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	61BC	A. BUILDING: _____ B. WING _____	C 07/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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M 000	Initial Comments The State Agency (SA) conducted a Complaint Investigation (CI), MS #18828, MS #18802, MS #18741, MS #18671, and MS #19421 at the facility from 7/25/22 through 7/29/22. During the survey, the SA determined the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements. The SA did not substantiate MS #19421 for abuse or MS #18802 for pressure sores, mouth care, hydration, misappropriation, environment, dietary services and physician services. The SA did not substantiate MS #18741 for abuse, but cited M500, M615, and M735 for a pressure wound related to the investigation. The SA substantiated MS #18671 related to Activities of Daily Living (ADL) care and cited M610.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate;	M 500		9/16/22

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M 500	Continued From page 1 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff	M 500		

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M 500	Continued From page 2	M 500		

and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

7. is free from mental and physical abuse;
8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint;
9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract;

10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

11. is not required to perform services for the facility that are not included for therapeutic

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M 500	Continued From page 3 purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights.	M 500		

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M 500	Continued From page 4 This Statute is not met as evidenced by: Based on interviews, record reviews, and facility policy review, the facility failed to notify a physician to obtain an order to provide a treatment to a resident admitted with a pressure ulcer for one (1) of two (2) residents reviewed for pressure ulcers. Resident #1 Findings Include: Record review of the facility's "Admission policy", revised 10/17 revealed, " ...Follow-Through 2. The licensed nurse will notify the physician (or medical provider) of pertinent assessment findings and if needed, clarify orders/medications..." Record review of Resident #1's "Face Sheet" revealed the facility admitted him on 2/18/22 with a diagnosis of Encounter for Other Orthopedic Aftercare, and he was discharged from the facility on 3/26/22. Record review of Resident #1's "Wound Assessment Report" with the "Date of Assessment" listed as 2/18/22 and the "Assessment Occasion" listed as "Admission" revealed a Stage 2 Pressure Ulcer to the sacrum. The "Date wound identified" was 2/18/22. The "Treatments" was indicated as "Pending treatment orders" and the "Date electronically signed" was on 02/18/2022 by Registered Nurse (RN) #1. Record review of Resident #1's "Physician Orders" for the month of February 2022, revealed a Physician Order dated 3/04/22 to "Cleanse stage 2 pressure injury to sacrum with NS (Normal Saline), pat dry, apply hydrogel	M 500	a. Resident #1 was discharged from the facility to his home with Home Health Services on 03/26/2022. b. All residents with wounds have the potential to be affected by this deficient practice. c. On 07/27/2022, an audit was conducted by the facility Treatment Nurse to ensure that all current residents with wounds have physician orders to treat each wound. The facility Treatment Nurse was in-serviced on 07/28/2022 by the Director of Nurses, and again on 08/17/2022 by the Director of Nurses regarding notification of Physician concerning wounds in order to obtain an order to treat. The Treatment Nurse and/or the Director of Nurses will ensure all residents admitted with wounds have accurate orders obtained from the Physician for their wound(s). d. Beginning on 08/18/2022 the Director of Nurses and Registered Nurse Case Manager, and/or Treatment Nurse will assess all new admits. The Director of Nurses will review at least 5 Physician orders per week for 2 weeks, then 3 Physician orders per week for 2 weeks, then 3 Physician orders one time a week for 2 months to ensure all wounds identified on admission have treatment orders. Areas of concern will be brought to the Quality Assessment and Improvement Committee for review. The Quality Assessment and Improvement Committee will convene on 09/08/2022 to discuss	

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M 500	Continued From page 5 impregnated gauze and cover with bordered dressing". The interval code was "MTH" to indicate treatments on Monday and Thursday. This was the first Physician's Order obtained for a treatment to Resident #1's pressure ulcer to the sacrum, which had been identified upon admission on 2/18/22. Resident #1 was at the facility for 14 days before a Physician's Order was obtained for a treatment to the sacrum. Record review of the electronic Treatment Administration Record (eTAR) for the month of February 2022 revealed there was no documentation that Resident #1 received treatment for the pressure ulcer to the sacrum that had been identified upon admission on 2/18/22. Record review of the eTAR for March 2022 revealed there was no documentation that Resident #1 received treatment for the pressure ulcer to the sacrum that had been identified upon admission on 2/18/22 until 3/7/22. A record review of Resident #1's Nurses Notes revealed there was no documentation related to notifying the physician or obtaining a Physician's Order for a treatment to the Stage 2 pressure ulcer to the sacrum. On 7/29/22 at 11:00 AM, the State Agency (SA) conducted an interview with the Director of Nursing (DON). She confirmed that the wound care nurse should have gotten a Physician Order for a treatment to the pressure ulcer to the sacrum when the resident was admitted to the facility. She stated that the treatment nurse should not do wound care without a physician's order.	M 500	further recommendations as needed. Additional training and/or disciplinary action will be considered as warranted.	

