MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 000	Initial Comments The State Agency (SA) determined during an annual recertification survey conducted by the SA on 5/23/19 and in conjunction with Healthcare Management Solutions (HMS) on behalf of the MS State Department of Health, from 5/20/19 through 5/23/19, the facility was not in compliance with the Mississippi Regulations for Minimum Standards for Institutions for Aged or Infirm with deficiencies cited at M500, M615, M620, M625, M705, M710, M735, M780, M810, M815, and M865. The census on 5/20/19 was 90 and the facility held a license for 120 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or	M 500		7/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 1 nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 2 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately	M 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 3 with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II	M 500	This plan of correction affirms our allegations that Plaza Community Living	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 4 Based on observation, facility policy review and interviews, the facility failed to ensure residents' rights of receiving mail on Saturday for seven (7) of seven (7) residents who attended the Resident Council Meeting, which had the potential to affect all 90 residents in the facility. The facility also did not provide privacy for phone communication on the South Unit for Resident #80 or the other 59 residents on the South Unit. Findings include: Review of the facility's policy titled "Resident Rights", dated 11/28/16, revealed: "The resident has the right to send and receive mail. . ." Review of the facility's policy titled "Telephone" dated June 1, 2000, indicated telephones were available to residents to make and receive private telephone calls. The policy also revealed there was a cordless telephone on the North Unit. There was no indication of any telephones that could be used privately on the South Unit. On 5/21/19 at 9:38 AM, a Resident Council meeting and group interview was conducted. The resident group consisted of seven (7) cognitively intact residents that could be reliably interviewed about their care and services. When asked if they received their mail on Saturdays, all seven (7) residents stated they did not receive their mail on Saturdays. On 5/21/19 at 10:36 AM, the Business Office Manager was asked if the residents always received their mail on Saturdays. She stated, "No", because the Activities Coordinator did not work on Saturdays. When asked if her mail at home was delivered on Saturdays, the Business Office Manager stated, "Yes." When asked if the	M 500	Center is in substantial Compliance with regulations & standards. This plan of correction has been respectfully developed as required for compliance with the Federal & State Regulations. This plan of correction does not constitute an admission of any deficient practice, admission or argument of truth of the facts, alleged or conclusions set forth in the statement of deficiencies 1. A Resident Council meeting was held on June 13, 2019 by Nursing Home Administrator informing residents of their right to have mail delivered within 24 hours of receipt and that a designated phone for private use is available on the Transitional Care Unit in the Communications Room and is located in a private office on the Nursing Administrative Hallway on the North Unit. A notification regarding the accessibility of a private phone, Resident Rights, and the delivery of personal mail was distributed to all in-house residents on June 28th, 2019 by Social Services Director. Residents were educated of posted signage that also listed the designated location by the Social Services Director. 2. All residents receiving mail or wishing to make/receive private phone calls have the potential to be affected. 3. Director of Nursing conducted staff in-services that were completed on June 21, 2019 regarding the right of residents to have private use of a phone. Social Service Director was in-serviced on June 19 and the Activity Department was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 500	Continued From page 5 residents at the facility should have the same right to receive their mail on Saturdays, she stated, "Yes." Resident #80 During an interview on 05/20/19 at 3:35, with the resident in her new room, she stated there was no place on the South Unit to have a private telephone conversation. Review of Resident #80's Significant Change Minimum Data Set (MDS) assessment, dated 3/23/19, revealed the resident was cognitively intact. The resident was her own representative and was involved in decisions about her care and services. A random observation of another resident on the South Unit, on 5/22/19 at 3:15 PM, revealed the resident talking on the telephone that rested on the nurses' station counter. There was no privacy for the resident during the call. At the time of the observation, Registered Nurse (RN) #58 confirmed there was no place on the South Unit for residents to talk on the telephone privately. An interview with the Assistant Director of Nursing (ADON) on 5/21/19 at 4:00 PM, confirmed there was no place on the South Unit for the residents to have privacy with their phone calls.	M 500	in-serviced on June 18th by the Nursing Home Administrator on the requirement to distribute resident mail within 24 hours of receipt. Mail distribution will be documented by the weekend staff and documentation will be maintained in the Receptionists Office. Residents will be reminded monthly at the Resident Council Meeting of their right to request the private use of a phone and the location of the designated phone. 4. Administrator to review mail distribution documentation beginning June 19, 2019 1X weekly for four weeks and 1X monthly for two months to ensure continued compliance with any negative findings to be reported in the monthly Quality Assurance meeting for review, revision, and/or resolution. Administrator will review Resident Council meeting minutes monthly beginning July 2019 for 4 months to ensure continued compliance and report any negative findings in the Quality Assurance meeting for review, resolution, and/or revision.	
