STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25A422	A. BUILDING _____ B. WING _____	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTER B CROOK NURSING FACILITY	840 NORTH OAK AVENUE RULEVILLE, MS 38771

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency conducted an annual re-certification survey at the facility from 12/5/22 to 12/8/22. During the survey, the SA determined that the facility was not in compliance with Medicare and Medicaid regulations for participation with deficiencies cited at F0604, F0638, and F0656. The facility is licensed for 60 of beds and at the time of the survey the census was 53.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for	F 604		1/9/23

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

Electronically Signed | 12/27/2022

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F 604	Continued From page 1 purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, facility policy review and record review, the facility failed to keep residents free from physical restraints for one (1) of 20 residents reviewed during the survey. Resident #2 Findings include: Review of the facility policy titled, "Restraints - Definitions", dated 12/1/14, revealed: 1. Physical restraints Any manual method or physical or mechanical device material or equipment attached or adjacent to the resident's body that the resident cannot remove easily which restricts freedom of movement for normal access to one's body. 2. Side Rails a. Side rail use is addressed in the same manner as any other restraint. b. side rails used as an enabler must be supported by documentation. c. The use of side rails as restraints is prohibited unless they are necessary to treat a resident's medical symptoms. d. Residents who attempt to exit a bed through between over or around side rails are at risk of injury or death. e. The potential for serious injury is more likely from a fall from a bed with raised side rails than from a fall from a bed where side rails are not	F 604	1. Resident # 2 had side rails removed on 12/07/22 by maintenance personnel. Resident # 2 had side rail/assist bar assessment on 12/08/22 by the Care Plan Coordinator. A 100% audit of all beds with side rails in use were reviewed for appropriate use. No other beds were found to have side rails used inappropriately. 2. This has the potential to affect every resident who has side rails in use. 3. Staff Practical Nurses and Registered Nurses were in-serviced on the appropriate use of side rails, side rail assessment form and the facility side rail policy on 12/08/22 & 12/09/22. The Director of Nursing and the In-service Coordinator conducted the inservice. A Side Rail Assessment form was completed on each resident actively residing in the facility on 12/08/2022 by the Care Plan Coordinator to determine if side rails were needed. 4. A monitor involving a 100% audit of beds for bed rail use was started by the (DON) Director of Nurses on 12/07/22 and will be conducted weekly for three weeks	

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F 604	Continued From page 2 used. f. If the resident is immobile and cannot voluntarily get out of bed due to a physical limitation, the bed rails do not meet the definition of a restraint. g. The same device may have the effect of restraining one individual but not another, depending on the individual resident's condition and circumstances. For example, partial rails may assist one resident to enter and exit the bed independently while acting as a restraint for another. h. Full side rails may be one or more rails along both sides of the residence bed that block 3/4 to the whole length of the mattress from top to bottom including: beds with one side placed against the wall (prohibiting the resident from entering and exiting on that side) and the other side blocked by a full rail (one or more rails) j. Side Rails Used a Positioning Devices - if the side rail has the effect of restraining the resident and makes the definition of a physical restraint for that individual, the facility is responsible to assess the appropriateness of that restraint. k. Side Rails Used with Residents Who Are Immobile i. if the resident is immobile and cannot voluntarily get out of bed due to physical limitation and not due to a restraining device or because proper assistive devices were not present, the bed rails do not make the definition of a restraint. ii. For residents who have no voluntary movement, the staff needs to determine if there is any appropriate use of bed rail. An observation, on 12/05/22 at 03:42 PM and 12/07/22 at 10:15 AM revealed Resident #2 in bed with two (2) full length rails up on each side of the bed.	F 604	then monthly for three months. The (DON) Director of Nursing shall bring findings of assigned audits to the Quality Assurance Committee on January 05,2023 then monthly for three months and as needed for review/revision and/or changes in the current plan of action to obtain substantial compliance.	

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F 604	Continued From page 3	F 604		

An observation and interview, on 12/07/22 on 12:20 PM with the Director of Nursing (DON) concerning Resident #2, revealed that the 2 full length side rails should be considered a restraint.

An interview on 12/8/22 at 11:20 AM, with Resident #2 revealed that she was glad the rails were off (the side rails were removed after the surveyor brought the side rails to the attention of the administration). She stated they took up all her room in the bed and she would bump her legs on them sometimes. Resident #2 stated that now she could sit up by herself.

Review of the physician orders dated 1/20/22 revealed Resident #2 may use side rails for mobility and to aid in turning and repositioning. The order did not give instructions to how many side rails, or if they should be full length or half length.

