STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255302	A. BUILDING _____ B. WING _____	03/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

(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 A Recertification Survey was conducted by Healthcare Management Solutions, LLC from 3/25/19 to 3/28/19, on behalf of the Mississippi State Department of Health. The facility was found not to be in substantial compliance with requirements of participation for Medicare and Medicaid. Deficient practice was cited at F574, F577, F641, F655, F656, F677, F755 and F880 . Census at the time of survey was 92, and the facility held a license for 106 beds.	F 000		
F 574 SS=E	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction	F 574		4/28/19

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

Electronically Signed | 04/11/2019

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 574	Continued From page 1 in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the	F 574		

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F 574	Continued From page 2 facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on interviews, review of the facility's, "A Matter of Rights Brochure," and review of the facility's, "Grievance/Complaints Policy," the facility failed to ensure eight (8) of eight (8) supplemental residents who attended the Resident Council Group meeting, Residents #5, #10, #14, #22, #33, #48, #72, and #76, were informed of their right to file a complaint to the State Survey Agency about the care and services they receive, and to be informed of additional advocacy groups available to them. Findings include: Review of the facility's brochure titled, "A Matter of Rights - A Guide to Your Rights and Responsibilities as a Resident, which the facility provides to residents upon admission indicated on page 13, "Residents have the right to contact information for state licensing and advocacy groups, including: the State Survey Agency . . . the State Senior Protection and Advocacy Agency, the Aging and Disability Resource Center, and [the] Medicaid Fraud Control Unit." Review of the facility's undated policy titled, "Grievance/Complaints Policy," indicated the residents, "may file a written complaint to the local Ombudsman's office or to the state health department." Review of the facility's last three (3) months of Resident Council "Meeting Minutes," dated 01/31/19, 02/2019, and 03/14/19, revealed no	F 574	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. 1. On April 1, 2019, the facility Administration updated the Residents Rights information to include location of survey results and contact information for the Mississippi Department of Health. On April 3, 2019, Social Services initiated distribution of the Residents Rights Information and location of survey results to all residents and/or family members. On April 25, 2019, the Administrator will attend resident council and update council on the following: survey results from March 2019, location of survey results, updated Resident Rights information that were distributed. On April 4, 2019, Resident #5 received Residents Rights Information to include right to file a complaint. On April 5, 2019, Resident #10 received Residents Rights Information to include right to file a complaint. On April 4, 2019, Resident #14 received Residents Rights Information to include	

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F 574	Continued From page 3 documentation to indicate the residents were provided with information on how to make a formal complaint to the State Agency, or information regarding Advocacy groups. During the Resident Council Group meeting, held on 03/26/19 at 9:00 AM, residents were asked if they have been informed of, and provided information on how to file a formal complaint to the State Survey Agency about the care they receive. Resident #33 stated, "No." Resident #14 stated, "I could probably figure that out on my own. I would probably just get on the phone and start calling people until you get through to the right agency, then get the right person I guess." Resident #5 stated, "I guess I would just go to the Resident Council President and try to get our problems straightened out together. I wouldn't know of how to contact our state if I needed to. That has never been mentioned to us." Resident #33 stated, "I don't really know what the process is or how to go about making a complaint to the state or contacting any other agencies. That is something we haven't been told about." Resident #72 stated, "I wouldn't even know where to start. That is something that we haven't been told about- who to call or what the process is." Resident #76 stated, "Me as well. I wouldn't know." Resident #22 stated, "We have never been given that information and that isn't something we have covered either." Resident #10 stated, "No one ever reviews that information with us of who to contact. No in deed." Resident #48 stated "No." Resident #14 then stated, "I would hope if anyone had a problem, we could get it worked out before going to the state." Resident #22 stated, "It would be nice to know that information if I ever needed to contact someone at the state or any other agency."	F 574	right to file a complaint. On April 5, 2019, Resident #22 received Residents Rights Information to include right to file a complaint. On April 4, 2019, Resident #33 received Resident Rights Information to include right to file a complaint. On April 3, 2019, Resident #48 received Resident Rights Information to include right to file a complaint. On April 4, 2019, Resident #72 received Resident Rights Information to include right to file a complaint. On April 11, 2019, Resident #76 received Residents Rights Information to include right to file a complaint. 2. All residents have the potential to be affected by failing to ensure that they are informed of their right to file a complaint to the State Survey Agency. 3. On April 1, 2019, Social Services staff were in-serviced, by the Administrator, on ensuring residents have received knowledge to include the updated Resident Rights information and location of survey results. Social Services will initiate reviews of Resident Rights information with quarterly care conferences on April 3, 2019.	

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F 574	Continued From page 4 During interview on 03/26/19 at 10:26 AM, Social Worker (SW) #1 stated, "Well, usually with any kind of situation, we call the Ombudsman and she helps us anytime we have a concern. We just verbally let them [the residents] know that they have rights, and they can contact the Ombudsman or the state [State Survey Agency] if they want to, but it has just been done verbally. Other than that, it's posted of who to contact." When asked if the residents receive any information on the process of contacting other advocacy agencies, or on the process of contacting the state if needed, Social Worker #1 stated, "They might get something in admissions. Not that I'm aware of anytime after that. Not that I'm aware of where residents would know how to go directly to the state agency." During a second interview on 03/27/19 at 9:00 AM, Social Worker #1 stated, "We don't review the state complaint information in every meeting. As far as routinely, we don't bring it up in every meeting. They get a resident rights book on admission. If I had a situation where I would need help, I would contact the Ombudsman, then she would come to explain the process. If there was a concern, I guess I would have to give them the information that is posted at the front lobby area." When asked how the facility informs the residents of their right to contact the State Survey Agency, Social Worker #1 stated, "We don't review it in every meeting . . . It's not something I review with them. We just know the information [contact information for the State Survey Agency and the Ombudsman Program] is there [posted on the wall in the front lobby] and if we need it, we can get it for them."	F 574	4. The Administrator will monitor the admissions process and quarterly care conferences, to ensure inclusion of Resident Rights information weekly x four (4) weeks and monthly x two (2) months. The monitoring/audits will be submitted by the Administrator to the Quality Assurance Performance Improvement (QAPI) Committee for review and recommendations monthly x three (3) months.	

