STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255171	A. BUILDING _____ B. WING _____	C 10/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINONA MANOR HEALTH CARE AND REHABILITATION CENTER	**627 MIDDLETON ROAD WINONA, MS 38967**

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F 000	INITIAL COMMENTS State Agency (SA) conducted a COVID-19 Infection Control (FIC), along with complaint(s), MS #17222, MS #17064, and MS #17104 from 10/18/2020 to 10/20/2020. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. SA substantiated CI MS #17222 and cited F-656 and F-657 related to care plans. The SA did not substantiate MS #17064 related to staffing and MS#17104 related to quality of care, with no deficiencies cited. No deficiencies were cited related to the COVID-19 Focused Infection (FIC) survey. At the time of the survey, the facility had a census of 78, with a license for 116 beds.	F 000		
F 656 SS=E	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	F 656		11/18/20

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

Electronically Signed | 11/13/2020

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F 656	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: CI MS #17222 Based on record review, staff interview and policy review, the facility failed to develop and implement a comprehensive person-centered wound care plan for two (2) of four (4) residents reviewed with wounds (Residents #3 and #4). Findings include: Review of the facility's "Plans of Care" policy, revised 09/25/2017, revealed, "Policy: An Individualized, person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s)	F 656	* A root Cause Analysis (RCA) was completed on 11/09/20 by Quality assurance Improvement committee and based on the findings that systems were not in being followed the facility failed to develop a comprehensive plan of care that included measurable objectives for wounds. The care plan for Resident #3 for the Suspected Deep Tissue was update on 10/20/20, the care plan was reviewed and implemented on 10/21/20 by the MDS Coordinator to ensure the SDTI had a care plan developed. The care plan for resident #4 for the	

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F 656	Continued From page 2 to the extent practicable and updated in accordance with state and federal regulatory requirements. The plan of care is to be maintained as part of the final medical record. Procedure: Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Develop and implement an Individualized Person-Centered Baseline plan of care within 48 hours of admission that includes, but not limited to, initial goals based on the admission orders, physician orders, dietary orders, therapy services, social services, PASARR recommendations, if applicable, and other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident's needs are met appropriately until the Comprehensive plan of care is completed..." Resident #3 Review of Resident #3's "Order Summary Report", dated 10/19/2020, revealed an order to "Cleanse SDTI (Suspected Deep Tissue Injury) to right heel with wound cleanser, pat dry with 4 x 4's (gauze), paint with betadine, apply ABD (abdominal) pad, wrap with Kerlex and secure with tape daily." Review of Resident #3's current comprehensive care plans revealed, no care plan present for the SDTI wound of the right heel. On 10/20/2020, at 9:00 AM, during an interview with the MDS (Minimum Data Set)/Care Plan Nurse, the DON (Director of Nursing), and the	F 656	unstageable wound to the right upper buttocks was initiated on 10/19/20, the care plan was reviewed and implemented on 10/21/20 by the MDS Coordinator to ensure the unstageable wound to the right upper buttocks had a care plan developed * A quality review of current resident with wounds completed by the MDS Coordinator to ensure a Comprehensive care plan is developed and implemented. * Re-education was conducted by the Director of Clinical Services (DCS) on 10/28/20 with the MDS Coordinator regarding ensuring a Comprehensive Care plan is developed and implemented for those residents with wounds. * Quality Improvement monitoring to be conducted by the MDS Coordinator or designee 5 times per week X 2 weeks then 3X weekly for 4 weeks, then weekly and PRN as indicated to ensure a Comprehensive Care Plan is developed and implemented for those residents with wounds. The findings of these quality monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Region Director of Clinical Services or designee.	

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ADON (Assistant Director of Nursing), they indicated the SDTI had been identified the week prior, and a wound care plan for the SDTI of the right heel had not been initiated yet.

