STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255311	A. BUILDING _____ B. WING _____	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT OAKS REHABILITATION AND HEALTHCARE CENTER	111 CHASE STREET BYHALIA, MS 38611

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 11/14/22 to 11/16/22 along with a complaint investigation (CI) MS19720 related to accidents hazards and reporting. The SA substantiated CI MS19720 for accidents and reporting and cited F609 and F689 at D levels. During the recertification survey, the SA determined that the facility was not in compliance with Medicare and Medicaid regulations for participation and cited regulatory deficiencies at F640, F695 and F880. Census at the time of survey was 46 and the facility was licensed for 60 beds.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to	F 640		12/29/22

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

Electronically Signed | 12/05/2022

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F 640	Continued From page 1 standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to complete and transmit a Minimum Data Set (MDS) assessment for one (1) of fourteen residents reviewed. Resident #41. Findings include: Review of a statement on letterhead and signed by the Administrator on 11/5/22 revealed, "We currently use RAI manual for timely submission	F 640	To prevent further misdating of resident assessment the MDS (Minimum Data Set) team of Great Oaks and the Regional Case Mix team are pulling the Admin/Discharge Report weekly in PCC (Point Click Care) to ensure all Discharge and/or End of PPS assessments are set timely. Resident #41 dischrged and not anticipated to return from the facility. Minimum Data set assessment was	

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F 640	Continued From page 2 and completion of MDS's." A record review, of Minimum Data Set (MDS) Assessment completed for Resident # 41 revealed that the resident entered the facility on 5/27/22 for Medicare Part A services. A Discharge Return Not Anticipated/End of Part A Stay, with an ARD date of 7/23/22, was transmitted and accepted on 11/11/2022. A record review of Resident #41's Discharge Return Not Anticipated/End of Part A Stay assessment with an ARD date of 7/23/22, revealed "Date RN Assessment Coordinator signed assessment as complete" was dated 8/6/22 but had been signed in error and Section A, B, C, D were dated complete on 11/1/22, and Section E was dated complete on 11/2/22. Record review of the Validation Report revealed that Resident #41's Discharge Return Not Anticipated/End of Part A Stay assessment was batched, transmitted and accepted on 11/11/2022. During an interview with the MDS nurse on 11/15/2022 at 9:20 AM, she revealed that upon review of the report they noticed that there were late days and realized that Resident #41's discharge assessment was not completed. She stated that she was off work and the new MDS nurse completed and transmitted the assessment. The MDS Coordinator stated that Resident #41's Discharge Return Not Anticipated/End of Part A Stay was transmitted and accepted on 11/11/2022 which was late. During an interview with the Assistant Director of Nursing (ADON) on 11/15/22 at 2:30 PM, she revealed that the facility does not have a policy regarding the timeliness of encoding and submitting MDS assessments, and that they	F 640	modified on 12/7/22 to correct the collection date to 11/11/22 and the completed date by 11/11/22 and resubmitted on 12/7/22 by the Regional Case Mix Nurse. ¿ Currently, 47 residents have the potential to be affected. ¿ The Regional Case Mix team will review the Quality Assurance Performance Improvement Committee approved Discharge Report from Point Click Care for the past 6 months beginning 12/2/22. The MDS will audit that all residents have a Discharge Minimum Data Set completed and transmitted and if an End of Prospective Payment System assessment was needed that this was completed as well. MDS will submit this report to administration when completed by 12/23/12. Going forward, MDS will pull this weekly beginning Friday 12/9/22 to review residents that discharged 12/2/22 to 12/8/22 and submit their findings to the Administrator on Friday 12/9/22. The MDS team would conduct QAPI approved process every week for 4 weeks, then 2 times a month for 1 month, then monthly for 3 months once the initial audit has been completed. Great Oaks will review all issues at our 12/15/22 Quality Assurance Performance Improvement Committee Meeting.	

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F 640	Continued From page 3 follow the Resident Assessment Instrument (RAI). During an interview, with the MDS Coordinator on 11/16/22 at 8:30 AM, she stated that the assessment was completed on 11/2/22 and the new MDS nurse incorrectly dated "Date RN Assessment Coordinator signed assessment as complete" with the date it should have been completed, which was 08/06/22, and not the date it was completed, which was 11/11/22. She stated that this was an unintentional error due to the nurse being new.	F 640	Regional Case Mix Team will run the Detailed Monthly Census Report in Point Click Care for the active billing month to ensure all needed discharge assessments have been completed and actively transmitted to validate details were not missed during the outlined plan every Friday beginning 12/2/22. This will be done monthly. Also, the discharge assessments from the previous week will be reviewed to ensure timely completion and active transmission. This action will occur weekly for four weeks, then two times a month for 1 month and then monthly for 3 additional months beginning 12/2/22 and reviewed by the Quality Assurance and Performance Team on 12/15/22 and then mpnthly for 12 months, The Regional Case Mix team will run the Missing Assessment report monthly for three months beginning 12/9/22 in Simple LTC to ensure there are not additional Minimum Data Set assessments that have populated to this report due to not being scheduled and/or completed in and alert the Minimum Data Set team accordingly for a plan of correction or completion. The Minimum Data Set Nurse and the Regional Case Mix Team will be responsible for overall compliance.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		12/29/22