M 615	45.21.3 Pressure sores Pressure sores. Residents with a pressure sore shall receive necessary treatment and service to promote healing and prevent the development of new pressure sores. Residents without pressure sores will not develop pressure sores unless the residents' clinical condition indicates they were	M 615		7/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 615	Continued From page 6 unavoidable. This Statute is not met as evidenced by: Level III Based on facility policy review, observations, record reviews, and interviews, the facility failed to provide treatment and services to prevent the deterioration of, and promote healing of a pressure ulcer, for one (1) resident, Resident #54, of four (4) residents reviewed for pressure ulcers. As a result of the facility's failure, Resident #54 sustained harm by developing an unstageable pressure ulcer to the right heel. The facility failed to prevent the deterioration of the pressure ulcer that went unmonitored from 3/27/19 until 4/19/19, and no documented treatment from 4/6/19 through 4/18/19. The pressure ulcer deteriorated from a Stage 2 to an unstageable pressure ulcer that required debridement (surgical removal of dead tissue). Findings include: A facility policy titled, "Skin Care Process", dated 1/17/18, indicated, ". . .It is the policy of this facility to provide care and services with the goal of maintaining the resident's skin integrity and to provide care and services that meet professional standards to treat the loss of skin integrity should it occur. . .Staff Roles. . .The following is recommended as a minimum, other responsibilities may be assigned as allowed by regulatory or licensing agencies. . .Registered Nurse. . .Conducts or supervises the Admit/Readmit Physical Evaluation, and the completion of the Braden scale [skin assessment] as well as other evaluations at determined times. . .Stages pressure wounds. . .Observes wounds weekly. . .Oversees the licensed practical nurse	M 615	1. Resident #54 wound was assessed on 05/24/19 by the Director of Nursing to ensure that wound treatment is appropriate and wound exhibited no negative findings. The licensed nurse failing to provide treatment as ordered was educated by the Director of Nursing on June 26, 2019. 2. This deficient practice has the potential to affect all facility residents with a pressure ulcer or identified as high risk for development of pressure ulcers. A 100% audit of all residents with pressure ulcers was conducted by the Medical Records Clerk and the Director of Nursing to ensure treatments were provided in accordance with the physician's orders the week of June 23, 2019. A 100 % Audit was conducted as of July 2, 2019 of all in-house residents Braden Scale by the Minimum Data Set Nurse, residents identified to be at risk for pressure areas body audits and skin assessments had been conducted and there were reviewed to ensure appropriate interventions were implemented. The facility Administrator and the Regional Nurse Consultant observed a sample of treatments administered to residents in the facility with pressure areas to ensure treatments were being provided as ordered. 3. Nursing staff were in serviced on June 4, 2019 and June 5, 2019 regarding the facilities policies and procedures on Skin Care and Treatment & Services for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 615	Continued From page 7 and nursing assistant in the implementation of the plan of care. . .Licensed Practical Nurse. . .May measure and document progress of wounds if trained and competent in wound evaluation ... Notifies the registered nurse or Medical Professional of any lack of healing or new issues related to a wound. . .Documentation should include, but is not limited to, regular skin inspections, pressure wound measurements and progress. . .When documenting, it is important to include the location of the wound, presence of exudate, pain, signs of infection, and the wound bed characteristics. . ." According to the National Pressure Ulcer Advisory Panel (NPUAP), ". . . Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister ...Granulation tissue, slough and eschar are not present ...Stage 3 Pressure Injury: Full-thickness skin loss in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar [dead tissue] may be visible. The depth of tissue damage varies by anatomical location; Undermining and tunneling may occur. If slough or eschar [dead tissue] obscures the extent of tissue loss this is an Unstageable Pressure Injury. . .Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. . ." Review of the admission Minimum Data Set (MDS) assessment, dated 3/12/19, revealed	M 615	Pressure Ulcers by the Director of Nursing. The facility has placed a Registered Nurse in the treatment nurse position full-time as of the week of July 8, 2019. The facility nurse management staff attended a pressure ulcer training session at Sunplex Subacute Center on Wednesday, July 10, 2019. Starting June 27, 2019, the Nurse Management Staff are reviewing nurses' notes, physician orders and daily shift reports in the morning standup meeting to discuss new pressure injuries and ensuring proper treatment is in place and documented. The Weekly Wound Reports will be reviewed in the Patients at Risk Meetings weekly by the Nurse Management Staff. 4. Beginning July 15, 2019, the Director of Nursing will audit all weekly pressure ulcer reports and all new admissions weekly for four weeks and monthly for two months to ensure that interventions are in place for residents at risk and that treatments are being administered per physician orders for any resident with pressure ulcers in the facility. The Director of Nursing will complete treatment observations 3 times a week for three weeks then weekly for three weeks to ensure treatments are being completed per physicians orders and preventative measures are in place. The Director of Nursing will bring the results of her audit to the monthly Quality Assurance Committee for review, revision, and/or resolution	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 615	Continued From page 8 Resident #54 was re-admitted to the facility on 3/5/19, with diagnoses including End Stage Renal Disease, Malnutrition, and Dementia. The MDS indicated the resident had severe cognitive impairments, scoring a 2 of 15 on the Brief Interview for Mental Status (BIMS). The assessment also documented the resident was readmitted with two (2) Stage 2 pressure ulcers. No measurements, wound location or description were included on the MDS. Review of the nursing "Progress Notes", dated 3/5/19, revealed the resident had a right inner and outer suspected deep tissue injury. No location was documented. The progress notes identified the resident with no edema. Review of the "Admission & Readmission Evaluation", dated 3/5/19, noted under "Skin Integrity", revealed Resident #54's skin was normal, warm, normal turgor, and dusky. There was an area that directed the clinical staff to document any skin concerns and it noted ". . .bilateral heels. . ." There was no additional and/or descriptive information documented regarding the resident's heels. A "Braden Scale for Predicting Pressure Sore Risk" dated 3/5/19, indicated Resident #54 was at low risk for the development of a pressure ulcer. Review of a "Physician Order" dated 3/5/19, directed staff to treat a fluid filled blister to the right inner heel with wound cleanser, to pat dry, and to apply a dry dressing daily. Review of a "Weekly Pressure Injury Record", dated 3/7/19, indicated Resident #54's right heel Stage 2 pressure ulcer was first identified on 3/7/19. The length of the pressure ulcer was two	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 615	Continued From page 9 (2) centimeters (cm) x 2 cm. The form noted there was no depth, tunneling, undermining, no exudate, and no odor present. The section titled "Additional Notes/Comments" revealed the wound was described as an intact fluid filled blister. The physician and the family were notified of the changes in the resident's skin. Review of a physician's (MD) "Progress Note", dated 3/7/19, indicated Resident #54 had a history of bilateral deep vein thrombosis (DVT) and was being treated with Eliquis (a medication to reduce the likelihood of a DVT). The MD's note indicated the resident had left leg edema, and the MD ordered a repeat ultrasound of the left leg. On 3/8/19, the ultrasound came back positive for a non-occlusive DVT to the left lower extremity. Continued review of the MD's "Progress Notes" revealed Resident #54 was seen by the MD on 3/19/19, and that visit note indicated the resident's skin was warm, intact, and dry. The resident was seen again on 3/21/19, 3/28/19, 4/4/19, 4/9/19, 4/11/19, and on 4/23/19, by the MD. Her skin was noted to be warm, dry, and intact on those visits. These assessments were follow-up to the presence of the DVT in the left leg. The existing Stage 2 pressure ulcer to the left heel resolved, but no evidence was found in the MD's progress notes that addressed the status of the resident's pressure ulcer on the right heel during the MD visits listed above. Review of the nursing "Weekly Body Audits", dated 3/20/19, 4/3/19, 4/10/19, 4/17/19, 4/24/19, and 5/1/19 revealed ". . .No new skin alterations. . ." There was no documentation on the body audits listed above that indicated Resident #54 had a Stage 2 pressure ulcer on the right heel, or that the wound was being monitored or treated.	