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M 500	Continued From page 6 On 7/29/22 at 12:06 PM, the SA conducted an interview with RN #1, who is the Wound Care /Treatment Nurse. She confirmed that she should have gotten a Physician Order on 2/18/22 for Resident #1 because he was admitted to the facility with a pressure ulcer to the sacrum. She confirmed that the eTAR did not have treatments documented for the sacrum wound until 3/7/22. She stated that although it is not documented on the eTAR, she treated the wound from 2/18/22 through 3/4/22 without a Physician Order until one was obtained on 3/4/22. On 7/29/22 at 12:33 PM, the SA conducted an interview with the Administrator. She confirmed that there was not a Physician Order to treat Resident #1's pressure ulcer to the sacrum when he was admitted on 2/18/22. She stated that the nurse should not have treated a wound without a Physician Order. She stated that from what she gathered the nurse knew the wound was there but realized a little later that there was no Physician Order.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting.	M 610		9/16/22

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M 610	Continued From page 7 This Statute is not met as evidenced by: Based on interviews, record reviews, and facility policy review, the facility failed to provide shower/bath assistance as scheduled to one (1) of three (3) residents reviewed who were dependent on staff for Activities of Daily Living (ADL) Care. Resident #7 A review of the facility's policy titled "Bathing", with a revision date of 10/17, revealed the purpose is to ensure resident comfort and dignity, to cleanse the body and promote skin health, and to observe for skin abnormalities (e.g., breakdown, redness, bruising) ..." On 7/27/22 at 3:35 PM, an observation of Resident #7 (Res #7) revealed the resident lying in bed wearing an off white, blue flowered print, short sleeve shirt. Resident's hair appeared unwashed and oily. On 7/28/22 at 4:04 PM, an observation and interview with Res #7 confirmed the shirt she was wearing (an off white, blue flowered print, short sleeve shirt) was the same shirt she had on the day before. Res #7 stated she had been wearing the shirt for a week because she had not had a bath in a week. The resident further stated her hair had not been washed in a month. Res #7 denied ever refusing to take a bath or receive care. A record review of the facility's "Bath Schedule" revealed Res #7's bath days were Mondays, Wednesdays, and Fridays. A record review of "Completed Care Details" for Res #7 revealed between the dates of 06/29/22 through 7/28/22 the resident received a complete bed bath on 7/18/22. There were no other dates	M 610	a. Resident #7 was assessed on 08/18/2022 by the Director of Nurses for any adverse effects related to how the facility failed to provide shower/bath assistance as scheduled. There were no adverse effects noted. b. All residents have the potential to be affected by this deficient practice. c. On 08/17/2022 an audit was conducted by the Facility Administrator and Director of Nurses to ensure all residents are provided shower/bath assistance according to the facility bath schedule. The certified Nurse's Aide assigned to provide baths/showers was in-serviced on 08/19/2022 regarding the bath schedule by the Facility Administrator and Director of Nurses. The Facility Administrator and Director of Nurses will ensure all residents are provided baths/showers as scheduled. d. Beginning on 08/18/2022 the Facility Administrator and Director of Nurses will observe 5 residents 1 time per week for 3 weeks, then 3 residents 1 time per week for 2 weeks, then 2 residents per week for 1 week to ensure all residents are provided baths/showers as scheduled. Areas of concern will be brought to the Quality Assessment and Improvement Committee for review. The Quality Assessment and Improvement Committee will convene on 09/08/2022 to discuss further recommendations as needed. Additional training and/or disciplinary action will be considered as warranted.	

