the MDS Coordinator will audit MDS assessments with regards to hospice services quarterly. Results of these audits will be brought by the MDS Coordinator to the Quality Assurance Performance Improvement (QAPI) meeting quarterly with recommendations as needed to ensure continued compliance.	

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F 637	Continued From page 17	F 637		

include Resident #71's admission or discharge from Hospice services.

Review of the physician orders, dated 7/07/19, revealed an order for Resident 71's admission to Hospice. A physician order dated 9/3/19, indicated to discharge Resident #71 from Hospice.

On 11/13/19 at 10:31 AM, interview with RN #1 revealed there was not a SCSA completed for the admission of Resident #71 to hospice services on 7/7/19. RN #1 also stated there should be a SCSA MDS completed anytime a resident goes on hospice services and comes off of hospice services, and there was not a SCSA completed after Resident #71 was discharged from hospice services on 9/3/19.

On 11/13/19 at 10:37 AM, an interview with RN #2 revealed she would expect the MDS to be coded accurately.

On 11/13/19 at 11:22 AM, an interview with LPN #1 revealed she did not complete a SCSA MDS assessment when Resident #71 had gone on hospice services, but knows she should have. She stated she didn't think she needed to complete a SCSA MDS when the resident comes off hospice. LPN #1 stated she used the RAI manual for completing the MDS assessment and there was not a SCSA completed after the resident was discharged from hospice services.

On 11/14/19 at 10:45 AM, interview with LPN #1 revealed, she attends a yearly state MDS training and yes, a SCSA should have been done for when Resident #71 was admitted on hospice services 7/7/19.

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F 637	Continued From page 18 Resident #76 Review of the Quarterly MDS, with an ARD of 10/3/2019, revealed Hospice Care was not checked for Resident #76. There was no documented SC MDS for Resident #76, related to hospice services, when the resident was admitted to hospice on 2/21/19. Review of the Physician Orders, dated 2/21/2019, revealed an order to admit Resident #76 to Hospice. On 11/13/2019 at 11:04 AM, an interview with Registered Nurse #1 revealed that the Quarterly MDS for Resident #76 was not coded correctly, nor was a significant change completed with an admission to Hospice, following the Physician Order on 2/21/2019. RN #1 stated they have 14 days to complete the Significant Change, but it was not performed. On 11/13/19 at 1:32 PM, an interview with the Director of Nursing (DON) revealed she would expect the MDS to be completed in a timely manner and to be accurate to reflect the resident's current status. On 11/13/19 at 3:20 PM, an interview with RN #1 revealed if the facility does not complete a SCSA when the resident goes on or come off of hospice services, then the MDS does not accurately reflect the resident's current status.	F 637		
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	F 656		12/27/19

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F 656	Continued From page 19 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. (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.	F 656		

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F 656	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, the facility failed to follow the care plan, related to catheter care, for one (1) of (23) resident care plans reviewed, Resident #44. Findings Include: Review of the "Care Plan-Comprehensive" policy, dated November 2017, revealed a comprehensive care plan is developed and maintained for each resident. Review of the Comprehensive Care Plan, initiated 6/12/19, revealed Resident #44 at risk for infection, related to the Foley catheter, with an intervention to provide Foley catheter care as ordered and to monitor for pain/discomfort due to catheter care. Observation on 11/13/19 at 2:15 PM, revealed Certified Nursing Assistant (CNA) #3 failed to hold the tip of the catheter tubing (close to the insertion site), to prevent trauma to the meatus, while providing catheter care to Resident #44. CNA #3 pulled the catheter outward, without securing the tubing, and Resident #44 stated it hurt. During an interview, on 11/13/19 at 2:26 PM, CNA #3 confirmed she failed to hold the catheter tubing close to the insertion site while providing catheter care to Resident #44. CNA #3 stated she was told to hold the head of the penis. During an interview, on 11/14/19 at 11:28 AM, Registered Nurse (RN) #2 stated she expected	F 656	1) Resident #44 was assessed for signs of urinary tract infection by the Director of Nursing (DON) on 11/13/19 at 1730hrs for discomfort, pain and irritation; patient reported none and no irritation was noted. 2) Rounds were made on 11/13/19 by the DON to determine any other residents with the potential to be affected by the same issue. No other residents identified. 3) Certified Nursing Assistant (CNA) #3 was in-serviced on 11/13/19 regarding proper catheter care and following the care plan; additionally. Starting 12/02/19, all CNAs were/will be in-serviced to include check-off return demonstration regarding following the care plan for catheter care which will be completed by 12/20/19 by Staff Development Coordinator and/or Director of Nursing and/or Assistant Director of Nursing. 4) Following completion of skills check-off audit, four (4) random skills checks on catheter care will be performed weekly, times twelve weeks, by Director of Nursing and/or Assistant Director of Nursing and/or Staff Development Coordinator and/or Unit Manager; the finds will also be discussed at monthly QA meetings. Results of these four random skills checks will be brought by the Staff Developer to the Quality Assurance Performance Improvement (QAPI) meeting quarterly with recommendations as needed to ensure continued	