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 615	Continued From page 10 Review of a "Weekly Pressure Injury Record" dated 3/21/19, indicated Resident 54's right heel Stage 2 pressure ulcer was first identified on 3/7/19. The length of the pressure ulcer was 2 cm x 2 cm. The form noted there was no depth, tunneling, undermining, no exudate, and no odor present. There were no comments under a section entitled "Additional Notes/Comments." The next "Weekly Pressure Injury Record" was not completed until 4/25/19, and noted Resident 54's pressure ulcer was a Stage 3. The length of the pressure ulcer was 1.8 cm x 1.4 cm. The form now noted the depth of the pressure ulcer was 0.4 cm. There was no tunneling, no undermining, there was a small amount of exudate, and the wound bed now had slough. It was noted the physician and the family were notified of the change in the resident's pressure ulcer. Under the section entitled "Additional Notes/Comments" it stated that the wound had slough and a new order was obtained for Santyl for gentle debridement. Review of the March 2019, "Treatment Administration Record (TAR), revealed Resident #54 had an order to clean the fluid filled blister to the resident's right heel, with wound cleanser, pat dry, and to apply a dry dressing, daily. The treatment start date was 3/6/19, and the end date was 3/23/19. There was no evidence that treatments were provided on 3/8/19, 3/11/19, 3/18/19, or on 3/21/19. Continued review of the March 2019 TAR revealed an order change, on 3/23/19, that directed staff to clean the fluid filled blister with wound cleanser, to apply betadine, and apply a dry dressing daily. A low air loss mattress was	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 615	Continued From page 11 ordered on this same date as an intervention. Review of a Registered Dietician's (RD) "Progress Note", dated 4/3/19, revealed the resident triggered for significant weight loss. The note documented the resident was consuming 50 to 75 percent of her meals, nutritional supplements were added, and the note indicated the resident had Stage 2 pressure ulcers to bilateral heels. Additional fortified cereal was added to her breakfast and fortified mashed potatoes were added to her lunch and dinner meals. Review of a "Patient at Risk (PAR)" note found in the electronic health record, and dated 4/5/19, identified the significant weight loss that Resident #54 sustained. There was no mention of the status of the resident's pressure ulcers Review of a 4/5/19 "Physician's Order" revealed instructions for staff to treat the fluid filled blister on the resident's right heel with wound cleanser, to apply betadine, and apply a dry dressing once daily. There was no documented evidence that the treatments were completed from 4/6/19 through 4/18/19. Review of the nursing "Progress Notes" dated 4/12/19, indicated a PAR meeting was held. The PAR note indicated Resident #54 had a Stage 2 pressure ulcer on her ". . .left heel. . ." and the ". . .right heel has resolved. . ." The PAR note was reviewed with the Licensed Practical Nurse/Wound Nurse (LPN/WN) on 5/22/19, and the LPN/WN confirmed the information in the PAR note was incorrect. The left heel wound had resolved, and the right heel wound had deteriorated.	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 615	Continued From page 12 Review of the nursing "Progress Notes" dated 4/19/19, revealed a PAR meeting was held. The "PAR" note stated Resident #54 had a right unstageable pressure injury. It specifically stated, ". . .The wound is stable. . .Patient denies pain with this wound. Patient removes bandage [sic] and requires redirection [sic] to elevate her feet r/t (related to) dementia. . .Action: Betadine and dry dressing and prn (as needed). Continue with current [sic] plan of care. . ." Review of a "Care Plan" dated 3/25/19, revealed Resident #54 had a Stage 2 pressure ulcer to the right inner heel. The care plan noted the focus was resolved on 4/12/19. One of the care plan goals was for the wound to show signs of healing and remain free from infection. The goal was documented as "resolved on 4/12/19." Another care plan intervention dated 3/25/19, directed staff to observe, document, and report as needed any changes to the skin status. The intervention specifically directed staff to document ". . .appearance, color, wound healing, s/sx (signs and symptoms) of infection, wound size (length X (by) width X depth, stage. . ." The intervention was documented as "resolved on 4/12/19." Review of the April 2019 TAR documented Resident #54 received daily treatments of betadine and dry dressing to the right heel from 4/1/19, through 4/5/19. Continued review of the April TAR revealed from 4/6/19 through 4/18/19, the resident did not receive wound care treatments. This was evidenced by entry areas marked with an "X" and no staff initials. Wound care treatments were resumed on 4/19/19, with new treatment orders, which included: "cleanse the wound, apply betadine, and apply a dry dressing daily." This treatment continued until 4/27/19, when the wound had deteriorated	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 615	Continued From page 13 significantly, and was an unstageable pressure ulcer on the right heel. The wound care orders were updated on 4/27/19, to include: "apply wound cleanser, apply nickel thick Santyl Ointment 250 unit/gram (a debriding ointment to help remove dead tissue from wounds), and cover with a dry dressing daily." The TAR indicated the resident received these treatments daily from 4/27/19, through 4/30/19. Review of a "Physician's Order" dated 4/26/19, revealed: "Santyl ointment 250 unit/gram (Collagenase), apply once daily and cover with a dry dressing for an unstageable pressure ulcer." On 4/29/19, a "Physician's Order" was obtained for the Physical Therapist (PT) to evaluate and to treat once by sharp debridement, to ". . .decrease devitalized tissue, and improve circulation to patient's wound as referred by wound care nursing staff. . ." Review of "Physical Therapy PT Evaluation & Plan