STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255331	A. BUILDING _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARRINGTON LIVING CENTER	701 SOUTH HOLLY STREET COLLINS, MS 39428

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and Complaint Investigation (CI) MS #19501, at the facility from 9/12/22 through 9/15/22. The SA did not substantiate CI MS #19501 for abuse and food served cold and uncooked. There were no deficiencies cited related to the complaint. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F576, F677, and F880. The facility held a license for 60 beds, and had a census of 59 at the time of the survey.	F 000		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages	F 576		10/28/22

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

Electronically Signed | 10/04/2022

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F 576	Continued From page 1 and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to ensure residents received their mail on Saturdays for two (2) of 15 sampled residents. Resident #1 and Resident #22. This had the potential to affect 59 residents. Findings Include: Record review of the facility policy "Mail and Telephone Services" with a revised date of 11/28/17 revealed "Purpose: To facilitate communication between the residents and their significant others via telephone and mail services ..." On 09/14/22 at 10:11 AM, during the Resident Council meeting, Resident #22 stated that they do not get mail on the weekends. There is no one at	F 576	1. Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. • The facility contacted the postmaster on Wednesday, September 14, and directed the facility to obtain the official E911 address from the county emergency management office. • The official address was obtained by the Administrator on Thursday, September 15. The E911 address was provided to the local postmaster for direction on placement of the mailbox. • The postmaster notified the facility of the location on Monday, September 26. The facility contacted 811 (Know what's below. Call before you dig.) for all locates. • Locates were completed on Thursday,	

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F 576	Continued From page 2 the facility to go to the post office to get the mail on Saturday. Resident #22 stated that she has inquired about the mail in the past and nothing was done about it. Record review of the "Face Sheet" revealed Resident #22 was admitted by the facility on 4/18/16 with a diagnosis of Unspecified Osteoarthritis. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/11/22 revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. On 09/14/22 at 10:35 AM, in an interview with Activities Director, stated that about a year ago, the residents agreed in a resident council meeting to only have their mail delivered Monday through Friday. She said the facility has a Post Office (PO) box and someone, usually the Administrator, must go to the post office to get the mail. She explained that neither herself nor the Administrator works on weekends, so the mail is not picked up at the PO box on Saturdays. On 09/15/22 at 1:38 PM, in an interview with Resident #1, she stated she does not get mail on Saturdays. She receives a lot of mail from family and friends, and also receives catalogs that she enjoys looking through. She would like to get mail on Saturdays. She regularly receives letters from her sister because it is the only way she can communicate with her. She stated that she had been told by the facility that she could not receive mail on Saturdays because no one is at the facility on weekends to get it. Resident #1 commented, "I would be thankful if I could get my	F 576	September 29. • The facility mailbox was installed on Friday, September 30. • Mail began being delivered to the facility mailbox on Monday, October 3. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. • All residents that receive mail have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. • Mailbox specific for facility was installed on Friday, September 30. • The Clerk will check the mailbox and distribute mail to the residents daily including Saturdays. If Clerk is not available, the Nurse Supervisor will get and distribute mail daily and continue as an ongoing process. • The Administrator did one-on-one in-services on mail and telephone services policy and procedure, on resident rights and responsibilities regarding receiving mail policy and procedure, and the importance of delivering mail every day and on the weekend. These in-services were completed on Friday, September 30. Staff in-serviced include Social Worker, Clerks, and all Registered Nurses that could serve as day Nurse Supervisor of the facility.	

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F 576	Continued From page 3 mail on Saturday". Record review of the "Face Sheet" revealed Resident #1 was admitted by the facility on 11/15/19 with a diagnosis of Essential (primary) Hypertension. Record review of the quarterly MDS with an ARD of 08/30/22 revealed Resident #1 had a BIMS score of 15, which indicated she was cognitively intact. On 09/15/22 at 2:35 PM, in an interview with the Administrator, she stated residents do not get mail on Saturday. Most of the facility's mail goes to the adjoined hospital's business office and no one is there to get the mail on Saturdays. She confirmed the facility also has a PO box that is checked Monday through Friday, but no one is at the facility to check it on Saturday. She stated that "It is the resident's right to receive mail on the weekends".	F 576	4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. • The Clerk or Nurse Supervisor will provide the residents with their mail daily and over the weekend. Mail began being delivered to the facility mailbox on Monday, October 3. • Every Monday for four weeks beginning on October 3, an audit will be obtained by the Administrator and/or Social Worker to ensure the mail was delivered to the residents over the weekend. Then audited through resident council for the following three months. • The findings of this audit will be discussed with the Resident Council at the next meeting on Wednesday, October 5. • This plan of correction will be reviewed at the next monthly Quality Assurance meeting on October 26 and ongoing until consistent, substantial compliance has been met. 5. Indicate the date(s) the corrective action(s) will be completed. • The corrective action will complete on October 28, 2022, with audits to continue until substantial compliance is reached.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		10/28/22

