STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255214	A. BUILDING _____ B. WING _____	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAWRENCE CO NURSING CENTER	700 JEFFERSON STREET SOUTH MONTICELLO, MS 39654

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F 000	INITIAL COMMENTS The State Survey Agency (SSA) conducted an annual recertification at the facility from 04/11/2022 through 04/14/2022. During the survey, the SSA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F641 and F656. The census at the time of the survey was 46, with a bed capacity of 60.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to accurately code the Minimum Data Set (MDS) related to a restraint for one (1) of 12 sampled residents. Resident #31 A record review of Resident #31's "Face Sheet" revealed the facility admitted the resident on 9/15/21 with diagnoses including Vascular Dementia without Behavioral Disturbance, Psychotic Disorder with Delusions, Major Depressive Disorder, and Anxiety Disorder A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/9/22 revealed Resident #31 had a Brief Interview of Mental Status (BIMS) score of 03 which indicated she was severely cognitively impaired. A review of Section G revealed	F 641	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. It is the policy of this facility to accurately assess and document the resident's status. Resident #31 was assessed on 4/13/22 by Director of Nursing (DON) with no adverse effects noted from the deficient occurrence. Resident #31□'s Minimum Data Set (MDS) was modified and corrected on 4/13/22 by MDS Nurse.	5/31/22

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

Electronically Signed | 04/28/2022

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F 641	Continued From page 1 Resident #31 required extensive assistance with two-person physical assist for bed mobility and used a wheelchair as a mobility device. Review of Section P0100 "Physical Restraints" indicated "Bed rail" was coded as "Used daily", which means the bed rail was coded as a restraint for the look-back period of the MDS assessment. 4/13/22 at 1:05 PM in an interview with RN #2, she reviewed Section P of the MDS with an ARD of 3/9/22 and stated the bed rail was coded as a restraint in error and she would correct the MDS. She confirmed the resident uses quarter side rails as an enabler and Resident #31 can transfer herself from the bed to her wheelchair without assistance. The quarter side rails do not prevent or restrict Resident #2's movement or transfers, and she uses them to sit up and to reposition herself in bed. On 4/13/22 at 2:00 PM, the SA observed resident's bed with quarter side rails on both sides of the bed. On 4/14/22 at 9:27 AM in an interview with RN #1, she confirmed the bed rail being coded as a restraint was in error. On 4/14/22 at 9:34 AM in an interview with the Administrator, he agreed that although it is his expectation that the MDS is accurately coded, he understands the role of the Care Plan/MDS nurse is difficult, detailed, and challenging.	F 641	All residents have the potential to be affected by this deficient practice. On 4/14/22 and audit was conducted by the MDS Nurse of Section P of all MDS's to verify accuracy. Copy of audit Assessment Summary Report is attached. The MDS nurses were inserviced on 4/13/22 and again 4/28/22 by MDS Nurse and Staff Development Coordinator (SDC) related to the Accuracy of Assessments. The MDS Nurse and the Assessment Registered Nurse (RN) will monitor MDS's for accuracy. The DON will begin 5/2/22 to observe 3 MDS□'s per day, 5 days per week for 4 weeks then 3 MDS'□s, 1 time per week for 2 months and then 3 MDS□'s once per month for 3 months to assure compliance with accuracy of assessments and report compliance to the Quality Assessment and Assurance Committee monthly beginning with the May 2022 meeting for the next 2 months and the Administrator weekly for 3 months beginning 5/6/22.	
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		5/31/22

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F 656	Continued From page 2	F 656		

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.

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F 656	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure a comprehensive person-centered care plan was developed with measurable objectives and individualized interventions for a resident with wandering behaviors for one (1) of 14 resident care plans reviewed. (Resident #31) Findings included: Review of the facility's "Care Plan Process" with a revision date of 08/17 revealed, " ...The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive person-centered plan of care ..." Review of the facility's "Elopement/Wandering-General Policy" with a revision date of 09/18 revealed, " ...b. A resident determined to be at risk to wander will be identified on the resident's comprehensive plan of care ..." A record review of Resident #31's "Face Sheet" revealed the facility admitted the resident on 9/15/21 with diagnoses including Vascular Dementia without Behavioral Disturbance, Psychotic Disorder with Delusions, Major Depressive Disorder, and Anxiety Disorder A record review of Resident #31's "Physician Orders List" revealed a physician's order with an order date of 1/13/2022 of "Elopement risk monitor placement of Wanderguard bracelet every sft (shift)"	F 656	It is the policy of this facility to develop and implement comprehensive person-centered care plans for its residents. Resident #31 was assessed on 4/13/22 by Director of Nursing (DON) with no adverse effects noted from the deficient occurrence. Resident #31□s care plan was updated on 4/13/22 by the Assessment Registered Nurse (RN). All residents have the potential to be affected by failure to develop, implement and follow care plans. An audit of all resident care plans was completed 4/26/22 by the Minimum Data Set (MDS) Nurse to verify each resident's side rail usage was properly assessed as an enabler for bed mobility and that applicable care plan was done, consents signed, and physician orders obtained. Copy of audit list is attached. The MDS Nurse and Assessment RN will develop, implement, and implement person-centered care plans for each resident. Nursing department was inserviced by the Staff Development Coordinator (SDC) on 4/13/22 and again 4/28/22 to develop, follow and execute care plans correctly including wandering behaviors. The facility Medical Director reviewed the policy Care Plan Process with no recommended changes on 4/15/22.	