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F 574	Continued From page 5 During an interview on 03/27/19 at 10:55 AM, the Director of Nursing (DON) stated, "On admission they [the residents] get some information on the State Survey Agency, then if there is a grievance, if we can't handle it, we would go to the Ombudsman. If they [the residents] are not happy with the Ombudsman, then I would let them know what the different layers are to go through, such as the Administrator or our Licensure and Certification State Agency." When asked how this information is communicated to the residents, the DON stated, "I think it would be by the posting on the wall, and they are given a booklet on admission. For now, we are not enforcing that information like the phone numbers to call, and who to contact. We don't routinely let them know of the State Agency, or a phone number to call, or any other agencies." When asked for the reason, the DON stated, "There really is no reason; we need to let the residents know that these are the proper agencies to contact if you need to. They need to be made aware of those options on a regular basis." During an interview on 03/17/19 at 11:20 AM, the Administrator stated, "On admission, we let people know and [also] in Resident Council. I know our Ombudsman tells them if you have any issues, you can call the state agency as well. If they [the residents] were to come to us and say 'I want to call' [the State Survey Agency], then we would give them the numbers. Our Social Workers are the ones that would ensure that information gets communicated to the residents."	F 574		
F 577 SS=E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to-	F 577		4/28/19

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F 577	Continued From page 6 (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility's resident admission information, the facility failed to ensure eight (8) of eight (8)supplemental residents, Residents #5, #10, #14, #22, #33, #48, #72, and #76, were informed of location of the facility's most recent survey results and plan of correction, and of their right to review those results without the assistance of staff. Findings include: Review of the facility's undated brochure titled, "A	F 577	1. On April 1, 2019, the facility Administration updated the Residents Rights information to include location of survey results and contact information for the Mississippi Department of Health. On April 3, 2019, Social Services initiated distribution of the Residents Rights Information and location of survey results to all residents and/or family members. On April 25, 2019, the Administrator will attend resident council and update council on the following: survey results from March 2019, location of survey results,	

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F 577	Continued From page 7 Matter of Rights-A Guide to your Rights and Responsibilities as a Resident," indicated: "Ready Access to information. Your right to have prompt and convenient access to information includes . . . We will post the results of the most recent inspection of our facility, together with any plan of correction currently in effect. We encourage residents and family members to review these . . . You have the right to be kept informed about the things that affect you. You also have the right: to read the facility's latest survey inspection results and any plan of correction in effect for the facility." Review of the minutes for the Resident Council meetings, dated 01/31/19, 02/2019, and 03/14/19, indicated none of the three (3)documents contained information related to the location of the state agency's survey results, or of the residents' right to be able to access and review the survey results without the assistance of the staff. Observation of the facility's lobby area on 03/26/19 at 10:30 AM, revealed a binder labeled, "Survey Inspection Results" on a table near the front entrance, which contained the results of the facility's most recent state agency survey and plan of correction. During the Resident Council Interview on 03/26/19 at 9:00 AM, which was attended by Resident #5, Resident #10, Resident #14, Resident #22, Resident #33, Resident #48, Resident #72, and Resident #76, the group expressed concerns related to not knowing the location of the state survey results, or of their right to view the survey results without staff assistance. The group also expressed this was a topic not covered at previous Resident Council	F 577	updated Resident Rights information that were distributed. On April 4, 2019, Resident #5 received Residents Rights Information and location of survey results. On April 5, 2019, Resident #10 received Residents Rights Information and location of survey results. On April 4, 2019, Resident #14 received Residents Rights Information and location of survey results. On April 5, 2019, Resident #22 received Residents Rights Information and location of survey results. On April 4, 2019, Resident #33 received Resident Rights Information and location of survey results. On April 3, 2019, Resident #48 received Resident Rights Information and location of survey results. On April 4, 2019, Resident #72 received Resident Rights Information and location of survey results. On April 11, 2019, Resident #76 received Residents Rights Information and location of survey results. 2. All residents have the potential to be affected by failing to ensure that they are informed of the location of the facility 's most recent survey results and plan of	

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F 577	Continued From page 8 meetings. When asked if the state's inspection results were available to read all stated, "No." Resident #72 then stated, "We wouldn't know where they are posted." Resident #5 stated, "No one has ever mentioned anything about the state inspection results or where those may be." Resident #14 stated, "That would be nice to know as a resident here, so we are informed of what the outcome was. But we wouldn't even know where to review that information." Resident #22 stated, "We didn't know that we could ask for that information." Resident #72 stated, "No one has ever mentioned anything about that. I don't know where the information is." During an interview on 03/26/19 at 10:26 AM, Social Worker (SW) #1 stated, "Regarding the state survey inspection results, we have the survey book located where they first come into the facility. It's not brought up in every resident council meeting." When asked how the residents are informed of their right to review the state survey results and the location of those results, Social Worker #1 stated, "I'm not sure we are doing that. I know they get a resident rights book when they first come in." During an interview on 03/27/19 at 10:55 AM, the Director of Nursing (DON) stated, "Other than having our [survey results] book at the front, I don't think there is anything we give them [the residents] or really update or inform them of the state survey results. I think we need to find out a way to make sure we review it more often in Resident Council." During an interview on 03/27/19 at 11:20 AM, the Administrator stated, "We always tell families and residents upon admission that the survey binder	F 577	correction. 3. On April 1, 2019, Social Services staff were in-serviced, by the Administrator, on ensuring residents have received knowledge to include the updated Resident Rights information and location of survey results. Social Services will initiate review of Resident Rights information with quarterly care conferences and for all new admissions. 4. The Administrator will monitor the admissions process and quarterly care conferences beginning April 1, 2019, to ensure inclusion of Resident Rights information weekly x four (4) weeks and monthly x two (2) months. The monitoring/audits will be submitted by the Administrator to the Quality Assurance Performance Improvement Committee for review and recommendations monthly x three (3) months.	