Resident #3 was initially admitted to the facility on 12/04/2009 and had a readmission on 12/25/2019. Her diagnoses included Multiple Sclerosis, Encephalopathy, Dementia, Hypertension, Depression, Osteoarthritis, Dysphagia, Gastroesophageal Reflux Disease, Glaucoma, and Constipation.

Resident #4:

Review of Resident #4's "Order Summary Report", dated 10/19/2020, revealed an order for "Cleanse unstageable to right upper buttock with NS (Normal Saline), pat dry, apply Santyl and Calcium Alginate and cover with a dry dressing daily and PRN (as needed)".

Review of Resident #4's current comprehensive care plans revealed no care plan present for the unstageable wound to his right upper buttocks.

On 10/20/2020, at 9:00 AM, during an interview with the MDS (Minimum Data Set)/ Care Plan Nurse, the DON (Director of Nursing), and the ADON (Assistant Director of Nursing) indicated the wound had been identified a few weeks prior, and no comprehensive care plan had been initiated for it yet.

Resident #4 was initially admitted to the facility on 08/02/2019, with a readmission date of 08/27/2020. His diagnoses included Hypoxic Ischemic Encephalopathy, Cardiomyopathy, Atrial Fibrillation, Diabetes, Hyperlipidemia,

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F 656	Continued From page 4 Tracheostomy, Right Sided Above the Knee Amputation, Gastrostomy Tube, Cerebral Vascular Accident, Neurogenic Bladder, Constipation, Athrosclerotic Heart Disease, Chronic Respiratory Failure, and Anemia.	F 656		
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 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: CI MS #17222	F 657	* A root Cause Analysis (RCA) was	11/18/20

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F 657	Continued From page 5 Based on record review, staff interview and policy review, the facility failed to review and revise comprehensive wound care plans for two (2) of four (4) residents reviewed with wounds (Residents #1 and #2). Findings include: Review of the facility's "Plans of Care" policy, revised 09/25/2017, revealed, "Policy: An Individualized, person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements. The plan of care is to be maintained as part of the final medical record. Procedure: Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Develop and implement an Individualized Person-Centered Baseline plan of care within 48 hours of admission that includes, but not limited to, initial goals based on the admission orders, physician orders, dietary orders, therapy services, social services, PASARR recommendations, if applicable, and other areas needed to provide effective care of the resident that meets professional standards of care to ensure that the resident's needs are met appropriately until the Comprehensive plan of care is completed...Review, update and/or revise the comprehensive plan of care based on changing goals, preferences, and needs of the resident and in response to current interventions...The interdisciplinary team shall	F 657	completed on 11/09/20 by Quality assurance Improvement committee and based on the findings that systems were not in being followed the facility failed to develop a comprehensive plan of care that included measurable objectives for wounds. Resident # 1 wound Care plan was updated to reflect the current status of the wound. Resident #2 The Care plans was revised and update to include the current treatment and status of the wound. * A quality review of current residents with wounds was completed by the MDS Coordinator to ensure the care plans is reviewed and revised with changes and as indicated. * Re-education was conducted by the Director of Clinical Services (DCS) on 10/28/20 ensuring the care plan is reviewed and revised with changes and as indicated for those residents with wounds. * Quality Improvement monitoring to be conducted by the Director of Clinical Services or designee 5 times per week X 2 weeks then 3X weekly for 4 weeks, then weekly and PRN as indicated to ensure care plans is reviewed and revised with changes and indicated for those residents with wounds. The findings of these quality monitoring to be reported to the Quality Assurance Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional	

