STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A156	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

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F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification from 2/18/19 through 2/21/19. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements of participation. The SA cited the regulatory deficiencies F 623, F 641, F 656, F 686, F 690, and F 880. At the time of the survey, the census was 101, and the facility held a license for 120 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, facility policy review, and record review, the facility failed to accurately code the comprehensive Minimum Data Set Assessment (MDS) for one (1) of 26 MDS assessments reviewed, Resident #86. Findings include: Review of the facility's policy titled, "Hospice", dated 4-10-13, revealed the facility will complete an MDS significant change in status assessment when the resident elects the Hospice benefit or when the benefit is revoked. Record review of a Physician's Order, dated 1-12-19, revealed Resident #86 was placed on Hospice Services. Review of Resident #86 Comprehensive MDS	F 641	This Plan of Correction is submitted under Federal and State Regulations and status applicable to Long Term Care Providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the scope and severity regarding any of the deficiencies are cited correctly. Rather, it is submitted as confirmation of our ongoing effort to comply with all State and Federal regulatory requirements. 1) The Minimum Data Set for resident #86 was corrected by Registered Nurse #8 to correct the coding to sections	3/31/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/15/2019

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F 641	Continued From page 1 Assessment, 14 day significant change, with an Assessment Reference Date (ARD) of 1-22-19, revealed inaccurate coding, as it did not include that Resident #86 had been placed on Hospice. An interview on 02/20/19 at 09:47 AM, with Registered Nurse (RN) #8/MDS Director, revealed the Comprehensive MDS Assessment 14 day significant change noted on the 1-22-19 MDS did not have Hospice services coded for Resident #86. RN #8 stated, "It's my bad. I guess I just over looked it. Hospice should have been marked on the MDS. I marked section J, that shows less than 6 month life expectancy but I just failed to mark the Hospice change on the MDS." An interview on 02/20/19 at 10:11 AM, with RN #5/Hospice Coordinator, revealed the Comprehensive MDS significant change should have identified that Resident #86 was placed on Hospice services. After reviewing the MDS, Section O, RN #5 identified that the "MDS does not indicate that Resident #86 was on hospice services and it should have been coded on the MDS." An interview on 02/20/19 at 10:14 AM, with the facility Administrator revealed, "After reviewing the MDS, Resident #86 is not identified as being placed on Hospice on the 14 day significant change and she should have been." An interview on 02/20/19 at 11:45 AM, with RN #8, Minimum Data Set (MDS) Nurse, revealed that she used the Resident Assessment Instrument (RAI) manual as a guide to code the MDS. An interview on 02/20/19 at 12:01 PM, with the	F 641	O0100.K and J1400 indicating that Hospice Services has been selected. The Minimum Data Set was resubmitted on 2/21/19. 2) The facility recognizes that all residents had the potential to have been affected by this alleged deficient practice. 3) Beginning on 3/11/19, any Minimum Data Set requiring a Significant Change will be reviewed to ensure accurate coding of Hospice Services in sections J1400 and O0100.K. The pre-transmission review will be conducted by the Minimum Data Set Assessment Nurse and the Minimum Data Set Coordinator. In the event that one of the two are not available, the Clinical Operations Director or the Nursing Home Administrator may conduct the review in their place. 4) The results of the reviews will be brought to the Quality Assurance Performance Improvement (QAPI) Committee by the Quality Assurance Coordinator and corrective action will be monitored and evaluated by the Committee monthly for at least three months. If any revisions of the plan of correction are needed, the revisions will be developed and approved by the Quality Assurance Performance Improvement(QAPI) Committee to ensure the plan of correction is achieved and sustained.	

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F 641	Continued From page 2 Director of Nursing (DON), revealed, "The MDS was not coded for Hospice Services for Resident #86, and it should have been."	F 641		
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		3/31/19

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F 656	Continued From page 3 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 record review, staff interview, and facility policy review, the facility failed to follow the comprehensive care plan regarding catheter care for two (2) of 26 resident care plans reviewed, Resident #57 and Resident #24; And failed to follow the comprehensive care plan regarding pressure ulcer/injury care for one (1) of 26 resident care plans reviewed. Resident #69. Findings include: A review of the facility's policy titled "Care Plan Policy", with a revision date of 2/23/17, revealed the resident's comprehensive care plan is based on comprehensive assessment; developed and implemented within 21 days of admission. Resident #24 A review of the comprehensive care plan with an onset date of 2/16/18, included interventions for the indwelling Foley Catheter for Resident #24: Leg strap to secure Foley catheter and catheter care with soap and water every shift and as needed (PRN). On 2/19/19 at 10:04 AM, observation of Resident #24 revealed she was lying in bed, on her back, awake and alert. Certified Nursing Assistant (CNA) #1 pulled Resident #24's covers back and	F 656	1) An appropriately sized leg strap has been ordered for Resident #24. The care plan will be updated as to size of the leg strap when the leg strap is received. Certified Nurse Aide #1 was in-serviced on 3/20/19, regarding the Foley Cath Care and the Peri Care Policy to include the use of a leg strap to secure the tubing and rotating the wash cloth during Foley Cath care and Peri Care. Certified Nurse Aide #1 was in-serviced on 3/20/19 regarding moving the Genitourinary bag to the side of the bed that the resident was being turned to. Certified Nurse Aide #2 was in-serviced on 2/21/19 regarding moving the Genitourinary bag to the side of the bed that the resident was being turned to. Registered Nurse #1 was in-serviced on 2/27/19 regarding proper handwashing procedure. The wound care policy was updated on 3/11/19 to include a glove change and handwashing between when the wound is	