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F 577	Continued From page 9 is at the front door. In general, if someone asks, 'Where is the survey book?' we can tell them." When informed of the residents' concerns regarding the location of the state survey results for the facility and their right to review the results, the Administrator stated, "It is what it is, and we can fix it."	F 577		
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 observation, record review, and interviews, the facility failed to ensure the accuracy of a comprehensive Minimum Data Set (MDS) assessment for one (1) of one (1) sampled residents, Resident #86, reviewed for accidents, of 22 sampled residents. Resident #86 was identified as at high-risk for falls prior to admission to the facility, and sustained a fall without injury while at the facility. The staff failed to include Resident #86's history of falls prior to, and after admission, on the resident's admission MDS and 14-day MDS assessments. This deficient practice had the potential to negatively impact the care planning process for Resident #86, and/or the implementation of fall prevention measures for Resident #86. Findings include: Interview with the Director of Nursing (DON) on 03/27/19 at 1:21 PM revealed the facility did not have a policy on falls. The DON provided a written and signed statement on 03/27/19,	F 641	1. On March 31, 2019, the Minimum Data Set (MDS) Coordinator submitted a corrected Minimum Data Set to include a fall since admission for Resident #86. The 14-day Minimum Data Set was coded correctly for Resident #86. Resident #86 had no additional fall(s) since the coding of the corrected (5-day) Minimum Data Set. 2. Residents who have an Minimum Data Set completed have the potential to be affected by failing to ensure accurate Minimum Data Set assessments. 3. On April 5, 2019, the Administrator in-serviced the Minimum Data Set nursing staff to include reviewing progress notes and risk management portal of the Electronic Health Record (EHR) to check for falls that should be coded on Minimum Data Set.	4/28/19

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F 641	Continued From page 10 indicating the facility did not have a "Fall" policy. The DON stated, "We would follow the RAI (Resident Assessment Instrument) process and we are supposed to code the MDS for a fall." Review of Resident #86's "Admission Minimum Data Set (MDS)," with an "Assessment Reference Date (ARD)" of 02/26/19, specified the resident had a "Brief Interview for Mental Status (BIMS)" (an evaluation of cognitive function) score of 00 out of 15, which indicated Resident #86 had severe cognitive impairment. The assessment indicated the resident fell during the month prior to his admission and had sustained a fracture related to a fall within six (6) months prior to admission. Further review of the MDS indicated the question, "Has the resident had any falls since admission/entry or reentry?" was marked: "No." Review of the "Care Area Assessment (CAA) Summary" for the Admission MDS (02/26/19) indicated, "At risk for falls related to impaired mobility, transfer, instability, and weakness. Fall risk upon admission." Review of Resident #86's 14-day MDS, with an ARD of 03/04/19, specified his BIMS score was three out of 15, which indicated continued severe cognitive impairment. The 14-day MDS question, "Has the resident had any falls since admission/entry or reentry?" was marked "No." The question, "Number of falls since admission?" was left blank. Observation on 03/25/19 at 11:00 AM, revealed Resident #86 sat in a wheelchair awaiting lunch to be served. The resident made no attempts to rise from his wheelchair.	F 641	4. The Director of Nursing or Assistant Director of Nursing will monitor Minimum Data Set coding beginning April 1, 2019, to ensure coding for falls is accurate, weekly x four (4) weeks and monthly x two (2) months. The monitoring/audits will be submitted by the Director of Nursing or Assistant Director of Nursing to the Quality Assurance Performance Improvement Committee for review and recommendations monthly x three (3) months.	

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	255302	A. BUILDING _____ B. WING _____	03/28/2019

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F 641	Continued From page 11 Observation of Resident #86's room on 03/25/19 at 11:05 AM, revealed a folded floor mat leaning against the wall, and a call light on the bed. During a phone interview with Family Member (FM) #7 on 03/25/19 at 11:53 AM, FM #7 stated, "He [referring to Resident #86] fell when he first went into the facility. They [referring to staff] found him on his knees on the pad. Since then, he has had no more falls." Review of Resident #86's undated "Face Sheet" found in the electronic medical record (EMR), and of the resident's "History and Physical," dated 02/18/19, found in the hard paper chart, indicated the facility admitted Resident #86 on 02/19/19, with diagnoses that included, Fracture of [an] Unspecified Part of Neck of [an] Unspecified Femur, Closed Fracture of the Left Hip, Fall, S/P [status post] Closed Reduction with Internal Fixation [of the] Left Intertrochanteric Femur Fracture on 02/13/19, Muscle Weakness, Repeated Falls, Difficulty in Walking, and Dementia Without Behavioral Disturbance. Review of a "Morse Fall Scale" (an assessment to determine fall-risk potential) for Resident #86 found in the EMR under the "Assessments" section, dated 02/19/19, indicated the resident was, "At high risk for falling." Further review of the document indicated under "Section A. History of falling," the staff answered the question, "Has the Resident ever fallen before?" as "Yes." Review of the "Progress Notes" for Resident #86 in the EMR, dated 02/26/19, indicated a "Late Entry" note for 12:30 AM, which read, "Called to room, noted resident on [the] fall mat on [his]	F 641		

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F 641	Continued From page 12 knees, attempting to get back in bed. Staff had just left [the] resident after providing incontinent care of bladder [sic]. [The] Resident stated, "I was trying to go home . . . denied pain/discomfort. Remains confused to place/time." Review of an "Incident Report," dated 02/26/19, found in Resident #86's EMR under the "Reports" section indicated the document referred to Resident #86's fall on 02/26/19: "Un-Witnessed-Resident was in his room on his knees by the bedside. The mat was in place. Resident was trying to get back into bed . . . The only knew [sic] findings on this resident was that his knees were red." Injury Type: No injuries observed at time of incident. No injuries noted post incident." Review of an additional "Morse Fall Scale" assessment, dated 02/26/19, found in Resident #86's EMR under the "Assessments" section, indicated Resident #86 was still at risk for falls. It further indicated on "Section A. History of falling. Has the Resident ever fallen before?" The staff documented, "No" to the question. During an interview on 03/27/19 at 1:00 PM, the MDS Assistant stated, "I see he [Resident #86] was admitted on 02/19/19. I'm seeing no falls marked on the MDS since admission. On the 14-day MDS done on [3/419], I also don't see any falls indicated since admission." When the MDS Assistant was asked if Resident #86 sustained a fall at the facility on 02/26/19, the MDS Assistant stated, "Yes, a change in one (1) level to another we would consider a fall and we will have to do an amendment to the MDS. We will have to correct it because it says here [referring to the progress notes dated 02/26/19, and the incident report	F 641		