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F 677	Continued From page 4 §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 observations, interviews, and record reviews, the facility failed to wash a resident's hair, who was dependent on staff for Activities of Daily Living (ADL) for one (1) of two (2) residents reviewed for ADL care. Resident #17 Findings Include: On 09/12/22 at 9:21 AM, during an observation and interview with Resident #17 stated she gets a bath once a week. The resident's hair looked oily and unclean. Resident #17 states that she gets her hair washed "sometimes." On 09/13/22 at 8:58 AM, in an observation and interview with Resident #17 said "I have not had a bath this week." The resident's hair continues to look oily and unclean. On 09/14/22 at 3:30 PM, in an observation and interview with Resident #17 stated she still has not had a bath this week and has never refused one. The resident's hair continues to look oily and unclean. On 09/15/22 12:06 PM, in an interview with Certified Nursing Assistant (CNA) #2 she stated that a bed bath consists of head-to-toe bath, including washing the resident's hair. On 09/15/22 at 1:02 PM, in an interview with CNA #7 she confirmed that a bed bath consisted of the	F 677	1. Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. • Resident #17 had hair washed on September 15, 2022. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. • All residents receiving ADL care for showers and washing of hair have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. • Certified Nurse Aide (CNA) #2 was in-serviced on Activities of Daily Living (ADL) care including showers and washing of hair by Director of Nurses (DON) on October 3, 2022. • All Nurses and CNAs were in-serviced beginning September 16, 2022, by Assistant Director of Nurses/Staff Educator; regarding the facility policy for ADLs including showers and hair care/washing of hair and proper documentation of ADL care. In-services were completed by October 4, 2022. • Bath/Shower CNAs will record	

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resident's whole body, including the hair. She verified that Resident #17's hair was oily.

On 09/15/22 at 1:05 PM, in an interview with Resident # 17 she stated that her hair needs washing. Resident #17 commented that although she received a bath yesterday, the CNA did not wash her hair.

On 09/15/22 at 1:07 PM, in an interview with Licensed Practical Nurse (LPN) #2 she stated that Resident #17's hair usually does not look oily and that Resident #17's hair, "Is a little oily".

On 09/15/22 at 1:10 PM, in an interview with the Director of Nursing (DON) she stated that Resident #17 just got off of non-weight bearing status this week and could now start receiving showers again. While the resident was on non-weight bearing status she had to receive bed baths. She said she had expected the CNAs to wash her hair when completing a bed bath because a bed bath included a head-to-toe bath.

On 09/15/22 at 3:40 PM, in an interview with CNA #5, she stated that baths and showers are documented in the Activities Daily Living (ADL) section in the computer when it is completed. She confirmed that when a resident receives a bed bath, it should include the hair being washed every time, but admitted that she does not wash the resident's hair with every bed bath. CNA #5 said that she washes residents hair "probably twice a week".

Record review of the "Face Sheet" revealed the facility admitted Resident #17 on 11/13/18 with diagnoses including Presence of Right Artificial Hip Joint and Unspecified Sequelae of Cerebral

showers beginning September 19, 2022, including hair care on shower days on the bath list. If any residents refuse bath/shower and/or hair washing, this information is to be reported to the Nurse Supervisor or Medication Nurse caring for the resident. The nursing staff began documenting the refusals in the resident's chart on September 19, 2022.

- The bath lists began being reviewed on September 26, 2022, by the DON for patterns of refusal. Residents with patterns of refusal will be addressed with education on the importance of baths/showers and/or hair care. These reviews will continue for four weeks, then monthly for three months and then quarterly until substantial compliance is reached.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.

- The DON began weekly audits of Activities of Daily Living care including showers and washing of hair on September 26, 2022, and will continue for four weeks, then monthly for three months and then quarterly until substantial compliance is reached.
- Audit results will be reviewed by the Quality Assurance Committee on October 26, 2022, and monthly for three months

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F 677	Continued From page 6 Infarction. Record review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/9/22 revealed a Brief Interview for Mental Status score of 11, which indicated Resident #17 has moderate cognitive impairment. Section G indicated Resident #17 required one-person physical assistance with bathing. Record review of the "Shower List" revealed Resident #17 received a "Bed Bath" on 9/12/22 and 9/14/22. Record review of the "Inservice Sign In Sheet" revealed the facility provided training on ADL care from 4/26/22 through 4/28/22.	F 677	until such time consistent substantial compliance has been achieved as determined by the committee. 5. Indicate the date(s) the corrective action(s) will be completed. • The corrective action will be completed by October 28, 2022, with audits to continue until substantial compliance is reached.	
F 880 SS=D	Infection Prevention & Control 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	F 880		10/28/22

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F 880	Continued From page 7	F 880		

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 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.