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F 656	Continued From page 4 Resident #24 was observed not to have a securing device to her catheter tubing. CNA #1 then wiped three (3) times from the resident's meatus area outward while securing the catheter tubing but without rotating her washcloth. CNA #1 then dried Resident #24's catheter tubing, washed her hands, and changed her gloves to perform peri-care. She wiped the resident's right groin area three (3) times without rotating the washcloth. Both CNA #1 and #2 repositioned Resident #24 onto her left side while the catheter drainage bag remained on the opposite side of the bed. CNA #1 placed a clean blue pad underneath Resident #24. Both CNA #1 and #2 repositioned Resident #24 onto her right side and finished straightening out the blue pad. During an interview, on 2/20/19 at 2:50 PM, RN #8 revealed she is the Care Plan Coordinator. RN #8 stated, she would expect the staff to follow the comprehensive care plan. Resident #69 Review of Resident #69's care plan, initiated 2/6/19, revealed a Deep Tissue Injury to the right upper calf with interventions which included to cleanse with normal saline, apply Santyl and cover with border foamed dressing daily and as needed. Observation on 2/20/19 at 2:05 PM, revealed RN #1 set up for Resident #69's wound care, assisted by RN #2. RN #1 raised the bed to a higher position, and she washed her hands again. While RN #1 was washing her hands, she turned the water off with her wet hands then pulled the paper towel down and dried her hands. She removed the Resident #69's right leg immobilizer, removed her gloves, washed her hands, and	F 656	cleaned and the new dressing is applied. Certified Nurse Aide #3 was in-serviced on 3/20/19 regarding the Foley Cath Care policy, to include cleaning the penis. Certified Nurse Aide #1 was in-serviced on 3/25/19 regarding the Care Plan Policy to include following the care plan for each resident. Certified Nurse Aides #2 and #3 and Registered Nurse #1 on were in-serviced on 3/20/19 regarding the Care Plan Policy to include following the care plan for each resident. 2) The facility recognizes that all residents who had the potential to have been affected by this alleged deficient practice. 3) Nurses and Certified Nurse Aides were provided education, beginning on 2/27/19 and ongoing until the completion date, regarding the Foley Cath Care Policy, the Peri Care Policy, and the Handwashing Policy by the Infection Control Nurse and the Certified Nurse Aide Coordinator. Nurses and Certified Nurse Aides were provided education, beginning 3/19/19 and ongoing until the completion date, regarding following the resident's care plan. Nursing staff were provided education on the updated Wound Care Policy, beginning 3/11/19 and ongoing until the completion date, by the Infection Control nurse.	

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F 656	Continued From page 5 again turned the water off before getting the paper towel to dry her hands. RN #1 applied clean gloves and stated the resident had pain medication before we entered the resident's room. She opened the pack of 4 x 4 gauze dressings and the bottle of Normal Saline (N/S) and poured the N/S over the 4 x 4 gauze dressings. She removed the resident's dressing, removed her gloves, washed her hands and turned the water off with her wet hands before getting a dry paper towel to dry her hands. She applied clean gloves and cleaned the resident's wound bed. The resident's wound bed was completely covered with slough and measured 3.0 x 1.3 x 0 CM. Using these same gloved hands, this nurse then applied the Santyl and applied the Aqua seal foam dressing. RN #1 applied the resident's immobilizer, placed all soiled dressings in a red plastic bag, and covered the resident back up. On 2/20/19 at 3:15 PM, an interview with the Director of Nursing (DON) revealed the facility staff are supposed to use the paper towel to turn the water off and not use their wet hands so they we are not touching the contaminated faucet. She also stated the wound care process should be to clean the wound, remove her gloves, wash her hands, apply new gloves, and apply the Santyl and dressing with the clean gloves. The DON also stated, RN #1 should have dried her hands and gotten a new paper towel to turn off the faucet and she should have washed her hands after cleaning the resident's wound bed. The DON confirmed the care plan wasn't followed by not providing proper procedure. Resident #57 Record Review of the Comprehensive Care Plan,	F 656	The Infection Control Nurse and the Certified Nurse Aide Coordinator will monitor Certified Nurse Aides providing Foley Cath Care and Peri Care 5 Certified Nurse Aides per week, beginning 3/25/19. The Infection Control Nurse and the Restorative Nurse will monitor Certified Nurse Aides and Nurses performing Handwashing 5 staff members per week, beginning 3/25/19. The Quality Assurance Coordinator will monitor the Care Plan for all residents with catheters monthly to ensure that the Care Plan is being followed regarding the use of leg straps, beginning 3/25/19. 4) The results of the monitoring will be brought to the Quality Assurance Performance Improvement (QAPI) Committee by the Quality Assurance Coordinator monthly for at least three months. If any revisions of the plan of corrections are needed, the revisions will be developed and approved by the Quality Assurance Performance Improvement (QAPI) Committee to ensure the plan of correction is achieved and sustained.	