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F 641	Continued From page 13 dated 02/26/19], he had a fall. The person who did the MDS just did not capture it. He went from a standing position to down on his knees on 02/26[/19] and that would be considered a fall." When asked about the facility's process for ensuring the MDS assessments are updated, the MDS Assistant stated, "We do an incident report, so we could look back, but obviously we missed it. We should have caught it, but we sure didn't." When asked how soon after someone falls would the MDS be changed or updated, the MDS Assistant stated, "Usually we try to change it within the first few days after a fall." During an interview with the DON on 03/27/19 at 1:21 PM, the DON stated, "We would consider that a fall on 02/26[/19], yes because he was laying in the bed 45 minutes earlier then staff saw him on his knees. We should have seen it on the MDS, but it wasn't caught." When asked about the facility's expectation in these matters, the DON stated, "We would follow the RAI (Resident Assessment Instrument) process and we are supposed to code the MDS for a fall." When the DON was asked if the facility had a falls policy, the DON stated, "I do not have a fall protocol. We go by the "Morse Fall Scale" on admission. I don't have a separate fall protocol. My expectation is for any unwitnessed fall, we are to do neuro checks which they did, notify family, physician, and assess for injury."	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and	F 655		4/28/19

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F 655	Continued From page 14 implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.	F 655		

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F 655	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of facility policy, the facility failed to ensure the staff fully completed a baseline care plan within 48 hours of admission that included all the information required to provide effective and person-centered care for one (1) of one (1) resident, Resident #86, selected for review of accidents, of 22 sampled residents. Additionally, the facility failed to provide a written summary of the baseline care plan to the resident and their representative. Findings include: Review of the facility's "Baseline Care Plan" Policy, implemented April 2018, indicated, "The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care . . . 1. The baseline care plan will . . . include the minimum healthcare information necessary to properly care for a resident . . . 2. Interventions shall be initiated that address the resident's current needs . . . once established, goals and interventions shall be documented . . . 4. A written summary of the baseline care plan shall be provided to the resident and representative. . . . The summary shall include, at a minimum, the following: a. The initial goals of the resident . . . c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility." Review of Resident #86's baseline care plan, dated 02/19/19, revealed the Social Services section of the care plan was blank and did not	F 655	1. On April 5, 2019, the summary of the baseline care plan was completed by the Minimum Data Set Licensed Practical Nurse for Resident #86. A copy of the baseline care plan was provided to the wife of Resident #86. On April 9, 2019, a comprehensive care plan was developed for Resident #86, by the Minimum Data Set Coordinator. A copy of the comprehensive care plan was provided to the wife of Resident #86 by Minimum Data Set Licensed Practical Nurse on April 8, 2019. 2. All residents admitted to the facility have the potential to be affected by failing to ensure staff fully complete baseline care plans. 3. On April 1, 2019, the facility Administration revised the policy for Base Line Care Plans to include requirement for completion of baseline care plan within 48 hours of admission. On April 5, 2019, Minimum Data Set nursing staff were in-serviced, by the Administrator, on the revised Base Line Care Plan Policy and the Comprehensive Care Plans Policy. 4. The Director of Nursing or Assistant Director of Nursing will monitor admission baseline care plans beginning April 1, 2019, to ensure they are complete and a copy provided to resident/family, weekly x four (4) weeks and monthly x two (2) months. The monitoring/audits will be submitted by the Director of Nursing or	

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F 655	Continued From page 16 include any comments or other documentation by the Social Services staff. The rehabilitation section did not include the resident's potential or actual problems with mobility and self-care needs, and had no treatment goals or interventions documented. The baseline care plan did not include the functional goals for the resident's care and treatment, did not include a written summary of the goals, objectives, and treatment interventions, and had did not include the signature of the resident or of the resident's representative. Review of an undated "Face Sheet" found in Resident #86's electronic medical record (EMR) under the "Diagnosis" section indicated the facility admitted the resident on 02/19/19, with diagnoses that included Fracture of [an] Unspecified Part of Neck of Unspecified Femur, Muscle Weakness, Repeated Falls, Difficulty in Walking, and Dementia without Behavioral Disturbance. During an interview with the Director of Nursing (DON) on 03/27/19 at 2:15 PM, regarding the baseline care plans, the DON stated, "When we open a baseline care plan upon admission, nursing, dietary, and therapy sections will be completed within those 72 hours, then at our 72 hours meeting, we do a summation with the family and the resident. Then the MDS (Minimum Data Set) person will sign and lock it for completion." The DON then stated, "We are looking at a incomplete baseline care plan. Not all sections have been fully completed and we don't have documentation that the resident's representative signed it, and we don't have staff such as therapy indicated on it." During a second interview with the DON on	F 655	Assistant Director of Nursing to the Quality Assurance Performance Improvement Committee for review and recommendations monthly x three (3) months.	

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F 655	Continued From page 17 03/27/19 at 2:44 PM, the DON stated, regarding Resident #86's Baseline Careplan, "It is a incomplete baseline care plan. We don't have a summary of it indicated, and our process is we send the family a copy and then we will take that signed copy and put it in the paper chart, but you wouldn't find a signed copy because it is incomplete." During an interview with the MDS Assistant on 03/27/19 at 3:13 PM, the MDS Assistant stated, "For some reason I don't remember why the family didn't sign. I recall we had a meeting scheduled for the family, and normally the families would sign it. I don't see where Social Services, Dietary, or Therapy signed their sections [to indicate completion of the section]. Usually Therapy will also come to the meeting with their information and they give it to the family, then I would put a note in the chart of who attended and what we talked about, any nursing concerns, medications, therapy goals. All that goes into the 72-hour progress note, but I don't see the 72-hour [progress] note. There is no note of our 72-hour meeting because the family did not come in. I don't see anywhere where anybody put a note in the chart as to the family not coming in. I don't know what happened with this one." During an interview on 03/28/19 at 8:55 AM, Social Worker (SW) #1 stated, "We do have a 72-hour initial meeting when someone is admitted, and we discuss a baseline care plan then. When a resident first comes in, our MDS person will get the baseline care plan signed by the family. Our MDS person will make sure it is reviewed and the family has signed, or if a phone conference was done, or the next time the family is in the building, we will leave the care plan at the	F 655		

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F 655	Continued From page 18 nurse's station for the family to sign. The families always get a copy of one but I'm seeing this one was incomplete."	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will 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	F 656		4/28/19

