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 _____	10/12/2017

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 Survey Agency (SA) conducted an annual recertification survey from 10/10/17 through 10/12/17 . During the survey, the SA determined the facility was not in compliance with the Centers for Medicare and Medicaid Services Conditions of Participation. The SA cited deficiencies at F279 and F441. The facility is licensed for 60 beds and the census at the time of survey was 57 .	F 000		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (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 279		11/16/17

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

Electronically Signed | 11/07/2017

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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F 279	Continued From page 1 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, facility policy review and record review the facility failed to develop a comprehensive care plan related to a resident's behavior of pulling out her hair, for	F 279	1) Immediate action taken for Resident #3 found to have been affected: Care plans of Resident # 3 were reviewed by QA Team on 10/13/2017 and updated	

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MS CARE CENTER OF DEKALB	220 WILLOW AVENUE DE KALB, MS 39328

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F 279	Continued From page 2 one (1) of 14 care plans reviewed, Resident #3. Findings include: Review of the facility's policy titled, Comprehensive Care Plans, with an implementation date of 01/05/17, revealed it is the policy of this facility to develop and implement a comprehensive person-centered care plan to meet a resident's medical, nursing, mental and psychosocial needs. The care plan will include an assessment of the resident's strengths and needs. The comprehensive care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being, and any specialized services the nursing facility will provide. The care plan will be reviewed and revised after each comprehensive and quarterly Minimum Data Set (MDS) assessment. Review of Resident #3's current Comprehensive Care Plan revealed no problems, goal or interventions related to the resident's behavior of pulling out her hair and putting it in her mouth. Review of Resident #3's Care Plan Conference Summary with a date of 08/23/17, revealed the resident's daughter was in agreement with her mother's plan of care. Resident is a Dialysis patient- facility has received numerous complaints from nurses at dialysis unit that resident is disruptive. Her yelling out has begun to annoy others there for treatment. Resident's family was informed of her pulling out her hair and putting in in her mouth. Family agreed to hair being cut very short. Consent form was forwarded to resident's daughter to be signed. Also informed	F 279	to include: Resident #3 hair trimmed close to head as Resident # 3 pulls out and eats. Family aware and consent. Mitt for hand placed on resident as resident continues to pull out hair and eat. Resident #3 can remove hand mitt at will, staff continues to monitor for safety. 2) Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected. 3) Actions taken/systems put into place to reduce the risk of future occurrences include: All interdisciplinary care plan team members responsible for writing care plans re-educated by MDS Coordinator/RN on the facility□'s policy (10/13/2017) and procedure for developing comprehensive care plans. A new Care Plan book was purchased and reviewed by Care Plan Team 10/26/2017 by MDS Coordinator/RN to ensure education, familiarity, and compliance. 4) How the corrective actions will be monitored to ensure the practice will not occur: Care plans will be reviewed weekly in accordance with the care plan review scheduled by MDS Coordinator. All care plans will be updated as indicated. Assistant Director of Nursing Services (ADON) will complete four (4) random weekly audits of care plan beginning	

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F 279	Continued From page 3 that referral has been sent to mental health consultant. Observation on 10/10/17 at 11:00 AM, revealed Resident #3 sitting in a reclining chair in her room. The hair on the right side of her head appeared much shorter than that on the left. There was a sock on the resident's right hand. Interview with Registered Nurse (RN) #1 on 10/10/17 at 11:00 AM, revealed Resident #3 had started pulling out her hair and putting it in her mouth. RN #1 stated the facility had gotten permission and cut the resident's hair very short but she still pulled at it. RN #1 stated the resident used to just pat herself on the head and this was a fairly new behavior. They put the sock on that hand to keep her from pulling out her hair. Interview with Licensed Practical Nurse (LPN) #1, Minimum Data Set (MDS) and Care Plan Nurse, on 10/12/17 at 11:00 AM, revealed she was aware that Resident #3 had been having some problems at dialysis, hollering and disturbing other patients. LPN #1 stated the resident liked to be left alone. LPN #1 recalled hearing something about Resident #3 hitting herself in the head and pulling out her hair. LPN #1 stated this behavior should have been documented in the nurses notes and care planned. Interview with Director of Nurses (DON) on 10/12/17 at 1:45 PM, revealed some of the Certified Nurse Aids (CNA's) put the sock on Resident #3's hand in hopes of keeping her from pulling out her hair. She stated the resident can and does pull the sock off any time she wishes. The DON stated that Psychology services had been seeing her at the facility and regulating her	F 279	10/18/2017 for six (6) consecutive weeks.	