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F 656	Continued From page 6 dated revealed Resident #57 was at risk for Urinary tract Infection's (UTI) related to Foley catheter and urinary retention. Interventions included: Change Foley catheter every month and as needed, leg strap to secure Foley catheter to prevent dislodging and injury, and catheter care with soap and water every shift. During an observation of catheter care, on 02/20/2019 at 8:56 AM, CNA #3 failed to clean Resident #57's penis during catheter care. CNA #3 secured the tubing, cleaned the tubing away from the meatus, turned the resident over, and cleaned the buttocks with soap and water. CNA #3 failed to follow the care plan by not washing Resident #57's penis during catheter care. During an Interview on 02/20/2019 at 03:12 PM, Registered Nurse (RN) #2 stated she expected the facility staff to follow the care plan.	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686		3/31/19

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F 686	Continued From page 7 by: Based on observation, staff interview, record review, and facility policy review, the facility failed to provide wound care in a manner to prevent the possible spread of infection for one (1) of three (3) resident wound care observations. Resident #69. Findings include: A review of the facility's policy titled "Dressing Change, Clean" with a revision date of 9/1/15, revealed the purpose of dressing change is to protect the wound, prevent irritation, prevent infection, and the spread of infection and to promote wound healing. The procedure revealed: wash hands and apply gloves, remove soiled dressing and discard in plastic bag. Dispose of gloves in plastic bag and wash hands. Put on a pair of clean gloves, cleanse wound with prescribed solution, perform treatment to wound as per Medical Doctor (MD) orders. Remove gloves and wash hands. Findings include: An observation on 2/20/19 at 2:05 PM, revealed RN #1, assisted by RN #2 set up for Resident #69's wound care to the right leg. RN #1 washed her hands, she turned the water off with her wet hands then pulled the paper towel down and dried her hands. She removed Resident #69's right leg immobilizer, removed her gloves, washed her hands, and again turned the water off before getting the paper towel to dry her hands. RN #1 applied clean gloves and opened the pack of 4 x 4 gauze dressings and the bottle of Normal Saline (N/S) and poured the N/S over the 4 x 4 gauze dressings. She removed the resident's	F 686	1) Registered Nurse #1 was in-serviced by the Infection Control Nurse on 2/27/19 regarding the Handwashing Policy. On 3/11/19, the Clean Dressing Change Policy was updated by the Quality Assurance Coordinator to include a glove change and handwashing between when the wound is cleaned and the new dressing is applied. 2) The facility recognizes that all residents who have wounds had the potential to have been affected by this alleged deficient practice. 3) Nurses and Certified Nurse Aides were in-serviced regarding the updated Handwashing Policy by the Infection Control Nurse, the Quality Assurance Coordinator, and the Certified Nurse Aide Coordinator beginning 2/27/19 and ongoing until completion date. Nurses were in-serviced regarding the updated Clean Dressing Change Policy by the Infection Control Nurse and the Quality Assurance Coordinator beginning 2/27/19 and ongoing until completion date. The Infection Control Nurse and the Restorative Nurse will monitor Certified Nurse Aides and Nurses performing Handwashing five staff members per week, beginning 3/25/19. 4) The results of the monitoring will be	