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F 656	Continued From page 19 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to develop comprehensive person-centered care plans for two (2) residents, Resident #86 and Resident #36), out of a sample of 22 residents. The staff failed to include the use of antidepressant medication on the care plan for Resident #86, and failed to include resident-specific interventions for repositioning on the care plan for Resident #36. Findings include: On 03/28/19 at 11:22 AM, the Director of Nursing (DON) provided a written statement to the survey team that read, "[Name of facility] does not have a policy for comprehensive care plan completion." Resident #86: Review of Resident #86's care plan, initiated on 02/20/19, indicated it did not include a care plan problem, goals, or interventions related to the resident's use of antidepressant medication. Review of Resident #86's "Physician Order Summary Report," which included the resident's "Active Orders" for 02/19/19 through 03/28/19, revealed orders for Sertraline HCL (an antidepressant medication), 100 milligrams (mg)	F 656	1. On April 5, 2019, a comprehensive care plan to include triggered Care Area Assessments (CAA) was completed for Resident #86 by the Minimum Data Set Coordinator. On March 28, 2019, the sacral ulcer care plan for Resident #36 was revised by the Director of Nursing to include resident individualized intervention to assist with repositioning/off-loading while in wheelchair. 2. Residents with comprehensive care plans have the potential to be affected by failure to develop comprehensive person-centered care plans. 3. On April 1, 2019, the facility Administration developed a policy for Comprehensive Care Plans. On April 5, 2019, Minimum Data Set licensed nursing staff were in-serviced by the Administrator on the revised Base Line Care Plan Policy and the Comprehensive Care Plans Policy. 4. The Director of Nursing or Assistant Director of Nursing will monitor admission comprehensive care plans to ensure they are complete as compared to Care Area	

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F 656	Continued From page 20 one (1) time a day for the diagnosis of "Depression," Trazodone HCL (an antidepressant medication), 25 mg one (1) time a day for "Depression" plus Trazodone HCL, 75 mg one (1) time a day at 8:00 PM for "Depression/Agitation." Further review of the "Physician Order Summary Report" revealed additional orders, which directed the staff to monitor the resident for the occurrence of side effects of antidepressant medications, for episodes of behaviors/mood disturbance, and for the outcomes of the interventions implemented during episodes every shift. Review of Resident 86's admission "Minimum Data Set (MDS)" with an "Assessment Reference Date (ARD)" of 02/26/19, indicated the facility admitted the resident on 02/19/19, with diagnoses that included Depression. The MDS specified the resident had a "Brief Interview for Mental Status (BIMS)" (a cognitive ability assessment tool) score of 00 out of 15, which indicated he had severe cognitive impairment. The assessment also indicated Resident #86 received antidepressant medication on all seven (7) days of the assessment's seven-day look-back period. Review of the "Care Area Assessment (CAA) Summary" section of the admission MDS, indicated the answers documented in the assessment triggered the care area, or "CAA," for "Psychotropic Medication Use." Further review of the "CAA Summary" indicated the staff would address Resident #86's use of antidepressant medication in his care plan. Review of Resident #86's subsequent 14-day MDS with an ARD of 03/04/19, also indicated the resident received antidepressant medication on	F 656	Assessment triggered care plans beginning April 1, 2019, to ensure they are complete and a copy provided to resident/family, weekly x four (4) weeks and monthly x two (2) months. The monitoring/audits will be submitted by the Director of Nursing or Assistant Director of Nursing to the Quality Assurance Performance Improvement Committee for review and recommendations monthly x three (3) months.	

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F 656	Continued From page 21 all seven days of the assessment's seven (7)-day look-back period. Review of Resident #86's EMR revealed a "Medication Administration Record (MAR)" for March 2019, which indicated the resident received Sertraline HCL 100 mg daily at 9:00 AM, Trazodone HCL 25 mg daily 9:00 AM for "Depression," and Trazodone HCL 75 mg daily 8:00 PM for "Depression/Agitation." During an interview on 03/28/19 at 11:05 AM, Licensed Practical Nurse (LPN) #3 stated, "[Resident #86] is getting Trazadone 75 mg at night for 'Depression/Agitation' and Trazodone 25 mg in the morning. He is also getting the Sertraline 100 mg a day for depression. We do monitor [Resident #86] for side effects every shift." When asked if there was a care plan for the use of the antidepressants, LPN #3 stated, "All I see is a care plan to maintain current level of function to be symptom free of dehydration. I don't see one for the medications." During an interview on 03/28/19 at 11:11 AM, the Director of Nursing Assistant stated, "There should be a care plan [for Resident #86]. We should have a psychotropic medications care plan. We do monitor for side effects, for changes in behavior type, the interventions done [sic], and the outcomes [of the interventions]. . . . we should have a care plan for this." When asked when a care plan should be developed, the Director of Nursing Assistance stated, "We get a baseline care plan within 72 hours, but we should also have a comprehensive care plan [for Resident #86] and I'm not seeing one." During an interview on 03/28/19 at 11:22 AM, the	F 656		

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F 656	Continued From page 22 DON stated, "On [Resident #86's] admission MDS dated 03/04/19, and on the 14-day MDS dated 02/26/19, Section N [for] antidepressant [medication] is marked 'yes' as being received in the last seven days." When asked if Resident #86 had a care plan for the use of the antidepressants, the DON stated, "I'm guessing we don't have a care plan. We should have one for the antidepressants." When asked about the process for developing a comprehensive care plan, the DON stated, "From the time of admission, we note the physician's orders [and] get the consents [for psychotropic medication administration]. . . . By day 21, we should have a care plan for every 'CAA' that triggered." When asked if there was a comprehensive care plan for behaviors, the DON stated, "No. . . . [the] MDS is the starting point for the care plans, starting with the [triggered] CAAs. I would have to ask the MDS person why the care plan was not completed." During an interview on 03/28/19 at 11:53 AM, the MDS Assistant stated, "On [Resident #86's] admission MDS, on Section N, I see antidepressant checked and that the resident received it in the last seven-day look-back period. On Section V, the CAA worksheet says he is at risk for side effects for [sic] antidepressant meds, proceed to care plan." When asked if Resident #86 had a comprehensive care plan, the MDS Assistant stated, "I don't see one. I'm sorry, I didn't develop one. . . .There should be a care plan for the antidepressant medications. I can't say why [it was not done]. He is getting the medications for depression and agitation and there should be a comprehensive care plan [for use of those medications]."	F 656		