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M 610	Continued From page 8	M 610		

for a complete bed bath or whirlpool bath, in the last 30 days.

On 7/29/22 at 11:00 AM, an interview with the Director of Nursing (DON) confirmed that it is very important for a resident to get their bath. She stated the nurses should be verifying that the Certified Nurse Aides (CNA)s are completing resident baths as scheduled. The DON stated that if a resident refused a bath, it should be reported to the nurse. The DON stated having hair washed should be included in the resident's bath unless the resident or family requests otherwise. The CNAs should let the nurses know if the resident is combative, refuses care, or anything else and that information should be documented.

A record review of the Nurses notes for Res #7 revealed no entries of Res #7 being combative or refusing care.

On 7/29/22 at 12:33 PM, an interview with the Administrator revealed residents have their hair washed when they get their baths. She stated that all activities of daily living are documented in the computer.

A record review of Resident #7 Face sheet revealed that the resident was admitted on 08/26/20 with diagnoses including Overactive Bladder and Major Depressive Disorder.

A record review of the Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/31/22, revealed Res #7 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated the resident had no cognitive dysfunction and a review of Section G revealed she required the one person to physically assist

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M 610	Continued From page 9 with bathing.	M 610		
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were unavoidable. This Statute is not met as evidenced by: Based on interviews, record reviews, and facility policy review, the facility failed to obtain a Physician's Order and to document that wound care was provided for one (1) of two (2) residents reviewed for pressure ulcers. Resident #1 Findings Included: Record review of the facility's policy "Admission", revised 10/17, "Follow-Through 1. The licensed nurse will notify the physician (or medical provider) of pertinent assessment findings and if needed clarify orders/medications ..." Record review of the facility's policy, "Dressing Change Policy and Procedure", with a revision date of 08/21, revealed, " ...Steps in the Procedure ...2. Review topical treatment order ..." Record review of Resident #1's "Wound Assessment Report" with the "Date of Assessment" listed as 2/18/22 and the "Assessment Occasion" listed as "Admission" revealed a Stage 2 Pressure Ulcer to the sacrum. The "Date wound identified" was 2/18/22. The "Treatments" was indicated as "Pending	M 615	a. Resident #1 was discharged from the facility to his home with Home Health Services on 03/26/2022. b. All residents have the potential to be affected by this deficient practice. c. On 07/27/2022 an audit was conducted by the facility Treatment Nurse to ensure that all current residents with wounds have a Physician order to treat, and that treatment of the wound is documented. The facility Treatment Nurse was in-serviced on 07/28/2022 by the Director of Nurses, and again on 08/17/2022 by the Director of Nurses regarding notification of Physician regarding wounds in order to obtain an order to treat, and ensuring documentation of wound treatment is completed. d. Beginning on 08/18/2022 the Director of Nurses and Treatment Nurse will perform wound care rounds to ensure all residents with wounds have Physician orders to treat, and that treatment of the wound is	9/16/22

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M 615	Continued From page 10 treatment orders" and the "Date electronically signed" was on 02/18/2022 by Registered Nurse (RN) #1. Record review of Resident #1's "Physician Orders" for the month of February 2022, revealed a Physician Order dated 3/04/22 to "Cleanse stage 2 pressure injury to sacrum with NS (Normal Saline), pat dry, apply hydrogel impregnated gauze and cover with bordered dressing". The interval code was "MTH" to indicate treatments on Monday and Thursday. The Physician's Order for wound care treatment was not received until 14 days after Resident #1 was admitted to the facility. Record review of the electronic Treatment Administration Record (eTAR) for the month of February 2022 revealed there was no documentation that Resident #1 received wound care for the pressure ulcer to the sacrum that had been identified upon admission on 2/18/22. Record review of the eTAR for March 2022 revealed there was no documentation that Resident #1 received wound care for the pressure ulcer to the sacrum that had been identified upon admission on 2/18/22 until 3/7/22. A record review of the Nurse's Notes for Resident #1 revealed there was no wound treatment documentation or physician orders for the Stage 2 pressure wound to the sacrum until 3/4/22. In an interview with the Director of Nursing (DON) on 7/29/22 at 11:00 AM, she confirmed there was no wound care orders received from the physician when Resident #1 was admitted to the facility and the treatment nurse should not do wound care without an order.	M 615	documented, 3 times per week for 3 weeks, then 2 times per week for 2 weeks, then 1 time per week for 2 months. Areas of concern will be brought to the Quality Assessment and Improvement Committee for review. The Quality Assessment and Improvement Committee will convene on 09/08/2022 to discuss further recommendations as needed. Additional training and/or disciplinary action will be considered as warranted.	