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F 686	Continued From page 8 dressing to the right leg, removed her gloves, washed her hands, and again turned the water off with her wet hands, before getting a dry paper towel to dry her hands. She applied clean gloves and cleaned the resident's wound bed. The resident's wound bed was completely covered with slough and measured 3.0 x1.3 x 0 Centimeters (CM). Using these same gloved hands, this nurse then applied the Santyl and applied the Aqua seal foam dressing. RN #1 applied the resident's immobilizer, placed all soiled dressings in a red plastic bag, and covered the resident back up. In an interview, on 2/20/19 at 3:30 PM, RN #1 stated after washing her hands, she should not have turned the water off with her wet hands. RN #1 stated she should have dried her hands first, then used another clean paper towel to turn the water off. She also stated after cleaning Resident #69's wound bed, she should have removed her soiled gloves, washed her hands, and applied clean gloves before applying the Santyl to the wound bed. On 2/20/19 at 2:53 PM, an interview with RN #3/Infection Control Coordinator, revealed the facility does yearly competency training which was done at the end of November 2018. She stated, regarding RN #1's procedure: "Well that would not be the appropriate way to wash her hands." RN #3 stated, the nurse should have washed her hands, dried her hands with a paper towel, gotten a clean paper towel to turn the water off, and discarded it. She stated, in other words, her wet hands should not have touched the faucet. RN #3 stated the wound care nurse (RN#1) should have removed her gloves and washed her hands after cleaning the wound bed.	F 686	brought to the Quality Assurance Performance Improvement Committee (QAPI) by the Quality Assurance Coordinator and corrective action will be monitored and evaluated by the committee monthly for at least three months. If any revisions of the plan of correction are needed, the revisions will be developed and approved by the Quality Assurance Performance Improvement (QAPI) Committee to ensure the plan of correction is achieved and sustained.	

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F 686	Continued From page 9 On 2/20/19 at 3:15 PM, an interview with the Director of Nursing (DON) revealed the facility staff are supposed to use the paper towel to turn the water off and not use their wet hands so they we are not touching the contaminated faucet. She also stated the wound care process should be to clean the wound, remove her gloves, wash her hands, apply new gloves, and apply the Santyl and dressing with the clean gloves. She stated that is an infection control issue. The DON also stated, RN #1 should have dried her hands and gotten a new paper towel to turn off the faucet and she should have washed her hands after cleaning the resident's wound bed.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		3/31/19

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F 690	Continued From page 10 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review, the facility failed to provide catheter care in a manner to prevent the possible spread of infection for two (2) of three (3) resident catheter care observations, Resident #57 and Resident #24, And failed to prevent possible trauma to the urethra for one (1) of three (3) catheter care observations, Resident #24. Findings include: A review of the facility's policy titled "Catheter Care Summary" with a revision date of 2/23/17, revealed: The purpose is to prevent infection and reduce irritation. Handwashing remains the single most important step in preventing the spread of infection. Wash the resident's genitalia and perineum thoroughly with soap and water (from front to back). Rinse the area well and towel dry. Resident #24	F 690	1) For Resident #24: An appropriately sized leg strap was ordered on 3/15/19 for Resident #24. When the leg strap arrives, it will be placed on the resident and the care plan will be updated to reflect the size of the leg strap being used. Certified Nurse Aide #1 was in-serviced on 3/21/19 by the Infection Control Nurse and the Certified Nurse Aide Coordinator regarding the Foley Cath Care Policy and the Peri Care Policy, to include the use of a leg strap to secure the tubing, rotating the wash cloth during Foley Cath Care and Peri Care, and glove changes. Certified Nurse Aide #1 was in-serviced by the Infection Control Nurse and the Certified Nurse Aide Coordinator on 3/21/19 regarding moving the Genitourinary bag to the side of the bed	

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F 690	Continued From page 11 A record review of Resident #24's physician orders, dated February 2019, revealed to maintain a 16 French (FR) 10 cubic centimeter (CC) Foley Catheter until excoriation resolves. Change catheter every month and as needed. Leg strap to secure Foley Catheter. Catheter care with soap and water every shift and as needed. Observation on 2/19/19 at 10:04 AM, revealed Certified Nursing Assistant (CNA) #1 provided catheter care to Resident #24, assisted by CNA #2. CNA #1 washed her hands, dry her hands with the paper towel, then turned the water off using the same paper towel that she dried her hands with. CNA #1 applied clean gloves, added some water to two (2) basins, and turned off the water with her same gloved hands. Using these same gloved hands, CNA #1 then placed two (2) plastic bags at the foot of the resident's bed and placed a wash cloth into the two (2) basins. While continue to use these same gloved hands CNA #1 pulled Resident #24's covers back and Resident #24 did not have a securing device to her catheter tubing. CNA #1 wiped three (3) times from the resident's meatus area outward while securing the catheter tubing, but without rotating her washcloth. CNA #1 then dried Resident #24's catheter tubing, washed her hands, and changed her gloves to perform peri-care. She wiped the resident's right groin area three (3) times without rotating the washcloth. Both CNA #1 and CNA #2 repositioned Resident #24 onto her left side while the catheter drainage bag remained on the opposite side of the bed. CNA #1 placed a clean blue pad underneath Resident #24. Both CNA #1 and #2 repositioned Resident #24 onto her right side and finished straightening out the blue pad.	F 690	that the resident is being turned to. Certified Nurse Aide #1 was in-serviced on 3/21/19 by the infection Control Nurse and the Certified Nurse Aide Coordinator regarding the Handwashing Policy. Certified Nurse Aide #2 was in-serviced by the Infection Control Nurse and the Certified Nurse Aide Coordinator on 3/21/19 on moving the Genitourinary bag to the side of the bed that the resident is being turned to. For Resident #57: Certified Nurse Aide #3 was in-serviced on 3/20/19 by the Infection Control Nurse and the Certified Nurse Aide Coordinator regarding the Foley Cath Care Policy, to include cleansing the penis. Certified Nurse Aide #4 was in-serviced by the Infection Control Nurse on 2/27/19 regarding the Foley Cath Care Policy. 2) The facility recognizes that all residents with Foley catheters had the potential to have been affected by this alleged deficient practice. 3) Nurses and Certified Nurse Aides were in-serviced beginning on 2/27/19 and on-going until completion date regarding the Foley Cath Care Policy, the Peri-Care Policy, and the Handwashing Policy by the Infection Control Nurse, the Quality Assurance Coordinator, and the CNA	