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F 656	Continued From page 23 Resident #36: Review of Resident #36's Care Plan, initiated on 01/04/19, indicated the staff were directed to, "Encourage turning and repositioning while in bed and discourage extended periods of sitting up." The care plan did not include resident-specific time frames for repositioning Resident #36, based on an assessment of the resident's unique risk factors for skin impairment. Observation on 03/25/19 from 9:00 AM to 9:15 AM, revealed Resident #36 sat in his wheelchair in the common area of A wing outside the Rehabilitation Area. During the observation, Resident #36 did nothing to change his position and no staff intervened to encourage, or prompt him to change his position. Observation on 03/25/19 from 10:03 AM to 11:00 AM, revealed Resident #36 sat in his wheelchair in the common area of A wing. During the observation Resident #36 did nothing to change his position, and no staff intervened to encourage or prompt him to change his position. Observation on 03/25/19 from 12:04 PM to 1:30 PM, revealed Resident #36 sat in his wheelchair in the common area of A wing. During the observation Resident #36 did nothing to change his position, and no staff intervened to encourage or prompt him to change his position. Observation on 03/25/19 from 2:30 PM to 3:15 PM, revealed Resident #36 sat in his wheelchair in the dining room. During the observation Resident #36 did nothing to change his position, and no staff intervened to encourage or prompt him to change his position.	F 656		

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F 656	Continued From page 24 Observation on 03/26/19 from 10:38 AM to 11:15 AM, revealed Resident #36 sat in his wheelchair in the common area of A wing. During the observation Resident #36 did nothing to change his position, and no staff intervened to encourage or prompt him to change his position. During an interview on 03/26/19 at 9:01 AM, Resident #36 stated that about two (2) years ago he developed a spinal infection that left him with very little sensation from the waist down. After a previous stay at this facility, Resident #36 stated he was able to return home with his wife serving as his primary care giver. However, at home he developed two (2) pressure ulcers in his sacral (lower back) region, which quickly worsened. When asked how often the staff assisted him with position changes throughout the day, Resident #36 stated, "Not as much as I should [be repositioned] . . . When I ask for help with repositioning, they will help me out of my wheelchair and help me into bed . . . When they help me to bed during the day to change my position, I stare at the ceiling and the four (4)walls and it gets me down. I prefer to be out with the people, going outside with my wife, and going to activities, especially music performances. So, I don't ask for help with repositioning." Resident #36 stated that he can lift himself in his wheelchair to relieve the pressure on his back, but forgets to do so, and added, "I think that would help if staff reminded me [to change positions] and didn't take me to bed." Review of Resident #36's admission MDS, with an ARD of 01/10/19, specified the resident had a BIMS score of 15 out of 15, which indicated he had no cognitive impairment. The assessment indicated Resident #36 exhibited no episodes of	F 656		

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F 656	Continued From page 25 rejection of care, and that his "Skin and Ulcer Treatments" included being placed on a turning and repositioning program. During an interview on 03/26/19 at 10:43 AM, Certified Nursing Assistant (CNA) #6 stated that Resident #36 can ask for repositioning during the day and the staff will help him back to his bed. She added that Resident #36 can also reposition himself by raising up in his wheelchair. During an interview on 03/26/19 at 2:00 PM, Licensed Practical Nurse (LPN) #4 stated that Resident #36 sits in his wheelchair for extended periods of time each day and added, "He can ask to go lay on his bed during the day, but he usually doesn't ask to return to his room." During an interview on 03/27/19 at 2:00 PM, the Rehabilitation Director reported that Resident #36 is seen in therapy every day, and that therapy staff work with the resident on rising from his chair and walking short distances. The Rehabilitation Director then stated, "As to his motivation, I am concerned that he seems so withdrawn and so flat most of the time, but he is willing to do whatever we ask of him." She added that Resident #36 knows to use his arms to press down on the arms of his wheelchair to raise his back and bottom off the wheelchair seat, but she was not sure how often he completed this maneuver throughout the day. She stated it would be better for relieving pressure from his back and bottom if he could be assisted to stand and walk at regular intervals when he is up and around during the day. She said she believed this change could be accomplished with some coordination between the nursing and rehab.	F 656		

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F 656	Continued From page 26 During interviews on 03/26/19 at 3:43 PM, and on 03/28/19 at 11:12 AM, the DON stated that Resident #36's repositioning needs could be better met with a change to his care plan to include specific requirements for position changes throughout the day.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to provide fingernail care for one (1) of three (3) sampled residents (Resident #79) with diabetes. This failure had the potential to affect all the residents that were dependent on staff for assistance with Activities of Daily Living (ADLs) and personal hygiene. Findings include: On 03/28/19 at 1:00 PM, the Director of Nursing (DON) was asked for the facilities policy for diabetic nail care and a policy for cleaning hands/nails before meals. At 1:30 PM, the DON returned and stated the facility did not have a policy addressing the diabetic nail care or the hand/nails being cleaned before meals. The electronic medical record for Resident #79 documented the resident had been admitted to the facility on 08/29/16. Resident #79's diagnoses included Diabetes Mellitus (DM) and Arthritis.	F 677	1. On March 30, 2019, nail care was provided to Resident #79 by the Registered Treatment Nurse. On April 5, 2019, Resident #79 's plan of care was revised to include new intervention that may help Resident #79 agree to nail care and other personal cares. On April 3rd and April 8th, 2019, evaluation of 36 of 93 resident' s nails, with the diagnoses of diabetes, were done by licensed nurses to ensure nails were trimmed/filed and clean. Issues identified were corrected. 2. All residents who require assistance with Activities of Daily Living (ADLs) have the potential to be affected by failing to provide fingernail care. 3. On April 5, 2019, the facility Administration developed a policy for Providing Nail Care. On April 5, 2019 in-servicing was initiated, by the Director of Nursing and Assistant Director of	4/28/19