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F 880	Continued From page 8 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 observations, staff interviews, and facility policy review, the facility failed to sanitize a full body lift between use for two (2) of four (4) observations. Findings Include: A review of the facility's policy, "Standard Precautions Infection Control", (undated), revealed, "Policy: All staff are to assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Therefore, all staff shall adhere to 'Standard Precautions' to prevent the spread of infection....Definitions: "Standard Precautions" represent the infection prevention measures that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where healthcare is delivered ..." On 09/12/2022 at 09:00 AM, the State Agency (SA) observed Certified Nursing Assistant (CNA) #1 retrieve a full body lift directly from the hallway and take it into an unsampled resident's room on the 400 Hall. CNA #1 did not sanitize the lift before use. CNA #3 assisted CNA #1 with transferring the resident inside the resident's room.	F 880	1. Address how corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. " Certified Nurse Aide (CNA) #1 wiped lift down with disinfectant wipes on September 12, 2022. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. " All residents using the lifts have the potential to be affected. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. " CNA #1 was in-serviced on lift use and cleaning of lifts and to remain calm when state auditors/visitors are in the facility by Director of Nurses on September 29, 2022. " CNA #2 is no longer employed with facility and was not in-serviced. " All Nurses and CNAs were in-serviced beginning September 16, 2022, by Assistant Director of Nurses/Staff Educator, regarding the facility□s policy and procedures on infection control	

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F 880	Continued From page 9 On 09/12/2022 at 09:19 AM, the SA observed CNA #1 pushing the full body lift out of the same unsampled resident's room and back into the hallway on 400 Hall. CNA #1 did not disinfect the lift after use. CNA #2 immediately retrieved the lift from the hallway and pushed it to the 300 Hall for CNA #4 to use. On 09/12/2022 at 09:34 AM, the SA observed CNA #4 pushing the lift inside the room of an unsampled resident room on the 300 Hall. CNA #4 was assisted in the room by Licensed Practical Nurse (LPN) #2. On 09/12/2022 at 09:40 AM, the SA conducted an interview with CNA #4, who stated that she did not clean the lift and that she did not know it was supposed to be cleaned. She stated that she more than likely had training on it but does not remember because she works PRN (as needed). On 09/12/2022 at 09:42 AM, the SA conducted an interview with LPN #2, who confirmed that she did not clean the lift, but has received training on infection control. On 09/12/2022 at 09:49 AM, the SA conducted an interview with CNA #1, who confirmed that she did not clean the lift and that she should have cleaned it. She stated that it is important to clean it because it can move one contamination from one resident to another resident. On 09/12/2022 at 09:55 AM, the SA conducted an interview with CNA #2, who stated that she was asked to bring the lift to CNA #4, so she grabbed it from the 400 Hall and brought it to the 300 Hall. She stated that she did nothing with it before or after that.	F 880	specifically the cleaning of all portable equipment before and after resident use. In-services were completed on October 4, 2022. " All staff is being trained on infection control and prevention by watching Sparkling Surfaces and Clean Hands from the online infection prevention training courses provided by the CDC. This training will complete on October 21, 2022. " A Root Cause Analysis (RCA) was conducted with Certified Nurse Aide #1, Infection Prevention/Quality Assurance Nurse, Assistant Director of Nurses, and Director of Nurse on September 30, 2022. The RCA will be reviewed and updated if necessary, with the Quality Assurance and Performance Improvement (QAPI) committee on October 26, 2022, and again with the governing body on October 27, 2022. " A Plan Do Study Act Cycle was completed with by an interdisciplinary team including the Infection Prevention Nurse, Assistant Director of Nurses, Director of Nurse, and two Certified Nurse Aides on September 30. " Holders for cleaning wipes were mounted on all lifts on October 4, 2022. These holders will ensure cleaning products are readily available for before and after resident use. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must	

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ARRINGTON LIVING CENTER	701 SOUTH HOLLY STREET COLLINS, MS 39428

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F 880	Continued From page 10 On 09/12/2022 at 10:03 AM, the SA conducted an interview with CNA #3 who confirmed that she did not clean the lift and that cleaning the lift slipped her mind. She also confirmed that she was supposed to clean the lift. On 09/13/2022 at 09:14 AM, the SA conducted an interview with the Infection Preventionist Nurse (IP) #1, who stated that the reason it is important to clean the equipment in-between use is to prevent the spread of infection. She confirmed that the lift should have been cleaned between usage and that staff had received training on that matter. On 09/13/22 at 10:36 AM, the SA conducted an interview with the Director of Nursing (DON), who confirmed that it is important to clean the equipment between use to cut down the spread of infection. She verified that the staff has had training and should have cleaned the lift. A record review of the "Inservice Sign In Sheet" revealed an inservice was conducted with the "Topic: Prevention and Control of Infection Standard Precautions Covid 19 protocols" with the "Date" listed as "July Inservice All Staff". The inservice sheet included the signatures of CNA #1, CNA #2, CNA #4, and LPN #2 which indicated they had received training on infection control.	F 880	be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. " Quality Assurance Nurse began infection control rounds regarding lifts and cleaning practices on September 27, 2022, and will continue every week for four weeks, then every month for three months, and then quarterly. " Audit results will be reviewed by the Quality Assurance Committee on October 26, 2022, and monthly for three months until such time consistent substantial compliance has been achieved as determined by the committee. 5. Indicate the date(s) the corrective action(s) will be completed. " The corrective action will be completed by October 28, 2022, with audits to continue until substantial compliance is reached. Timeline attestation attached.	