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F 690	Continued From page 12 On 2/20/19 at 3:40 PM, an interview with the Director of Nursing (DON) revealed that CNA #1 should have discarded the soiled paper towel and used a clean paper towel to turn the water off after washing her hands. The DON also stated a lot of glove changing and hand washing opportunities of the CNA #1 were missed. She stated CNA #1 should have moved the catheter drainage bag on the side of the bed that the resident was turned to prevent the catheter from being pulled out, especially since the catheter did not have a securing device. On 2/20/19 at 3:50 PM an interview with Registered Nurse (RN) #3 revealed, CNA #1 should have thrown that paper towel away and got a new one to turn the water off. This nurse stated the resident should have had a securing device to her catheter, because the catheter could become dislodged. RN #3 also stated CNA #1 should have changed her gloves after turning the water off. She stated each swipe should be with another wash cloth. RN #3 stated the washcloth should be rotated and when you have a catheter bag, you would want it on the same side that you turn the resident so the catheter tubing does not pull, which can cause the catheter to become dislodged. She stated CNA #1 should have dried her hands before touching the paper towel handle and stated that this is a potential infection control risk. On 2/21/19 at 11:05 AM, an interview with CNA #1 revealed that re-wiping the catheter tubing could cause the resident to get an infection. She also stated she does not use a securing device on Resident #24, because the nurses had stated a securing device may irritate the resident's skin	F 690	Coordinator. The Infection Control Nurse, the Certified Nurse Aide Coordinator, and the Restorative Nurse will monitor Certified Nurse Aides providing Foley Cath Care and Peri Care five CNAs per week, beginning 3/25/19. The Infection Control Nurse and the Restorative Nurse will monitor Certified Nurse Aides and Nurses performing hand washing five staff members per week, beginning 3/25/19. 4) The results of the monitoring will be brought to the Quality Assurance Performance Improvement (QAPI) Committee by the Quality Assurance Coordinator and corrective action will be monitored and evaluated by the Committee monthly for at least three months. If any revisions of the plan of correction are needed, the revisions will be developed and approved by the QAPI Committee to ensure the plan of correction is achieved and sustained.	

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F 690	Continued From page 13	F 690		

and cause redness. This CNA stated the staff try to keep the catheter tubing in a safe position but does not use any measures to prevent the catheter tubing from pulling. She also stated the catheter tube could be pulled out if there is no securing device on it.

On 2/21/19 at 11:20 AM, an interview with the Director of Nursing (DON) revealed not rotating the washcloth could put germs back into the meatus. The DON also stated there could be a traumatic dislodging of the catheter and there could be damage to the urethra if a securing device wasn't used.

On 2/21/19 at 11:35 AM an interview with CNA #2 revealed CNA #1 should have rotated her washcloth, because she wiped the catheter tubing about three (3) times. She stated the catheter bag was still hooked to the bed and should have been unhooked and moved, so it would not be pulled out. This CNA also stated the nurses are constantly putting the straps on and she does not know what is happening to them. She stated not having a catheter strap in place could cause the catheter tubing to be pulled out.

Resident #57
Observation on 02/20/2019 at 8:56 AM, of catheter care with CNA #3 and CNA #4, revealed, CNA #3 failed to clean Resident #57's penis during catheter care. CNA #3 secured the tubing, cleaned the tubing away from the meatus, turned the resident over, and cleaned the buttocks with soap and water.

