STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255251	A. BUILDING _____ B. WING _____	08/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MS CARE CENTER OF DEKALB	220 WILLOW AVENUE DE KALB, MS 39328

(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 The State Agency (SA) conducted an annual recertification survey at the facility from 07/30/19 to 08/01/19. During the SA determined the facility failed to meet the Medicare and Medicaid Requirements for Participation, cited deficiencies at F641, F656, and F695. The census at the time of the survey was 60. The facility was licensed for 60 beds.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review and facility policy review, the facility failed to ensure Minimum Data Set (MDS) assessments were accurate for two (2) of 19 residents reviewed. The facility failed to accurately code Resident #28 regarding an anticoagulant medication, and Resident #45 for Urinary Tract Infections (UTIs). Findings include: Review of the facility's "Accuracy of Assessments" policy, dated November 2016, revealed the facility must ensure the assessment represents accurately the resident's status during the observation/look back period. Resident #45 Review of the quarterly MDS, dated 07/03/19, revealed Resident #45 was on an anticoagulant	F 641	1. Corrective Action will be accomplished by: Immediate action was taken for Residents #28 and #45 of 19 residents reviewed to correct Minimum Data Set (MDS) Assessments. Resident # 45: The MDS Nurse made corrections (9/4/2019) on current MDS to accurately classify the medication Plavix. All nurses were in-serviced by Registered Nurse/Director of Nursing (RN/DON) and Registered Nurse/Assistant Director of Nursing (RN/ADON) on 8/1/2019 the differences between anti-platelet and anti-coagulant. Resident was assessed for excessive bruising, bleeding and dark tarry stools by Registered Nurse (RN)DON and found none noted. Resident # 28 The MDS Nurse made	9/11/19

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F 641	Continued From page 1 medication for seven (7) days. Review of Resident #45's July 2019 Physician's Orders revealed the resident was not on any anticoagulant medications. Resident #45 did have orders for Plavix 75 milligrams (mg) per tube daily for circulation and Aspirin 81 mg per tube daily for circulation. On 07/31/19 at 3:02 PM, an interview with the MDS Coordinator revealed she had several people working part time to assist her with MDSs, and she bet they coded Resident #45's Plavix as an anticoagulant. The MDS Coordinator stated Plavix is not an anticoagulant, and should not be coded as such. She stated accuracy of the MDS is important because it reflects the care the resident is receiving and should be correct. The MDS Coordinator stated she reviews all the MDSs and signs off on their completion. She stated she did not catch that it was incorrect. Resident #28 Review of the MDSs for Resident #28, dated 12/10/18 (Significant Change), 03/13/19 (Quarterly), and 06/05/19 (Quarterly), revealed she was coded as having a Urinary Tract Infection (UTI). Review of the physician's orders revealed no orders for antibiotics related to UTIs since December 2, 2018. On 07/31/19 at 3:59 PM, an interview with the Director of Nursing (DON) revealed Resident #28 had a UTI in December (2018), but not March or June (2019). The DON stated the nurse completing the MDS did not uncheck the box for	F 641	corrections (8/04/2019) on current MDS to accurately classify the resolved UTI. The Infection Control Registered Nurse monitored the completion of the anti-biotic and the resolved UTI so that the MDS would be accurately reported. 2. How will facility identify other residents having the potential to be affected by the same deficient practice: 60 residents were identified as having the potential of being affected as 60 residents are subject to MDS assessments quarterly. RN/ADON in-serviced MDS Nurse (8/4/2019)to the accuracy of MDS assessments prior to transmitting to State. 60 residents MDS are being checked by ADON for accuracy quarterly beginning 8/4/2019. 3. Measures taken and put into place/systemic changes made to ensure that deficiency practice is prevented: A) Infection Control Registered Nurse and RN/ADON In-serviced staff (3) on accuracy of MDS 8/4/2019; B)Beginning 8/4/2019, as it regards medications of anti-platelets vs. anti-coagulants, Medical records will ensure that action of the doctors orders for medications of anti-coagulants and/or anti-platelets are correctly classified. C)Effective 8/4/2019 Infection Control Registered Nurse, Medical Records will routinely monitor completion of antibiotic and resolution of UTIs or other infectious processes and Pharmacy Consultant will monitor antibiotics monthly.	