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F 279	Continued From page 4 medication to try to control these behaviors. The DON acknowledged there was no care plan or documented interventions for Resident #3's behavior of pulling out her hair. Review of the facility's face sheet revealed the facility admitted Resident #3 on 03/26/16. The resident's diagnoses included Dysphagia, Type II Diabetes Mellitus, Gastro-esophageal Reflux Disease (GERD), Essential (Primary) Hypertension, Acute on Chronic Congestive Heart Failure, End Stage Renal Disease, Delusional disorders, and Anxiety Disorder, unspecified. Review of Resident #3's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/16/17, revealed staff assessed the resident with moderate impairment with cognitive skills for daily decision making.	F 279		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2);	F 441		11/10/17

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F 441	Continued From page 5 (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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 441		

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F 441	Continued From page 6 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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, facility policy review, and record review, the facility failed to ensure resident care equipment was cleaned and stored in a manner to prevent the possible spread of infection for one (1) of one (1) residents reviewed with a continuous positive airway pressure (CPAP) mask; the only resident in the facility with CPAP. [Resident #4] Findings include: Observations on 10/10/17, at 11:30 AM and 4:30 PM, revealed Resident #4's CPAP mask in the bed rails under the bed spread and not covered or bagged. Observations on 10/11/17 at 10:00 AM, at 12:30 PM and 3:30 PM, revealed Resident #4's un-bagged CPAP mask on the floor beside her bed. Observation on 10/12/17 at 10:45 AM, revealed Resident #4's CPAP mask on the nightstand not covered or bagged. Review of Resident #4's Physician Orders with an order date of 06/24/15, revealed orders for Continuous Positive Airway Pressure (CPAP) to be put on at bedtime and removed at 6:00 AM.	F 441	1) Immediate Action taken for Resident # 4 that was affected, included: Manufacturer□s guidelines for infection control/routine Maintenance for CPAP machine was reviewed for Resident # 4 and immediately added under TAR (10/12/2017). 2) Identification of other residents having the potential to be affected was accomplished by: The facility has determined that all resident using a CPAP machine would be affected; however, the facility has only one CPAP machine on premises, Resident #4. 3) Actions taken/systems put in place to reduce the risk of future occurrences include: In-Service by Infection Control Coordinator, RN, 10/12/2017, nurses and staff - infection control, including proper maintenance of CPAP machine per manufacturers guidelines. Use and Infection Control procedures were included in Treatment Plan and included in daily TAR. In-Service by Infection Control Coordinator, RN, all staff, 11/14/2017, Infection Control to include	

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F 441	Continued From page 7 Review of Resident #4's Treatment Administration Record (TAR) for October 2017, revealed the CPAP mask to be put on at 8:00 PM and removed at 6:00 AM. Check marks and nurses initials in the 6:00 AM and 8:00 PM slots under the dates 10/01/17 through 10/11/17, indicated the mask was applied and removed on those dates. Further review of the TAR revealed a new entry on 10/12/17, to remove the CPAP mask at 6:00 AM daily and wipe the mask with a damp paper towel and allow to air dry. Interview with Assistant Director of Nurses (ADON) on 10/10/17 at 11:30 AM, revealed staff puts the CPAP mask on Resident #4 at night and takes it off in the morning, but sometimes the resident will take it off herself. The ADON stated there are orders to put the CPAP on and take it off on the TAR, but there are no orders for cleaning/storage that she was aware of. Interview with Registered Nurse (RN) #2, Infection Control Nurse, on 10/12/17 at 12:50 PM, revealed CPAP masks should be in a bag and should be cleaned daily. RN #2 stated the the nurse on duty when the CPAP mask is taken off is responsible for cleaning the mask. RN #2 stated that Resident #4 will take the mask off and put it where ever she wants but the nurses should clean and bag it. RN #2 stated that it was definitely an infection control issue if the mask is on the floor. Interview with Director of Nurses (DON) on 10/12/17 at 1:45 PM, revealed the facility did not have any specific policy for CPAP cleaning and storage. She stated that Resident #4's was the only CPAP in the facility and the CPAP mask	F 441	care of CPAP and other devices. Purchased a SoClean Sanitizer and all Staff in-serviced by RN/ADON on 11/21/2017. 4) How the Corrective Action will be monitored to ensure the practice will not occur. CPAP treatment/Infection Control procedures added to Treatment Plan (TAR) and monitored daily by Infection Control Coordinator x 2 weeks, and complete one random audit weekly x six (6) weeks. Audit records will be reviewed by Quality Assurance committee until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with Resident Council for comments.	

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F 441	Continued From page 8 should not be in the bed or on the floor, it should be bagged. The DON stated that Nurses are responsible for the cleaning and care of the CPAP equipment and it could cause infection if not cleaned or if left on the floor. Review of the facility's face sheet revealed the facility admitted Resident #4 on 08/31/10. Resident #4's diagnoses included Diabetes Type II, Essential (Primary) Hypertension, Osteoarthritis, Idiopathic Neuropathy, Obstructive Sleep Apnea, Chronic Obstructive Pulmonary Disease and Glaucoma. Review of Resident #4's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/04/17, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident had moderate cognitive impairment.	F 441		

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	255251	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/13/2017**

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MS CARE CENTER OF DEKALB	**220 WILLOW AVENUE** **DE KALB, MS 39328**

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K 000	INITIAL COMMENTS 42 CFR 438.70(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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