During an Interview on 02/20/2019 at 08:31 AM, License Practical Nurse (LPN) #1 stated that Resident #57 completed antibiotic's on 1/10/2018,

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F 690	Continued From page 14 for a Urinary Tract Infection (UTI). She stated that Resident #57 had chronic UTI's. During an Interview on 02/20/2018 at 03:24 PM, CNA #3 confirmed she forgot to clean Resident #57's penis while providing catheter care. CNA #3 said she normally cleaned the resident's penis during catheter care. During an Interview on 02/20/2019 at 3:48 PM, CNA #4/Lead Supervisor confirmed CNA #3 failed to clean the penis while providing catheter care. The CNA supervisor said the CNA's will be in-serviced on catheter care after today. During an Interview on 02/20/2019 at 03:35 PM, The Director of Nursing (DON) confirmed CNA #3 should clean the penis when providing catheter care.	F 690		
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	F 880		3/31/19

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F 880	Continued From page 15 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 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.	F 880		

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F 880	Continued From page 16 §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, staff interview, record review, and facility policy review, the facility failed to wash hands in a manner to prevent the possible spread of infection for two (2) of three (3) residents observer, Resident #69 and Resident #64; AND failed to provide a safe and sanitary environment to help prevent the development and transmission of disease and infection for one (1) of three (3) observations, Resident #79. Findings include: A review of the facility's policy titled "Standard Precautions", with a latest revision date of 10/2015, revealed adherence to hand hygiene techniques including washing hands with soap and water or use of an alcohol-based hand rub, reduces transmission of antimicrobial resistant organisms and overall infection rates. The policy also revealed that resident care equipment the facility's Standard Precautions policy is to ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned and disinfected. A review of the facility's policy titled "Handwashing/Hand Hygiene Policy and	F 880	1) For Resident #69: Registered Nurse #1 was in-serviced by the Infection Control Nurse on 2/27/19 regarding the Handwashing Policy. On 3/11/19, the Clean Dressing Change Policy was updated by the Quality Assurance Coordinator to include a glove change and handwashing between when the wound is cleaned and the new dressing is applied. For Resident #24: Certified Nurse Aide #1 was in-serviced by the Infection Control Nurse and the Certified Nurse Aide Coordinator on 3/21/19 regarding the Foley Cath Care Policy and the Peri Care Policy, to include the use of at leg strap to secure the tubing, rotating the wash cloth during Foley Cath Care and Peri Care, and glove changes. Certified Nurse Aide #1 was in-serviced by the Infection Control Nurse and the Certified Nurse Aide Coordinator on	

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F 880	Continued From page 17 Procedure" undated revealed, this facility considers hand hygiene the primary means to prevent the spread of infections. The facility's procedure indicated, dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel. Resident #69 On 2/20/19 at 2:05 PM, RN #1 set up for Resident #69's wound care, assisted by RN#2. Observation revealed, RN #1 washed her hands, she turned the water off with her wet hands. then pulled the paper towel down and dried her hands. She removed the Resident #69's right leg immobilizer, removed her gloves, washed her hands, and again turned the water off before getting the paper towel to dry her hands. RN #1 applied clean gloves and opened the pack of 4 x 4 gauze dressings, and the bottle of Normal Saline (N/S), and poured the N/S over the 4 x 4 gauze dressings. She removed the resident's dressing, removed her gloves, washed her hands and turned the water off with her wet hands before getting a dry paper towel to dry her hands. She applied clean gloves and cleaned the resident's wound bed. On 2/20/19 at 2:53 PM an interview with Registered Nurse (RN) #3, the Infection Control Coordinator revealed the facility does yearly competency trainings which was done at the end of November 2018. She stated "Well, that would not be the appropriate way to wash her hands." RN #3 stated the nurse should have washed her hands, dried her hands with a paper towel, gotten a clean paper towel to turn the water off, and discard it. She stated her wet hands should not have touched the faucet. On 2/20/19 at 3:15 PM. an interview with the	F 880	3/21/19 regarding moving the Genitourinary bag to the side of the bed that the resident is being turned to. Certified Nurse Aide #1 was in-serviced by the Infection Control Nurse and the Certified Nurse Aide Coordinator on 3/21/19 regarding the Handwashing Policy. Certified Nurse Aide #2 was in-serviced on 3/21/19 by the Infection Control Nurse and the Certified Nurse Aide Coordinator regarding moving the Genitourinary bag to the side of the bed that the resident was being turned to. For Resident #79: The Standard Precautions Policy was updated regarding the cleaning of reusable equipment such as pulse oximeters on 3/11/19 by the Quality Assurance Coordinator. Registered Nurse #9 was in-serviced by the Infection Control Nurse on 3/19/19 regarding the updated Standard Precautions Policy to include the types of equipment to be cleaned such as a pulse oximeter. 2) The facility recognizes that all residents had the potential to have been affected by this alleged deficient practice. 3) Nurses and Certified Nurses Aides were provided education beginning on 2/27/19 and ongoing until completion date	