Record review of the side rail assessment dated 11/14/22 revealed the reason side rails are being utilized is to increase bed mobility and allow Resident #2 to shift his/her weight. The number of rails indicated for use is 2. The length of side rails did not indicate if the side rails should be full length or half and they were not documented as a restraint.

Record review of Resident #2's Face Sheet revealed she was admitted to the facility on 3/9/21 with diagnoses that include Chronic Congestive Heart Failure, Rheumatoid Arthritis, Type 2 Diabetes Mellitus.

Record review of Resident #2's Minimum Data Set (MDS) with an Assessment Reference Date

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F 604	Continued From page 4 (ARD) of 11/14/22 revealed a Brief Interview for Mental Status (BIMS) score of 12 which indicated Resident #2 was moderately impaired. An interview, on 12/7/22 at 3:00 PM with the Director of Nurse (DON) revealed she did not realize they had so many beds with full rails up. She stated that they are working now on getting rails changed throughout the facility. An interview with the Administrator on 12/8/22 at 9:15 AM revealed that he understands the regulation but, in his mind they had considered the side rails as safety for the residents. He stated there had been no injuries related to side rail use. An interview, on 12/8/22 at 10:50 AM with the Care Plan Coordinator revealed she does side rail assessments on residents and did not document the side rails as restraint. She stated that she goes to the room and does a complete assessment. She stated that she did not feel like she had seen a resident who did not not need their side rail, full or otherwise.	F 604		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and facility policy review, the facility failed to complete a Quarterly Minimum Data Set (MDS)	F 638	1. The missing Minimum Data set assessment for resident #39 was completed by the Minimum Data Set	1/9/23

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F 638	Continued From page 5 Assessment, within 120 days, for 1 of 20 residents reviewed in the sample for MDS Assessments. Resident #38 FACILITY Resident Assessment Review of the facility policy titled, "Resident Assessments," revised November 2019, revealed "Policy Statement, A comprehensive assessment of every resident's needs is made at intervals designated by OBRA and PPS requirements. ... 2. Quarterly Assessment - Conducted not less frequently than three (3) months following the most recent OBRA assessment of any type." An interview on 12/07/22 at 01:30 PM with the Minimum Data Set (MDS) Nurse revealed she neglected to open the Quarterly MDS Assessment for the Assessment Reference Date (ARD) 10/18/22 for Resident #38. She revealed she had Resident #38's name written in on the MDS calendar, on 10/18/22, to remind her to open the Quarterly MDS Assessment for completion. She also revealed there was documentation entered in the Departmental Notes in the electronic health record (EHR), by facility staff members, for the Quarterly MDS Assessment for 10/18/22, and it was discussed in the care plan meeting. She noted it was her fault the Quarterly MDS Assessment for Resident #38 was not submitted, in the 120 day time frame, and the Quarterly MDS Assessment should have been completed. She revealed no other staff had knowledge of how to open a MDS Assessment. An interview on 12/7/22 at 01:40 PM with the	F 638	Coordinator on 12/09/22. A 100% audit was conducted on 12/07/22 by the Minimum Data Set Coordinator and the Care Plan Coordinator to ensure that all Minimum Data Set assessments had been opened and none had been missed. 2. Each resident in the facility has the potential to be affected. 3. The Minimum Data Set Coordinator was inserviced by the Director of Nursing on 12/07/2022 on facility policy regarding Minimum Data Set completion and shall be inserviced by Case Mix training and Minimum Data Set Training as offered. The Minimum Data Set Coordinator shall run the Minimum Data Set Schedule report monthly starting December 7, 2022 then monthly for three months to verify all residents are current with Minimum Data Set Assessments. 4. A weekly monitor began on 12/07/22 and continues weekly for three weeks, involving the Minimum Data Set Coordinator and the Care Plan Coordinator reviewing the Minimum Data Set Schedule Report for 100% compliance of assessments completed. The monitor shall continue ongoing on a monthly basis. The monthly Minimum Data Set calendar shall be used to determine that all schedule Minimum Data Set Assessments are opened, completed and transmitted. The Minimum Data Set Coordinator shall bring findings of the assigned audits to the Quality Assurance Committee meeting on January 05, 2023	