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F 656	Continued From page 21 the staff to follow the care plan (which would include providing care the correct way). RN #2 stated CNA #3 should have held the catheter tubing while providing care, to keep the catheter tubing from coming out. During an interview, on 11/14/19 at 11:46 AM, the Director of Nursing (DON) confirmed CNA #3 failed to follow the care plan by not securing the tubing, which is part of catheter care. The DON said the tubing could come out by pulling on it. A review of the facility's face sheet revealed the facility admitted Resident #44 on 4/10/2019, with diagnoses, which included Retention , Urinary Tract infection (UTI), Hematuria and Benign Prostatic Hyperplasia. Review of Resident #44's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/3/2019, revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident is cognitively impaired.	F 656	compliance.	
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 facility statement review, the facility failed to follow standards of practice, related to enteral feeding pumps, in accordance to the care	F 658	1) The feeding pump for Resident #25□s feeding pump was turned back on by assigned West Wing LPN immediately after care was completed on resident.	12/27/19

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F 658	Continued From page 22 plan, for one (1) of nine (9) resident care observations, Resident #25. This was as evidenced by a Certified Nursing Assistant (CNA) turned off a feeding pump, instead of getting a licensed nurse to turn the pump off, during care of the resident. Findings include: Review of a statement, documented on facility letterhead, dated 11/14/19, revealed: "We follow the practices of Mississippi State guidelines of CNAs not turning off enteral feeding pumps". Review of the Mississippi Nurse Aide Candidate Handbook, dated March 2017, revealed no documentation of any directive for the CNA to turn on/off feeding tube pumps. Review of Resident #25's care plan, initiated 10/19/18, revealed the nurse was designated as the staff member, to hold or turn off the tube feeding, while giving ADL (Activity of Daily Living) care or anytime the bed is flat in position. On 11/13/19 at 4:06 PM, during catheter care observation, Certified Nursing Assistant (CNA) #1 stopped the enteral feeding pump before laying the bed in a flat position and providing catheter care on Resident #25. On 11/13/19 at 4:25 PM, interview with CNA #1, with CNA #2 present, revealed it was "ok" for them to pause the enteral feeding to care for the resident, but they could not restart it. CNA #1 said she had to let the nurse know when care was completed. CNA #1 and CNA #2 both said they had competency training during orientation related to care of catheters. Neither of the CNA's	F 658	Resident #25 was assessed by Director of Nursing on 11/13/19 at 5:00pm to ensure no issues related to the tube feeding being turned off. 2) Audits were completed on 11/13/19 by the DON to determine if any other residents receiving enteral feedings had the potential to be affected by this same issue. No other issues were identified. 3) CNA #1 was in-serviced on 11/13/19 by Staff Development Coordinator on scope of practice regarding operation of enteral feeding pumps. Starting 12/02/19, all CNAs were/will be in-serviced by Staff Development Coordinator regarding scope of practice to be completed by 12/20/19. 4) On a weekly basis, Staff Development Coordinator will monitor three (3) instances of perineal care on residents with enteral feeding pumps to ensure that the feeding pumps are being turned off/on by the Nurse, 1x/week times six weeks. Results of these 3 instances/week will be brought by the Staff Developer to the QAPI Meetings quarterly with recommendations as needed to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255174	A. BUILDING _____ B. WING _____	11/14/2019

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F 658	Continued From page 23 could identify any deficiency. On 11/14/19 at 11:09 AM, interview with the Director of Nursing (DON) revealed she was made aware of the CNA's stopping the feeding pump during the care, which was not in their scope of practice; the nurse should have stopped the feeding. The DON stated the CNAs have not been told in training they can stop the feeding pumps. On 11/14/19 at 11:14 AM, interview with Licensed Practical Nurse (LPN)/Staff Development (SD) Nurse, revealed the CNA's were not to touch or adjust feeding pumps, because it was the responsibility of the nurses. She said both CNA #1 and CNA #2 had competency training related to peri/catheter care, but it wouldn't have addressed the tube feeding because they are not responsible. The SD Nurse said she would check to see if any education had been provided on the care of a resident with an enteral tube to the CNAs. Review of the competency "Skills Check" list for CNA #1, dated 8/27/19, and CNA #2, dated 5/31/19, related to perineal care and catheter care, did not reveal any documentation related to the care of resident with an enteral tube. On 11/14/19 at 12:56 PM, The SD Nurse confirmed care of a enteral tube was not on the competency check list for CNA #1 or CNA #2. She also said no in-services were provided, prior to 11/13/19, related to care of a resident with a feeding tube.	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		12/27/19