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F 880	Continued From page 18 Director of Nursing (DON) revealed the facility staff are supposed to use the paper towel to turn the water off and not use their wet hands so they are not touching the contaminated faucet. She stated that is an infection control issue. The DON also stated she (RN #1) should have dried her hands and gotten a new paper towel to turn off the faucet. On 2/20/19 at 3:30 PM, an interview with RN #1 revealed after washing her hands, she should have not turned the water off with her wet hands. RN #1 stated, she should have dried her hands first and then used another clean paper towel to turn the water off. Resident #24 Observation on 2/19/19 at 10:04 AM, revealed Certified Nursing Assistant (CNA) #1 provided catheter care to Resident #24, assisted by CNA #2. CNA #1 washed her hands, dry her hands with the paper towel, then turned the water off using the same paper towel that she dried her hands with. CNA #1 applied clean gloves, added some water to two (2) basins, and turned off the water with her same gloved hands. Using these same gloved hands, CNA #1 then provided catheter care to Resident #24. While she continue to use these same gloved hands, CNA #1 pulled Resident #24's covers back and wiped three (3) times from the resident's meatus area outward while securing the catheter tubing, but without rotating her washcloth. CNA #1 then dried Resident #24's catheter tubing, washed her hands, and changed her gloves to perform peri-care. She wiped the resident's right groin area three (3) times without rotating the washcloth. Both CNA #1 and CNA #2 repositioned Resident #24 onto her left side and CNA #1 placed a clean blue pad underneath	F 880	regarding the Foley Cath Care Policy, the Peri Care Policy, the Handwashing Policy, and the Equipment Cleaning Policy by the Infection Control Nurse, the Quality Assurance Coordinator, and the Certified Nurse Aide Coordinator. The Infection Control Nurse and the Certified Nurse Aide Coordinator will monitor Certified Nurse Aides providing Foley Cath Care and Peri Care five Certified Nurse Aides per week, beginning 3/25/19. The Infection Control Nurse and the Restorative Nurse will monitor Certified Nurse Aides and Nurses performing Handwashing five staff members per week, beginning 3/25/19. The Restorative Nurse will monitor nurses properly cleaning the pulse oximeter 1 staff member per week, beginning 3/25/19. 4) The results of the monitoring will be brought to the Quality Assurance Performance Improvement Committee by the Quality Assurance Coordinator and corrective action will be monitored and evaluated by the Committee monthly for at least three months. If any revisions of the plan of correction are needed, the revisions will be developed and approved by the Quality Assurance Performance Improvement (QAPI) Committee to ensure the plan of correction is achieved and sustained.	

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F 880	Continued From page 19 Resident #24. Both CNA #1 and #2 repositioned Resident #24 onto her right side and finished straightening out the blue pad. On 2/20/19 at 3:40 PM, an interview with the Director of Nursing (DON) revealed that CNA #1 should have discarded the soiled paper towel and used a clean paper towel to turn the water off after washing her hands. The DON also stated a lot of glove changing and hand washing opportunities of the CNA #1 were missed. On 2/20/19 at 3:50 PM an interview with Registered Nurse (RN) #3 revealed, CNA #1 should have thrown that paper towel away and got a new one to turn the water off. RN #3 also stated CNA #1 should have changed her gloves after turning the water off. She stated each swipe should be with another wash cloth. RN #3 stated the washcloth should be rotated. She stated CNA #1 should have dried her hands before touching the paper towel handle and stated that this is a potential infection control risk. On 2/21/19 at 11:05 AM, an interview with CNA #1 revealed that re-wiping the catheter tubing could cause the resident to get an infection. On 2/21/19 at 11:20 AM, an interview with the Director of Nursing (DON) revealed not rotating the washcloth could put germs back into the meatus. On 2/21/19 at 11:35 AM an interview with CNA #2 revealed CNA #1 should have rotated her washcloth, because she wiped the catheter tubing about three (3) times. Resident #79 An observation on 02/18/19 at 11:34 AM, revealed Registered Nurse (RN) #9 entered Resident #79's room to administer a breathing treatment and take an Oxygen Saturation (O2 Sat). RN #9 had the pulse oximeter in her right	F 880		