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F 641	Continued From page 2 UTI. She stated she had a nurse on the floor completing MDSs and the Infection Control Nurse was assisting with MDSs. On 07/31/19 at 4:17 PM, an interview with Registered Nurse (RN) #1 revealed she had assisted with MDSs for about six (6) months, but has limited knowledge regarding completion of the MDSs.	F 641	4. Facility plan of correction and Monitoring its performance to ensure solutions are sustained: A) A full-time MDS Coordinator will be employed to concentrate on MDS Accuracy; B) Effective 8/4/2019 RN/ADON/Interim MDS Coordinator will oversee MDS Input weekly until new MDS Coordinator is comfortable - 6 months; C) Medical Records will monitor Weekly x 12 audits of MDS to ensure accuracy; D) Nurse Consultant will randomly check MDS for accuracy - Quarterly x 1; E) Quality Assurance and Performance Improvement (QAPI) will review findings make recommendations and changes as needed to ensure compliance (monthly x 3 beginning August 4, 2019); F) Resident Council will be apprised of problem and resolution by RN/ADON 8/22/2019.	
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	F 656		9/11/19

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F 656	Continued From page 3 physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to follow the Comprehensive Care Plan for storage of an Oxygen (O2) cannula, for one (1) of 19 care plans reviewed, Resident #16. Findings include: Review of the care plan for Resident #16 revealed a Problem, dated 12/06/18, of requiring	F 656	1. Corrective action was taken for Resident # 16 to ensure Comprehensive Care Plan was followed: Immediate action taken for Resident #16 found to be affected by Registered Nurse Assistant Director of Nursing (RN/ADON)reviewing the Comprehensive Care Plan (8/1/2019), with changes made noting the Oxygen cannula should be stored in a bag to prevent possible infection. All staff present	

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F 656	Continued From page 4 use of oxygen PRN (as needed) SOB (shortness of breath). The Approaches included: Make sure oxygen tubing was stored properly when not in use. On 07/30/19 at 1:33 PM, an observation revealed Resident #16 lying in bed with an oxygen cannula on. No storage bag was noted in room. When Resident #16 was asked what he does with his tubing when he is not wearing it, he stated he just wraps it around the machine. He stated he has not had a bag to put it in. On 07/31/19 at 3:30 PM, an observation revealed Resident #16 asleep in bed. The resident was not wearing oxygen. The oxygen tubing was wrapped around the O2 concentrator and not in a storage bag. On 07/31/19 at 4:30 PM, an observation with Registered Nurse (RN) #1 confirmed the resident's oxygen cannula should be in a bag to prevent contamination and possible infection. On 07/31/19 at 4:45 PM, an interview with the Director of Nursing (DON) revealed Resident #16's oxygen cannula should be stored in a bag to prevent possible infection. She confirmed the care plan was not followed.	F 656	was in-serviced by RN/ADON immediately (8/1/2019) as to Infection Control and the need to keep masks/cannulas secured in zip-lock bag while not in use. Resident #16, able to make decisions for self, was also counseled (8/1/2019) by RN/ADON as Resident is Care Planned to use Oxygen as needed and can apply and remove cannulas at will. 2. Facility will identify other residents having the potential to be affected by the same deficient practice: The facility determined that 10 of 60 residents has the potential of being affected by the deficient practice of Masks/Cannula tubing not stored properly in the bag under the Comprehensive Care Plan. All staff in-serviced (8/15/2019) Infection Control Registered Nurse to the importance of following a person centered comprehensive care plan. 3. Measures put into place or systemic changes made to ensure the deficient practice is resolved: A) All Person-Centered Comprehensive Care Plans are being scrutinized by Medical Records, RN/ADON and Interdisciplinary Care Team to ensure it covers the requirements of the individual. Staff, including (Quality Assurance Performance Improvement (QAPI) Team, Direct Staff, Environmental, Dietary, Interdisciplinary Team, Nursing, etc. were involved in reviewing the individual's needs and appropriate changes made to the Comprehensive Care Plan	

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F 656	Continued From page 5	F 656	(8/15/2019). 4. Facility plans to monitor its performance to make sure that solutions are sustained by: Effective 8/1/2019 A)Infection Control Registered Nurse (8/1/2019) will begin monitoring Masks/cannulas Tubing to ensure that they are secured in a bag and to ensure there are ample bags available to prevent infection to residents weekly x 12; B) Interim Minimum Data Set (MDS)Coordinator, staff and Nursing to Update Comprehensive Care Plans daily, as needed. Interdisciplinary Team will review residents' care plans weekly as they come due and if significant change occurs - weekly x 12 beginning 8/7/19, to ensure 60 residents comprehensive Person-Centered Care Plans have been reviewed and updated for accuracy; C) MDS Coordinator and Medical records to monitor monthly x 3 and report to QAPI beginning 8/9/2019; D) Quality Assurance and Performance Improvement (QAPI) will review findings make recommendations and changes as needed to ensure compliance (monthly x 3 beginning August 4, 2019); E)Resident Council to be informed of Deficiency and Findings.	
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		9/11/19