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F 677	Continued From page 27 On 03/25/19 at 3:25 PM, Resident #79 was observed sitting in her wheelchair in her room. Resident #79's fingernails were observed with a brown substance underneath the uneven, and partially painted fingernails. Resident #79's toenails were observed to be long and uneven. The resident was asked how long it had been since she had her nails trimmed. Resident #79 stated the facility used a Podiatrist which she hadn't seen for a long time, so she had not had her toenails clipped. Resident #79 stated she didn't know how long it had been since she had her fingernails trimmed and painted but that had been a long time too. During an interview on 03/27/19 at 12:13 PM, with Registered Nurse (RN) #5, the RN was asked who was responsible to ensure a diabetic resident's nails were clean and clipped. RN #5 stated that when an aide gets a resident up to eat the aide should ensure the resident's hands and fingernails are clean. RN #5 stated there are ladies who volunteer to paint residents' nails every Wednesday. RN #5 stated if a resident was not a diabetic or receiving an anticoagulant medication the aides could cut and trim the resident's nails. RN #5 stated if the resident was a diabetic or receiving an anticoagulant medication the nurses would cut and trim the resident's fingernails and toenails. RN #5 said the facility had a podiatrist who would come into the facility to cut the residents' toenails but does not remember when or if the podiatrist still came to the facility. RN #5 stated the certified nurse aide (CNA) is responsible to notify the nurse when a diabetic resident required their fingernails or toenails trimmed.	F 677	Nursing, for licensed nurses and certified nursing assistants (CNAs) on the nail care policy. 4. The Director of Nursing or Assistant Director of Nursing will monitor nail care to ensure nails are clean and trimmed/filed beginning April 1, 2019, weekly x four (4) weeks and monthly x two (2) months. The monitoring/audits will be submitted by the Director of Nursing or Assistant Director of Nursing to the Quality Assurance Performance Improvement Committee for review and recommendations monthly x three (3) months.	

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F 677	Continued From page 28	F 677		

Resident #79's significant change "Minimum Data Set (MDS)", with an "Assessment Reference (ARD)" date of 03/02/19, indicated Resident #79 had a "Brief Interview for Mental Status (BIMS)" with a score of 15 out of 15, which indicated the resident had no cognitive impairment. Resident #79 required the physical assistance of two (2) or more staff members for bed mobility, transfers and required physical assistance of two staff with personal care which included washing her face and hands.

The "Care Plan" for Resident #79 with a review date of 03/02/19, documented, "6/6/18: I often refuse staff assist with my ADL needs, then complain that I don't get the help I need." The interventions included: "6 /6/18: Staff will continue to encourage me to accept assist with ADL needs, if I become agitated, they will wait a few minutes, then come back & ask me again. Assess and anticipate my needs: food, thirst, toileting needs, personal needs, supplies, comfort level, body positioning, pain etc. I have an ADL self-care performance deficit & I often choose to decline staff assist with my ADL needs. I require increased assist with Dressing, toileting, hygiene, bathing, bed mobility transfers and ambulation d/t decreased endurance. I have Diabetes Mellitus."

On 03/28/19 at 10:15 AM, Licensed Practical Nurse (LPN) #2 was asked to go look at Resident #79's fingernails and toenails. The resident was lying in her bed. Resident #79's fingernails were observed uneven, dirty underneath the nails, and partially coated with chipped polish. LPN #2 stated Resident #79 was a diabetic and the CNA was not able to clip Resident #79's fingernails or toenails. LPN #2 stated the CNA needed to let a nurse know when Resident #79's nails required

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F 677	Continued From page 29 clipping. LPN #2 was asked why the resident's fingernails had a brownish substance underneath the nails observed for three (3) days of the survey. LPN #2 stated the staff should be cleaning Resident #79's nails everyday if her fingernails are observed dirty. LPN #2 stated the resident eats some of the time with her hands and probably gets food underneath her nails. LPN #2 then observed Resident #79's toenails. LPN #2 stated Resident #79's fingernails and toenails needed cleaned and clipped. On 03/28/19 at 10:27 AM, Resident #79 was asked if staff washed her hands before she ate her meals. Resident #79 stated they would sometimes take a wet wash cloth and wipe off her hands but used no soap and never cleaned underneath her fingernails. On 03/28/19 at 10:32 AM, LPN #2 stated Resident #79 was very moody, but she knows that's no excuse for dirty and unclipped fingernails and unclipped toenails. LPN #2 stated the resident is diabetic and the nurses need to be told by the CNA staff when the resident needed her nails clipped.	F 677		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		4/28/19

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F 755	Continued From page 30 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the manufacturer's recommendations for the Blood Glucose Meter it was determined the facility failed to ensure glucometers were kept in safe operating order based on the manufacture's recommendation for three (3) of four (4) glucometers on two (2) of two (2) nursing units. Findings include: The facility's policy for the daily calibration and documentation of the glucometers (blood glucose monitoring system) was requested, but not provided by the Director of Nursing (DON) by the	F 755	1. On April 1, 2019, control checks were completed by nursing staff on four (4) of four (4) glucometers. No issues were identified. On April 1, 2019, the facility Administration developed a glucometer control check policy to include frequency of control checks to be completed. On April 5, 2019, resident accucheck results were reviewed, by the Director of Nursing and Assistant Director of Nursing, to include any abnormal readings and compare to control checks of glucometers. No issues were identified. 2. Residents receiving sliding scale	

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F 755	Continued From page 31 end of the survey. Review of the manufacturer's recommendations for the SmartMeter Blood Glucose Meter, undated, revealed it was recommended to perform solution controls according to protocol set by the institution. Instances when control checks should be conducted include: questionable test result; when the performance of the meter or test strips are uncertain; if the meter is dropped; and when you troubleshoot the meter. Do not use the system to test the blood until you get a test result that falls within the control range. Review of the Glucometer Logs on 03/27/18 for the North Hall on Unit A from 01/01/19 through 03/27/19, revealed the glucometer had not been tested on two (2) days. Review of the Glucometer Logs on 03/27/18 for the North Hall on Unit B revealed from 01/01/19 through 03/27/19, the glucometer had not been tested on 12 days. The glucometer on the South Hall on Unit B had not been tested on nine (9) days. During an interview on 03/28/19 at 10:45 AM, with the Director of Nursing (DON), the DON stated the night shift nurses were responsible for performing the glucometer calibrations. The DON said it was important to make sure the glucometers were working correctly to ensure the residents' blood glucose readings were correct. The DON stated it was her responsibly to make certain the glucometer checks were being done and obviously, she was not checking often enough.	F 755	insulin and orders for accuchecks have the potential to be affected by failing to ensure glucometers are kept in safe operating order. 3. On April 1, 2019, Licensed Practical and Registered Nursing staff in-services were initiated by the Director of Nursing (DON) on the new policy to include control checks to be completed daily by 11p-7a nurse and completion of the glucometer control check logs. 4. The Director of Nursing or Assistant Director of Nursing will monitor the glucometer control check process beginning April 1, 2019, weekly x four (4) weeks and monthly x two (2) months. The monitoring/audits will be submitted by the Director of Nursing or Assistant Director of Nursing to the Quality Assurance Performance Improvement Committee for review and recommendations monthly x three (3) months.	
F 880	Infection Prevention & Control	F 880		4/28/19