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F 695	Continued From page 4 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 observations, resident and staff interviews and record reviews the facility failed to prevent the likelihood of a combustible event as evidenced by not posting "Oxygen in Use" signage at the entrance of resident's rooms for two (2) of eight (8) residents reviewed with oxygen in use. Unsampled Resident #17 and Resident #108 Findings include: Record review revealed the facility does not have a policy regarding the posting of "Oxygen in Use" signage. The facility administrator provided documentation on the facility letterhead dated 11/15/22 that revealed, "(Facilities proper name) is a non-smoking facility. We do not have a current policy related to smoking signage and oxygen usage". An observation on 11/14/22 at 2:31 PM, revealed Resident #108 sitting in his wheelchair receiving Oxygen (O2) via nasal cannula at 2Liters/minute (L/M) and there was no "O2 in Use" sign on the resident's room door. An observation on 11/15/22 at 9:02 AM, revealed that Resident #108 was on continuous O2 via nasal cannula at 2L/M with no "O2 in Use" sign on the resident's room door.	F 695	1. Director of Nursing corrected this deficiency on 11/15/22 by putting up "oxygen in use" signage at every door of our residents that use oxygen. Signage was placed on resident room #108 on 11/15/22 that stated "Oxygen in Use" to immediately correct the issue that was noted. 2. Currently 17 residents use oxygen and have the potential to be affected. The system used to ensure the problem does not reoccur is at the daily morning standup meeting of management, we will report out a count of how many current residents are on oxygen and any potential residents coming with oxygen needs. This count will be done before morning standup and recorded daily by the RN Supervisor or designated weekend charge RN. 3.Central Supply has ordered more signage stating "Oxygen in Use" for future residents that require oxygen. Staff was inserviced on 12/2/22. Staff will be inserviced 2 times monthly beginning	

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F 695	Continued From page 5 An observation and interview on 11/15/22 at 10:12 AM, revealed Resident #108 lying in bed receiving O2 via nasal cannula at 2L/M. An interview at this time with the resident revealed he wears the O2 continuously. An observation on 11/15/22 at 2:04 PM, revealed Resident #17 was receiving O2 via nasal cannula at 2L/M with no "O2 in Use" signage on the resident's room door. An observation and interview on 11/15/22 at 3:00 PM, with the Assistant Director of Nurses (ADON) confirmed Resident #108 was receiving O2 continuously and Resident #17 was receiving O2 as needed. She confirmed there was no "O2 in Use" sign on Resident #17 or Resident #108's room doors. An interview on 11/16/22 at 9:10 AM, with the Director of Nurses (DON) and the ADON confirmed that they do not put up "O2 in Use" signs. They both revealed that even petroleum products could cause O2 to combust so therefore the purpose of putting the "O2 in Use" signage up would be to prevent a combustible event from occurring. Record review of Resident #108's Admission Record revealed he was admitted to the facility on 10/31/22 with medical diagnoses that included Acute Respiratory Failure with hypoxia. Record review of Resident #108's Physician's Orders revealed the following: Order dated 10/31/22-O2 at 2 liters per minute via nasal cannula continuously. May titrate to 3-4 LPM to keep O2 saturation (sats) >/=92% (percent),every shift for O2 sat >/=92%.	F 695	12/2/22 for 1 month and then once monthly for 3 additional months. This was approved by the Quality Assurance and Performance Improvement Committee on 12/6/22. 4.RN Supervisor began auditing on 11/15/22 daily. RN Supervisor will report findings to the Quality Assurance and Performance Improvement Committee monthly monthly beginning with our 12/6/22 meeting with no end date. Director of Nursing is responsible for monitoring and compliance. RN Supervisor began auditing daily on 11/15/22 and will continue to do so daily as was approved on 12/2/22.	

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F 695	Continued From page 6 Record review of Resident #108's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/2/22 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicates the resident is cognitively intact. Record review of Resident #17's Admission Record revealed an admission date of 8/12/22 with medical diagnoses that included Acute Pulmonary edema and Chronic Obstructive Pulmonary Disease. Record review of Resident #17's Physician's Orders revealed the following: Order dated 8/30/22-O2 at 2 Liters per minute via nasal cannula continuously. May titrate to 3-4 LPM to keep O2 sats >92% as needed for O2 sat >92%. Record review of Resident #17's MDS with an ARD of 11/14/22 revealed a BIMS score of 14 which indicates the resident is cognitively intact.	F 695		
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:	F 880		12/29/22

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F 880	Continued From page 7 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a 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.	F 880		