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F 695 SS=D	Continued From page 6 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to provide storage for Resident #16's oxygen (O2) nasal cannula to prevent the possible spread of infection and/or contamination one (1) of four (4) resident's receiving oxygen therapy. Findings include: Review of the facility's "Quality Assessment and Assurance Component" policy, not dated, revealed: To use disposable tubing, masks, and cannulas for patients receiving oxygen therapy. This equipment is to be discarded as this procedure dictates. 11. When not in use, store the mask/cannula in a plastic bag clearly labeled with the resident's name and date. On 07/30/19 at 1:33 PM, an observation revealed Resident #16 lying in bed with his oxygen cannula on. No storage bag was noted in the room. When asked what he does with his tubing when he is not wearing it, he stated he just wraps it around the machine. Resident #16 stated he has not had a bag to put it in.	F 695	1. Corrective action was taken for Resident # 16 to ensure Comprehensive Person-Centered Care Plan is consistent with professional standards of practice and facility Infection Control Policy as it regards the securing of cannula and tubing: Immediate action taken for Resident #16, found to be affected by deficient practice of infection control, by Registered Nurse Assistant Director of Nursing (RN/ADON)reviewing the Comprehensive Care Plan (8/1/2019) and assessing resident for signs and symptoms of infection as evidenced by no elevated temperature, increased cough, congestion or shortness of breath and a CBC drawn 8/05/2019 shows white count within normal limits. Changes made to the Comprehensive Person-centered care plan noting the Oxygen cannula should be stored in a bag to prevent possible infection. All staff present were in-serviced by RN/ADON immediately (8/1/2019) as to Infection Control and the need to keep masks/cannulas secured in zip-lock bag while not in use. Resident #16, able to	

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F 695	Continued From page 7 On 07/31/19 at 3:30 PM, Resident #16 was observed asleep in bed. The resident was not wearing oxygen. The oxygen tubing was wrapped around the O2 concentrator, and not in a storage bag. On 07/31/19 at 4:30 PM, an observation with Registered Nurse (RN) #1 confirmed Resident #16's oxygen cannula was not in a bag. She confirmed the cannula should be in a bag to prevent contamination and possible infection. On 07/31/19 at 4:45 PM, an interview with the Director of Nursing (DON) revealed Resident #16's oxygen cannula should be stored in a bag to prevent possible infection.	F 695	make decisions for self, was also counseled (8/1/2019) by RN/ADON as Resident is Care Planned to use Oxygen as needed and can apply and remove cannulas at will. Resident completed a return demonstration of placing cannula and tubing in bag for storage (8/1/2019). 2. Facility will identify other residents having the potential to be affected by the same deficient practice: The facility determined that 10 of 60 residents has the potential of being affected by the deficient practice of Masks/Cannula tubing not stored properly in the bag under the Comprehensive Care Plan. All staff in-serviced (8/15/2019)by Infection Control Registered Nurse to the importance of Infection Control and keeping masks clean and secured in a personal storage bag.. 3. Measures put into place or systemic changes made to ensure the deficient practice is resolved: A) Bags were purchased 8/1/2019 and Director of Nursing (DON) placed the bags on the nurses carts to be used when finding oxygen cannulas/face masks without protection. DON instructed nurses to place all cannulas/face masks in bag for infection control. B) Quality Assurance Performance Improvement (QAPI) team met on 8/9/2019 to discuss the importance of infection control and having masks/cannulas secured in bags to	

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F 695	Continued From page 8	F 695	prevent contamination and possible infection; C) Infection Control Registered Nurse on 8/15/2019 in-serviced all staff as to the importance of infection control, emphasizing the importance of cleaning and replacing masks and cannulas in storage bags; D) RN/ADON counseled residents that are capable of making a decision for self care of the importance of infection control and to place cannulas/masks in storage bag after use or to call staff for assistance. 4. Facility plans to monitor its performance to make sure that solutions are sustained by: Effective 8/1/2019 A) All treatments with masks/cannulas added to nurses Treatment Administration Record (TAR) by Medical Records on 9/5/2019 to check for proper storage of cannula/masks; B) Infection Control Registered Nurse monitor (8/1/2019)daily randomly x 14 days and weekly x 9 the cannula's masks to ensure the cannulas/masks are properly stored per facility policy; C) Monitoring records of Infection Control Masks/cannulas presented to Quality Assurance and Performance Improvement (QAPI)Team to review findings, make recommendations and	

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F 695	Continued From page 9	F 695	changes as needed to ensure compliance (monthly x 3 beginning August 4, 2019); ; D) Resident Council to be informed of deficient practice and findings and to be counseled by Infection Control Registered Nurse in the use of cannulas/masks and securing them in personal bags after use. 8/22/2019	

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	255251	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/06/2019**

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K 000	INITIAL COMMENTS 42 CFR 483.70 (a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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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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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 08/06/19 reveals the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were cited.	E 000		

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