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F 638	Continued From page 6 Administrator confirmed the Quarterly MDS Assessment should have been completed for Resident #38, that it was missed by the MDS Nurse, and other staff did not report they had not completed their section, of the Quarterly MDS Assessment, because it was not opened. He revealed the Quarterly MDS Assessment should have been completed and submitted, for Resident #38, to ensure monitoring was being done of care indicators, to assist in monitoring for possible status changes, and to report the care being provided to Resident #38 at the nursing facility. He also revealed the Quarterly Assessment not being completed indicated the nursing facility was not following the Omnibus Budget Reconciliation Act of 1987 (OBRA) Assessment Schedule. An interview on 12/7/22 at 02:05 PM with the Social Worker revealed he was not aware that the Quarterly MDS Assessment, with an ARD of 10/18/22, had not been opened by the MDS Nurse. He confirmed he had documented in the Departmental Notes on 10/19/22, but could not recall that he had not completed his sections of the Quarterly MDS Assessment for the ARD of 10/18/22. An interview on 12/7/22 at 02:15 PM with MDS Nurse revealed she did not look for the MDS Quarterly Assessments, with an ARD of 10/18/22, to conduct her care plan meeting, but she did confirm she had the care plan meeting, on 10/21/22, for the quarterly review relevant to the Quarterly MDS Assessment ARD of 10/18/22. Record review of the MDS Calendar revealed Resident #38's name written in on 10/18/22 to indicate her ARD, and a "Q" was written behind	F 638	then monthly for three months and as needed for review/revision and/or changes in the current plan of action to obtain substantial compliance.	

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F 638	Continued From page 7 her name to indicate the assessment due was a quarterly assessment. Record review of the care plan "Quarterly Review Dates" sign-in sheet revealed a care plan meeting was conducted relevant to the Quarterly MDS Assessment with an ARD of 10/18/22, for Resident #38.	F 638		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656		1/9/23

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F 656	Continued From page 8 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to implement care plans for the use of side rails for one (1) of six (6) residents reviewed for side rails. Resident #17 Findings include: Review of the facility care plan policy with a revision date of December 2016, titled, "Care Plans, Comprehensive Person-Centered" revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan will	F 656	1. On 12/20/22, the Care Plan Coordinator updated/ revised for resident # 17 to reflect the use of side rails. The Care Plan Coordinator conducted a 100% audit of care plans on December 20, 2022 of all residents that require the use of side rails. All other care plans reflected the use of side rails for the resident. 2. All residents residing in the facility have the potential to be affected. 3. All facility nurses were in-serviced on the facility care plan policy on 12/22/22 by the Staff Education Coordinator. 4. The Care Plan Coordinator or the Director of Nursing shall monitor that all changes to any resident's side rail assessment shall be reflected in the	

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F 656	Continued From page 9 reflect currently recognized standards of practice for problem areas and conditions. An observation, on 12/05/22 at 02:47 PM revealed Resident #17 in bed with all four side rails up. An observation, on 12/06/22 at 02:30 PM revealed Resident #17 in bed with all four side rails up. An observation, on 12/07/22 at 8:06 AM revealed Resident #17 in bed with all four (4) rails up. An interview, on 12/7/22 at 11:35 AM with Certified Nursing Assistant (CNA) #1 revealed to her knowledge Resident #17 has always had four rails up. CNA #1 stated that they have care plans for the residents in a binder at the nurses desk and thinks Resident #17's plan is for four side rails. Record review of the comprehansive care plan for Resident #17 revealed a problem with an onset date of 4/25/17 related to the total assistance with all of the activities of daily living (ADL) due to severe impaired cognition as evidenced by a low brief interview for mental satus score and impaired mobility due to diagnosis of Left sided Hemiplegia following a Cerebrovascular Accident. Approaches that include: padded siderails x two (2) for secure self injury precautions and may have side rails to define perimeters per responsible party. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/7/22 revealed a Brief Interview for Mental Status (BIMS) score of 00 which indicated Resident #17	F 656	resident's care plan. This audit shall be conducted weekly starting December 20, 2022 for one month. The Care Plan Nurse shall bring findings of this audit to the Quality assurance Meeting on January 05, 2023 then monthly or as needed for review / revision.	

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F 656	Continued From page 10	F 656		

had severe cognitive impairment.

Review of the Face Sheet revealed Resident #17 was admitted to the facility on 12/24/13 with diagnoses which include Hemiplegia following unspecified cerebrovascular disease, Aphasia, Major depressive disorder, Type 2 Diabetes Mellitus, and Generalized Anxiety Disorder.

An interview, with the Administrator (ADM) on 12/8/22 at 10:00 AM revealed if the care plan called for two side rails and four side rails where up, obviously they were not following the care plan.

On 12/08/22 at 10:15 AM, an interview with the Director of Nursing (DON) confirmed care plans were not being followed for residents with four side rails up .

On 12/8/22 at 10:50 AM an interview with the Care Plan Coordinator revealed she does side rail assessments on all residents. The care plan is developed based on the physician orders and every resident has an order for side rails. She stated that she did not feel like she had seen a resident who did not not need their side rail, full or otherwise.