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M 615	Continued From page 11 In an interview with Registered Nurse (RN) #1 on 7/29/22 at 12:06 PM, she confirmed that she is the Treatment Nurse for the facility. She stated that she should have gotten a wound care order from the physician when Resident #1 was admitted on 2/18/22 with the sacrum pressure ulcer. She explained that although she was treating the pressure wound to the sacrum from 2/18/22 through 3/4/22, she did not have a Physician's Order and she was not documenting it on the eTAR. During an interview with the Administrator on 7/29/22 at 12:33 PM, she confirmed that there was not a wound care order for Resident #1 for the pressure ulcer to his sacrum. She also confirmed that if the nurse had completed wound care, she should have documented it on the eTAR. Record review of Resident #1's "Face Sheet" revealed the facility admitted him on 2/18/22 with a diagnosis of Encounter for Other Orthopedic Aftercare, and he was discharged from the facility on 3/26/22.	M 615		
M 735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information.	M 735		9/16/22

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M 735	Continued From page 12 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3)	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	61BC	A. BUILDING: _____ B. WING _____	C 07/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRANDON COURT	100 BURNHAM ROAD BRANDON, MS 39042

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M 735	Continued From page 13 years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to maintain an accurate medical record regarding wound care treatment for one (1) of two (2) residents reviewed for wounds. Resident #1 Findings Include: Record review of the facility's policy, "Medical Records", with a revision date of 04/17, revealed, "Policies and Procedures This facility maintains a separate resident record on each resident ...that are complete, accurate ..." Record review of Resident #1's "Wound Assessment Report" with the "Date of Assessment" listed as 2/18/22 and the "Assessment Occasion" listed as "Admission" revealed a Stage 2 Pressure Ulcer to the sacrum. The "Date wound identified" was 2/18/22. The "Treatments" was indicated as "Pending treatment orders" and the "Date electronically signed" was on 02/18/2022 by Registered Nurse (RN) #1. Record review of the electronic Treatment Administration Record (eTAR) for the month of February 2022 revealed there was no documentation that Resident #1 received wound care for the pressure ulcer to the sacrum that had been identified upon admission on 2/18/22. Record review of the eTAR for March 2022 revealed there was no documentation that	M 735	a. Resident #1 was discharged from the facility to his home with Home Health Services on 03/26/2022. b. All residents have the potential to be affected by this deficient practice. c. On 07/27/2022, an audit of medical records for all residents with wounds was conducted by the Treatment Nurse to ensure accuracy of medical records regarding wound care treatment. The facility Treatment Nurse was in-serviced on 07/28/2022 by the Director of Nurses, and again on 08/17/2022 by the Director of Nurses regarding ensuring wound care treatment is being documented accurately in the resident's medical record. d. Beginning on 08/18/2022, the Director of Nurses and Treatment Nurse will perform an audit of medical records for residents with wounds to ensure accuracy 3 times per week for 3 weeks, then 2 times per week for 2 weeks, then 1 time per week for 2 months. Areas of concerns will be brought to the Quality Assessment and Improvement Committee for review. The Quality Assessment and Improvement Committee will convene on 09/08/2022 to discuss further recommendations as needed. Additional training and/or disciplinary action will be considered as warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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M 735	Continued From page 14 Resident #1 received wound care for the pressure ulcer to the sacrum that had been identified upon admission on 2/18/22 until 3/7/22. A record review of the Nurse's Notes revealed there was no documentation for Resident #1 that indicated wound care was provided. On 7/29/22 at 12:06 PM, in an interview with RN #1, she confirmed that the resident was admitted to the facility on 2/18/22 with a stage 2 pressure ulcer to his sacrum. She stated she treated the pressure wound without a physician order and without documenting the treatment on the eTAR. On 07/29/22 at 12:33 PM, in an interview with the Administrator, she confirmed that if the nurse was treating the pressure ulcer, she should have documented on the eTAR.	M 735		