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F 690	Continued From page 24 §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 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, record review, and facility policy review, the facility failed	F 690	1) Resident #44 was assessed for signs of urinary tract infection by the Director of	

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F 690	Continued From page 25 to provide catheter care in a manner to prevent infection and trauma to the meatus for one (1) of two (2) catheter care observations, Resident #44, as evidenced by not anchoring the tubing to prevent pulling on/pulling out the catheter, while providing care. Findings Include: Review of the facility's policy, "Catheter Care, Urinary", dated July 2015, revealed the purpose of the procedure was to prevent infection of the resident's urinary tract, which included to retract the foreskin on the penis and maintain the position of the hand throughout the procedure. Observation on 11/13/19 at 2:15 PM, revealed Certified Nursing Assistant (CNA) #3 provided catheter care to Resident #44. The CNA failed to hold the tip of the catheter tubing, next to the foreskin of the penis, to prevent trauma to the meatus. CNA #3 pulled the catheter outward, without securing the tubing. Resident #44 said it hurt when she pulled the tubing. In an interview, on 11/13/19 at 2:26 PM, CNA #3 confirmed she failed to hold the catheter tubing while she provided catheter care to Resident #44. CNA #3 said she was taught to hold the head of the penis. In an interview, on 11/14/19 at 11:46 AM, the Director of Nursing (DON) confirmed CNA #3 failed to prevent possible infection and trauma to the meatus, by not securing the tubing, while providing catheter care to Resident #44. The DON said the tubing could have come out when the CNA pulled outward on the tube.	F 690	Nursing (DON) on 11/13/19 at 5:30pm for discomfort, pain and irritation; patient reported none and no irritation was noted. 2) Rounds were made on 11/13/19 by the DON to determine any other residents with the potential to be affected by the same issue. No other residents identified. 3) CNA #3 was in-serviced by Staff Development Coordinator on 11/13/19 regarding proper catheter care. Starting 12/02/19, in-services and skills check-off return demonstration was/will be completed by 12/20/19 by Staff Development Coordinator and/or Director of Nursing and/or Assistant Director of Nursing to ensure proper catheter care. 4) Starting 12/16/19, four(4) random skills checks on catheter care will be performed weekly, times twelve weeks, by the Director of Nursing and/or Assistant Director of Nursing and/or Staff Development Coordinator and/or Unit Manager. Results of the random skills checks will be brought to the Quality Assurance Performance Improvement (QAPI) meetings quarterly with recommendations as needed to ensure continued compliance.	

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F 850	Continued From page 26	F 850		
F 850 SS=D	Qualifications of Social Worker >120 Beds CFR(s): 483.70(p)(1)(2) §483.70(p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is: §483.70(p)(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and §483.70(p)(2) One year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the facility license, the facility failed to employ a Licensed Social Worker (LSW), to provide social services, for three (3) of three (3) days of survey. Findings include: During an interview, on 11/14/19 at 11:54 and 11:58 AM, the Administrator revealed their employed Social Services person is out on medical leave, and he was responsible for doing the social services duties while she was out. The Administrator stated they do not have a LSW working at the facility and they are licensed for 160 beds. The Administrator stated they have a current census of 100 residents. Review of the facility license revealed the facility is licensed for 160 beds until March 2020.	F 850	1) A Qualified Social Worker was hired full-time to meet the social services needs of the residents. This full-time social worker started on 12/09/19. 2) Rounds were completed by the new social worker between 12/9/2019 and 12/12/19 to determine if any residents had the potential to be affected by this deficiency. There were no issues noted. 3) The Administrator was in-serviced on 12/6/2019 by the Nurse Consultant on the regulation regarding have a full-time social worker with a license of more than 120 beds. 4) Starting 12/20/2019, a quarterly audit will be performed by the Administrator to	12/27/19

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F 850	Continued From page 27	F 850	ensure a qualified social worker is employed full-time to meet the residents□ social needs and to ensure compliance with this plan of correction. Results of these audits will be brought by the Administrator to the Quality Assurance Performance Improvement (QAPI) meeting quarterly with recommendations as needed to ensure continued compliance.	

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	255174	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/12/2019**

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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 | 11/27/2019

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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E 000	Initial Comments ********** Survey conducted on 11/12/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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