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F 657	Continued From page 6 ensure the plan of care addresses any resident needs... Note: The resident's plan of care encompasses many documents that are part of the resident's clinical record including, but not limited to, structured care plan documents, MARS (Medication Administration Records), TARS (Treatment Administration Records), physician orders, flow records, and/or legal documents that would drive the plan of care for the individual resident." Resident #1 Review of Resident #1's "Order Summary Report" dated 10/19/2020, revealed and order to "Clean left lateral ankle with wound spray, pat dry, apply Santyl ointment to affected areas. Apply Calcium Alginate to affected areas, cover with 4x4 gauze and cover with Optifoam adhesive dressing daily until healed. Review of Resident #1's care plan for his left lateral ankle wound, initiated on 06/22/2020, revealed, "I have a stage 2 pressure ulcer to my left ankle..." Review of Resident #1's "Order Summary Report" dated 10/19/2020, revealed and order to "Clean right lateral ankle with wound spray, pat dry, apply Santyl ointment to affected areas. Apply Calcium Alginate, cover with 4x4 gauze, then cover with Optifoam adhesive dressing daily until healed. Review of Resident #1's care plan for his right lateral ankle wound, initiated on 07/10/2020, revealed, "I have a stage 2 pressure ulcer to my right ankle..." On 10/19/2020 at 2:10 PM, during an interview	F 657	Directors of Clinical Services/designee.	

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with the wound treatment nurse/Licensed Practical Nurse (LPN) #1, regarding using a debriding agent on stage 2 pressure ulcers, revealed she indicated the wounds on his left and right lateral ankles were no longer stage 2 pressure ulcers and were now stage three (3) pressure ulcers. The physician had ordered Santyl to eat away the slough on the wound beds.

Review of Resident #1's handwritten physician's order, dated 08/04/2020 revealed an order to "turn resident side to side every 2 hours" due to a pressure ulcer on his gluteal cleft/sacrum.

Review of Resident #1's current wound care plans revealed, neither care plan for his left or right ankle wounds had been updated to reflect the current stage of the wounds, nor had any of his wound care plans been updated with the specific order to turn Resident #1 from side to side every two (2) hours.

On 10/20/2020 at 9:00 AM, during an interview with the MDS (Minimum Data Set)/Care Plan Nurse, the Director of Nursing (DON), and the Assistant Director of Nursing (ADON), confirmed Resident #1's left and right ankle wounds were now stage 3 pressure ulcers. They also verified his comprehensive care plan had not been revised to reflect the changes of staging, nor the specific order to "turn side to side every 2 hours".

Resident # 1 was admitted to the facility on 05/08/2020 with diagnoses of Traumatic Brain Injury, Seizures, Atrial Fibrillation, Hypertension, Gastroesophageal Reflux Disease, Anxiety, Muscle Spasms, Neurogenic Bladder, Aphasia, and Constipation.

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Resident #2

Review of Resident #2's "Order Summary Report" dated 10/19/2020 revealed an order to "Cleanse SDTI to left heel with wound cleanser, pat dry with 4 x 4's, paint with betadine, apply and, wrap with kerlix and secure with tape daily".

Review of Resident #2's care plan revealed, "I have an STDI to my Left Heel...Interventions: Cleanse STDI to left heel with NS, Pat Dry, Swab with Sureprep and Pad with Optifoam dressing daily."

Further review of Resident #2's "Order Summary Report" revealed an order to "Clean left outer knee stage 2 with wound cleanser, pat dry with 4x4's, apply calcium alginate and bordered dressing daily."

Review of Resident #2's care plan revealed, "I have an abrasion to my left outer knee...Interventions: Clean with NS, Pat dry, swab with Sureprep and pad with Optifoam daily".

On 10/20/2020 at 9:00 AM, during an interview with the MDS/Care Plan Nurse, the DON, and the ADON, they indicated Resident #2's wound care plans had not been updated and revised to include the new treatment order for Betadine to his SDTI on his left heel, and the wound on his left outer knee was no longer an abrasion, but had become a stage 2 pressure ulcer. The wound care plan for his left knee had not been revised and updated to reflect the change.

Resident #2 was admitted to the facility on 01/17/2019 with the diagnoses of Cerebral Vascular Accident, Dementia without Behaviors,

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F 657	Continued From page 9 Anemia, Hyperlipidemia, Gastostomy Tube, Constipation, Gastroesophgeal Reflux Disease, Neurogenic Bladder, Hypertension, Diabetes, and hemiplegia of the Left side.	F 657		