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F 880	Continued From page 8 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review, the facility failed to prevent the likelihood of the spread of infection as evidenced by failure to disinfect a multi-use equipment device during a medication pass for one (1) of three (3) observations of a multi-use device. Findings include: Review of the facility policy titled, "Cleaning and Disinfection of Resident-Care Items and Equipment" with a revision date of 10/2022 revealed under the "Policy Statement...Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control) recommendations for disinfection and the OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard". This review revealed under "Policy Interpretation and Implementation...#1. C. (3) non-critical items require cleaning followed by either low-or intermediate-level disinfection following manufacturers' instructions... #5. Reusable items	F 880	1.Director of Nursing pulled Licensed Practical Nurse #1 from the cart and immediately had her in serviced on infection control, Proper use of barriers and proper cleaning and kill time of medical devices on 11/15/22. On 11/15/22, all remaining staff were in-serviced. The Director of Nursing, on 11/15/22 also created personalized bags with a blood pressure cuff, O2 sensor, Glucometer, thermometer, and stethoscope for our COVID rooms. Resident #1 discharged on 11/17/22 but was audited on 11/15/22 and 11/16/22 for proper infection control usage and cleaning while being cared for during in room vists by the Director of Nursing and Assistant Director of Nursing. 2.47 residents have the potential to be affected. 3.The Staff Development Coordinator who	

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F 880	Continued From page 9 are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment)..." An observation on 11/15/22 at 10:40 AM, revealed Licensed Practical Nurse (LPN) #1 took a blood pressure cuff out of the side drawer of the medicine cart, entered room 215D ,then placed it on top of the resident's overbed table with no barrier. She placed it on the resident's wrist and obtained his blood pressure, then took it off of the resident's wrist and placed it back on top of the resident's overbed table. She then returned to the medicine cart with the blood pressure cuff and placed it back in the side drawer on top of another blood pressure cuff. This observation revealed LPN #1 did not clean the blood pressure cuff before entering the resident's room, no barrier was used, and the blood pressure cuff was not cleaned after it was used on the resident and it was placed back into the medication cart on top of other items before it was disinfected. An interview on 11/15/22 at 10:50 AM with LPN #1, confirmed she did not clean the blood pressure cuff before using it to obtain the resident's blood pressure in room 215D, did not use a barrier before she put it on top of the resident's overbed table and placed it back in the medicine cart drawer without cleaning. She revealed the blood pressure cuff is a multi-use blood pressure cuff and stated that she should have cleaned the blood pressure cuff with the "Micro-Kill" wipes she has in the bottom drawer of her medicine cart before using it to take the resident's blood pressure and should have cleaned it before placing it back inside the drawer of the medicine cart. She confirmed that the uncleaned blood pressure cuff touched another	F 880	is also the Infection Preventionist will give weekly education for four weeks on infection control, proper use of barriers and proper cleaning and kill time of medical devices then bi-weekly for 4 weeks and then quarterly for 12 months for all Great Oaks employees. The trainings will be reviewed beginning 12/15/22 at our monthly Quality Assurance Performance Improvement Meeting as they begun on 12/2/22. The facility identified that Mock surveys will need to be performed routinely and randomly to address and train the staff about being directly observed by superiors 2 times per month beginning 12/9/22 after being approved by the Quality Assurance Performance Improvement Committee on 12/8/22. The facility will also begin an inservice on the human aspect of being intentional about your job even under the stress of being surveyed or audited. This inservice will begin 12/12/22 after being approved by the Quality Assurance Performance Improvement Committee on 12/8/22. These inservices will include all Great Oaks staff. The skills checkoffs will begin on 12/12/22 and be performed on all nursing, maintenance, housekeeping, and certified nursing assistants on infection control. Our root cause analysis was performed by our leadership team on 12/8/22 and attached to this ePOC. The CMS CDC assigned directed mandatory training of the YouTube video "Sparkling Surfaces" began 12/7/22 will be completed by the deadline of 12/14/22 as proposed by CMS	

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F 880	Continued From page 10 blood pressure cuff inside the drawer which contaminated it also. She revealed the reason the multiuse equipment needs to be cleaned in between resident use is to decrease the spread of infection. An interview with the Director of Nurses (DON) and the Assistant Director of Nurses (ADON) on 11/16/22 at 9:15 AM, confirmed that multi use equipment needed to be cleaned between resident use to prevent the spread of infection. They both confirmed that not cleaning multi-use equipment between residents could lead to the spread of infection. Review of the facility in-services revealed the facility had an infection control in-service on 6/15/22 and 10/18/22 that included cleaning multi use equipment. This review revealed these in-services were attended by LPN #1.	F 880	by 100% of Great Oaks emloyees. 4.Beginning 12/2/22 Director of Nursing or Infection Preventionist will monitor proper cleaning of equipment by observing 4 nurses a week for four 4 weeks and then 2 times a week for 3 weeks and then monthly thereafter for 3 months. The skills checkoffs will begin on 12/12/22 and be performed on all nursing, maintenance, housekeeping, and certified nursing assistants. A report will be submitted to the Quality Assurance Performance Improvement committee monthly for 12 months beginning 12/15/22 at our regularly scheduled monthly meeting for further recommendation. Any changes and revisions deemed necessary after review for monitoring and compliance will be initiated through the Quality Assurance Performance Committee.	