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F 656	Continued From page 4 A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/9/21 revealed Resident #31 had a Brief Interview of Mental Status (BIMS) score of 03 which indicated she was severely cognitively impaired. Review of Section P0200 "Alarms" indicated "Wander/elopement alarm" was coded as "Used daily", which means the wander guard bracelet was in use during the look-back period of the MDS assessment. A record review of Resident #31's Care Plan revealed there was no comprehensive person-centered care plan on the resident's medical chart related to her wandering behaviors and there were no individualized interventions related to the use of a wander/elopement alarm bracelet. On 4/12/22 at 2:56 PM, the State Agency (SA) observed Resident #31 sitting in her room in her wheelchair. The SA did not see a wander/elopement alarm bracelet on the resident and asked Certified Nursing Assistant (CNA) #3 if the resident wears the device. CNA #3 pulled up the resident's pants leg and the SA observed the wander/elopement alarm bracelet attached to Resident #3's left ankle. A record review of the "Departmental Notes" for Resident #31 revealed a nurses note dated 1/12/22 at 12:33 AM, "Up walking the halls. Confusion noted with conversations. Having a conversation with self about going home..." A record review of the "Departmental Notes" for Resident #31 revealed a nurses note dated 1/12/22 at 1:56 AM, "Resident combative, hitting staff with house shoe. Keeps repeating she is	F 656	Minimum Data Set (MDS) Nurse or SDC will observe beginning 5/2/22, 3 resident care plans per day, 5 days per week for 4 weeks then 3 resident care plans, 1 time per week for 2 months and then 3 resident care plans once per month for 3 months to assure compliance with care plans development and implementation and report compliance to the Quality Assessment and Assurance Committee monthly at its May 2022 meeting for the next 2 months and the Administrator weekly beginning 5/6/22, for 3 months.	

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going home that her house is just over there ..."

A record review of the "Departmental Notes" for Resident #31 revealed a nurses note dated 1/12/22 at 1:41 PM, "Resident behavors (sic) elevated. Unable to redirect. Up walking in hallway ..."

A record review of the "Departmental Notes" for Resident #31 revealed a nurses note dated 1/12/22 at 2:37 PM, "Resident has new order noted for wanderguard bracelet due to wandering about facility and at risk for elopement ...The nurse explained to her that her mother has walked all over the building today and even went to front door ..."

A record review of the electronic Treatment Administration Record (eTAR) for January 2022, February 2022, March 2022, and April 2022 revealed daily charting by a licensed nurse to "Check functioning of wanderguard device daily", which indicated the device had been in use since 1/12/2022.

On 4/13/22 at 9:44 AM, during an interview with Certified Nursing Assistant (CNA) #1, she stated the daily tasks and plan of care for residents are displayed on the kiosks located in the hallway. CNA #1 pulled up Resident #31's tasks from the kiosk and demonstrated how she documents that the wander/elopement alarm bracelet is in place by clicking on "yes" to the question, "Did the resident have all safety devices and special equipment for the shift per the plan of care and resident summary?"

On 4/13/22 at 9:49 AM, during an interview with Licensed Practical Nurse (LPN) #1, she stated

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Resident #31 wandered more frequently when she was first admitted to the facility. She confirmed Resident #31 verbalizes at times that she wants to go home, and she will go to the front door. LPN #1 retrieved a white binder labeled "Wandering and Smoking" from the top of the chart rack at the nurse's station and the SA observed Resident #31's face sheet and picture in the binder. LPN #1 advised the SA that the resident's care plan is located in her medical chart.

On 4/13/22 at 9:53 AM, during an interview with RN #2, she reviewed the resident's care plan in the medical chart and confirmed there was no care plan in place for Resident #31's wandering behaviors or for the use of the wander/elopement alarm bracelet. She stated, "It's just not in here".

On 4/13/22 at 10:29 AM, during an interview with RN #1 who is the Interim Director of Nursing (DON), she stated RN #2 had made her aware there was no care plan in the resident's chart for Resident #31's wandering behaviors or for the use of the wander/elopement alarm bracelet. She agreed that a care plan should have been developed.

On 4/14/22 at 9:34 AM in an interview with the Administrator, he agreed that although it is his expectation that care plans are developed, he understands the role of the Care Plan/MDS nurse is difficult, detailed, and challenging.