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F 880 SS=D	Continued From page 32 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 33 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to follow infection control practices regarding hand hygiene. Specifically, when conducting a skin assessment and wound care for one (1) of 23 sampled residents (Resident #6). Findings include:	F 880	1. On April 2, 2019, the weekly wound assessment was completed for Resident #6 by the Certified Wound Specialist to identify any issues related to failure to perform hand hygiene during skin assessment and wound care by Licensed Practical Nurse #1. No issues were identified. 2. All residents have the potential to be	

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	255302	A. BUILDING _____ B. WING _____	03/28/2019

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SENATOBIA HEALTHCARE & REHAB	402 GETWELL DR SENATOBIA, MS 38668

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F 880	Continued From page 34 Review of the facility's policy titled, "Hand Washing Policy," undated, revealed it was the policy of the facility that hand-washing will be done as follows: by all staff frequently throughout their shift to reduce the transmission of organisms from resident to resident; to reduce the transmission of organisms from the nursing staff to the resident; to reduce the transmission of organisms from the resident to the staff; before and after resident care; and after contact with body fluids or excretions, mucous membranes, non-intact skin or wound dressings. On 03/27/19 at 4:40 PM, observation of wound care and a skin assessment for Resident #6 revealed Licensed Practical Nurse (LPN) #1 applied Calazime to the resident's coccyx with her gloved hand. The LPN, wearing the same gloves, proceeded to complete the full body skin assessment of the resident. After completion of the skin assessment the LPN repositioned the resident, covered the resident with a blanket, used the bed controls to lower the bed, placed the call light in reach of the patient, gathered supplies, left the patient room, entered the hallway, deposited used supplies in trash, picked up the keys on top of the medication cart wearing the same soiled gloves. The LPN then removed the soiled gloves and did not sanitized or wash her hands. When asked if she had completed the procedure, the LPN replied, "Yes." Review of the Order Summary Report for Resident #6, dated 03/05/19, revealed the resident had an order to apply Calazime (a topical (skin) cream) to wound on coccyx every shift. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 12/21/18, revealed the	F 880	affected by failing to follow infection control practices regarding hand washing. 3. On March 29, 2019, Licensed Practical Nurse #1 was in-serviced by the Staff Development Coordinator to include handwashing and gloving. On April 1, 2019, the Staff Development Coordinator observed Licensed Practical Nurse #1 performing wound care. No infection control issues were identified. On April 1, 2019, in-servicing was initiated by Staff Development Coordinator and Assistant Director of Nursing, to include hand washing and gloving, for Licensed Practical and Registered nursing staff. 4. The Director of Nursing or Assistant Director of Nursing will observe Licensed Practical Nurse #1 performing treatments or wound care, to ensure hand hygiene and gloving to maintain infection control is followed beginning April 1, 2019, weekly x four (4) weeks and monthly x two (2) months. The Staff Development Coordinator or Assistant Director of Nursing will observe Licensed Practical and Registered nursing staff performing treatments or wound care, to ensure hand hygiene and gloving to maintain infection control is followed beginning April 1, 2019, weekly x four (4) weeks and monthly x two (2) months. The monitoring/audits will be submitted by the Director of Nursing or Assistant Director of Nursing to the Quality Assurance Performance Improvement Committee for review and recommendations monthly x three (3) months.	

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F 880	Continued From page 35 resident had one Stage 3 pressure ulcer. Review of the Weekly Observation Tool, dated 03/05/19, revealed Resident #6 had a Stage III pressure ulcer to the coccyx that measured 3.0 mm (millimeters) long by 3.0 mm wide and was 1.0 mm deep. The wound was well-defined and improving. Interview on 03/27/19 at 5:05 PM, with LPN #1 revealed she was aware that she should have removed the gloves and sanitized her hands between glove changes. The LPN commented, "Sometimes I double glove. I should have removed the gloves and sanitized my hands between glove changes." Interview with the Director of Nursing (DON) on 3/28/19 at 10:50 AM, confirmed the LPN should have removed gloves, performed hand hygiene and reapplied clean gloves after applying the cream to the coccyx area. The DON stated, "She came to me and said she needed an in-service on Hand Hygiene." The DON also stated, "This practice could cause organisms to spread through out the facility."	F 880		

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	255302	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/29/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA) ...	K 000		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		5/28/19

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

Electronically Signed | 04/11/2019

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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K 918	Continued From page 1 separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observations and testing the facility failed to achieve the required transfer time of 10 seconds when testing the generator in accordance with NFPA 110 Chapter 4, Table 4.1 (b) & 4.3 Type. This condition has the potential to affect 100% of the residents and staff. Findings include: On March 29, 2019 at, 10:50 AM, the generator had a failed test of transferring power to the facility within the required 10 seconds. The tested transfer time was recorded at 19.57 seconds. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview.	K 918	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. 1. On 4/2/19, Thompson Power (generator vendor) noted a damaged 4 pole breaker in transfer switch box and investigated the cause of the delay in power transfer to facility and stated "the failure is commonly caused by an electrical surge to these control components and recent local area history confirms that possibility." 2. Due to the nature of the deficiency, all facility residents have the potential to be affected. 3. The facility Administrator provided education to Maintenance Director related to documentation of staff audits on the education and return demonstration of transferring power. On 4/1/19, the Maintenance Director in-serviced staff across all shifts how to manually transfer power in the event of a power failure that required the generator	

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K 918	Continued From page 2	K 918	to engage along with return demonstration. A new 4 pole breaker was ordered 4/9/19 and insurance company was notified. 4. The facility Administrator will audit the weekly staff audits beginning April 1, 2019 weekly for (4) weeks, then monthly for (2) months to ensure compliance with the standard. Audit findings will be submitted to facility Administrator on a weekly basis and will be submitted to the Quality Assurance Committee for review and recommendations for (3) months.	

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 3/29/19 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 | 04/11/2019

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