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F 880	Continued From page 20 lab coat pocket. RN #9 removed the pulse oximeter from her pocket and placed it on Resident #79' forefinger without cleaning the pulse oximeter. After she obtained the O2 Sat, RN #9 took the pulse oximeter off of Resident #79's fore finger and placed it back into the right pocket of her lab coat, without cleaning the pulse oximeter. She then exited the room with the pulse oximeter in her right pocket of her lab coat. Observation on 02/18/19 at 02:40 PM, revealed RN #9 entered Resident #79's room to administer a breathing treatment and to take Resident #79's O2 Sat. RN #9 pulled the pulse oximeter from her right coat pocket, placed it on Resident #79's forefinger, without cleaning the pulse oximeter. After obtaining the O2 Sat, RN #9 removed the pulse oximeter from Resident #79's forefinger and placed it back into her jacket pocket, without cleaning the pulse oximeter. She then exited the room with the pulse oximeter in her right pocket of her lab coat. A third observation on 02/18/19 at 03:46 PM, revealed RN #9 entered Resident #79's room for a breathing treatment and an O2 Sat reading. RN #9 took the pulse oximeter from her right lab coat pocket and placed it on resident #79's forefinger, without cleaning the pulse oximeter. After obtaining the O2 Sat reading, RN #9 removed the pulse oximeter and placed it back into the right pocket of her lab coat, without cleaning the pulse oximeter. She exited the room with the pulse oximeter in the right pocket of her lab coat. An interview on 02/18/19 at 03:50 PM ,with RN #9, confirmed the pulse oximeter was in her coat pocket and she pulled it out and placed the pulse oximeter on Resident #79's finger without	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A156	A. BUILDING _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	305 WEST MOODY STREET POPLARVILLE, MS 39470

(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 21 cleaning it first. RN #9 then removed the pulse oximeter and placed it back in her right pocket without cleaning it. RN #9 stated, "It should not have been in my pocket. You don't know what kind of germs are in your pocket because you don't know where all your hands have been and what germs are in there. I just put it there and never really thought about it". RN# #9 stated, "I should have cleaned the O2 Sat machine before using it and after using it. I can see where it would be an infection control issue." An interview on 02/20/19 at 02:51 PM, with the Director of Nursing (DON), confirmed, "It was an infection control issue because your pocket is dirty and it should not have been in her pocket at all", referring to the pulse oximeter in RN #9's pocket. The DON farther stated, "The pulse oximeter should have been cleaned before using it on the Resident #79." An interview on 02/20/19 at 03:05 PM, with RN #3/Infection Control Nurse, revealed, "If you observed the pulse oximeter in her pocket and it not being cleaned before using, it then it needs to be addressed as an infection control issue. She should have not had it in her pocket, and it should have been cleaned before and after using it, and not put back in her pocket". An interview on 02/20/19 at 03:08 PM, with the Administrator revealed, "Having it in her pocket and not cleaning it properly is an infection control issue."	F 880		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 25A156	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 2/21/2019
NAME OF PROVIDER OR SUPPLIER **PEARL RIVER CO NURSING HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **305 WEST MOODY STREET POPLARVILLE, MS**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	25A156	A. BUILDING: _____ B. WING _____	2/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	**305 WEST MOODY STREET POPLARVILLE, MS**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 1

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on Record Review, Facility Policy review, and staff interview, the facility failed to notify the Office of Mississippi Long-Term Care Ombudsman of a resident's transfer to an acute care facility for one (1) of five (5) residents reviewed for transfers. Resident #2

Findings include:

A review of the Facility Policy, titled, "Requirements for Transfers and Discharges", dated 04/01/2018, revealed that it is the policy of this facility that in accordance with federal regulations for nursing homes, a copy of all emergency transfers to an acute care facility will be emailed on a monthly basis to the Ombudsman Program.

A review of Resident #2's medical record revealed: "Nurse's Notes", dated 01/15/2019, which documented that the resident was sent out to the hospital to be evaluated, related to a decrease in level of conscientiousness. The Nurse's Notes further revealed that Resident #2's Nurse Practitioner (NP) was notified and gave the order to send resident to the hospital.

A review of Resident #2's medical records documentation, titled, "Physician's Telephone Orders", dated 01/15/2019, revealed an order from Resident #2's NP to discharge Resident #2 out to the hospital to be evaluated related to a diagnosis of a gastro-intestinal (G.I.) bleed.

A review of the facility's documentation, titled, "Emergency Transfers From Pearl River County Nursing Home For January 2019", revealed that Resident #2 had not been added to the transfer form, and had not been reported to the Office of the Mississippi Long Term Care Ombudsman.

During an interview, on 02/20/2019 at 11:47 AM, Licensed Practical Nursed (LPN) #2/ Admission Coordinator stated that Resident #2's transfer to an acute care facility had not been added to the list of residents transferred from the facility during the month of January 2019. LPN #2 stated, "I don't know how I missed it."

During an interview, on 02/21/2019 at 10:19 AM, the Director of Nursing (DON) confirmed that Resident #2 had been transferred out to the hospital on 01/15/2019, and should have be listed as one (1) of the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	**305 WEST MOODY STREET POPLARVILLE, MS**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 2 that were transferred out to the hospital for January 2019. The DON stated the list is emailed to the State Ombudsman office ever month.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A156	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/20/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	**305 WEST MOODY STREET** **POPLARVILLE, MS 39470**

(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
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		

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

Electronically Signed | 03/08/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A156	A. BUILDING _____ B. WING _____	02/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 2/20/19 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 | 03/08/2019

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