of Treatment" dated 4/30/19, noted the condition of Resident 54's right heel pressure ulcer as follows: length of the pressure ulcer was 2.0 centimeters (cm); width was 2.5 cm; depth/exposure, subcutaneous tissue, fascia depth measure 0.4 cm; edge was distinct, rolled and thickened; undermining was absent; no tunneling; necrotic (dead) tissue type was loosely adherent yellow slough; necrotic tissue amount was greater than 50 percent but less than 75 percent of the bed covered; the skin surrounding wound was normal; peri-tissue description was shiny; peripheral tissue induration was less than two (2) cm around the wound; granulation amount was less than 25 percent of wound filled; mild odor; and, minimal amount of drainage. There was no infection noted. Under a section entitled	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 615	Continued From page 14 "Assessment Summary" the physical therapist (PT) documented Resident #54 had an unstageable pressure ulcer to the right heel that measured 2.5 cm by 2.0 cm with 0.4 depth with the presence of necrotic tissue over 50 percent of wound bed with rolled edges. Interview was conducted with the LPN/WN on 5/22/19 at 2:40 PM, in the LPN/WN office space, so the LPN/WN could reference the EHR during this interview. The wound nurse stated she had been on vacation and was not responsible for the wound care during that time. When asked specifically, she confirmed she had worked during the time frame of 3/21/19, through 4/25/19. The LPN/WN referenced an Excel spreadsheet on her computer where she documented her wound care notes. The LPN/WN stated this spreadsheet was not included in the residents' EHRs. She stated that she emails the spreadsheet information to the Director of Nursing (DON), the Administrator, the Medical Director, and the MDS Coordinator weekly, but it is not included in the residents' medical record. An interview was conducted with the Medical Records (MR) staff member on 5/22/19 at 3:39 PM. The MR staff stated the LPN/WN collected information on the Excel sheet and this sheet was then used to discuss concerns in the weekly PAR meeting. She stated the weekly body audits were used by nursing to identify any new skin issues on the resident's body. A subsequent interview with the MR staff member was conducted on 5/22/19 at 5:17 PM. The MR staff member confirmed there were no weekly skin records for Resident #54 from the 3/21/19 weekly assessment until the 4/25/19 skin assessment, which identified any changes in the resident's skin condition.	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 615	Continued From page 15 The DON was interviewed on 05/22/19 at 4:19 PM, and she stated staff participated in weekly PAR meetings. She said her expectations were for the staff to clinically assess the wounds, keep up with the weekly pressure ulcer forms, and to identify if the wound was healing or not. She said she expected staff to measure the wounds and describe the wounds. The DON once again stated the Excel document kept by the LPN/WN was not considered part of the clinical record. The DON confirmed Resident #54's pressure ulcer had deteriorated and that treatments and assessments had not been provided as ordered. An interview was conducted with the LPN/WN, DON, and the Administrator on 5/23/19 at 8:32 AM. During the interview, the care plans were discussed and the LPN/WN stated that when "staff" resolved the left heel wound, the treatments to the right heel wound were inadvertently discontinued in the electronic health record (EHR) too. This action discontinued any electronic notifications to the LPN/WN regarding Resident #54's right heel pressure ulcer. The LPN/WN also stated the electronic record to address the weekly skin assessments were discontinued in error. The LPN/WN stated the entry in the progress note dated 4/12/19, was an error and the entry should have noted the left heel pressure ulcer was resolved and not the right heel. The DON stated the Excel document was a Quality Assurance (QA) document and the measurements should be on this document. At 9:28 AM, the DON was interviewed and stated the LPN/WN was not wound certified. On 5/23/19 at 9:45 AM, the MR staff presented the Excel documents and stated these were the personal notes of the LPN/WN and could not be	M 615		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 615	Continued From page 16 copied. The following information was documented from the Excel documents: on 3/27/19, the document identified the resident had a suspected deep tissue injury and it was a current Stage 2 pressure ulcer, describe as an intact blister and was noted as improved with treatment of betadine and a dry dressing. On this same date the Excel document identifies the Resident #54 had an intervention of a low air loss mattress, heel protector, and nutritional supplements. There were no measurements identified. Further review of the Excel documents revealed for 4/2/19, there was no documentation related to the resident's right heel wound. An observation of Resident #54's wound was conducted on 5/23/19 at 11:25 AM. The LPN/WN was observed to attempt to provide the resident wound care. The resident's right heel had purulent drainage over most of the wound bed. The resident refused wound care at this time. The resident refused to have the LPN/WN replace the dressing to her right heel during this observation. The DON was interviewed on 5/23/19 at 4:09 PM. She once again confirmed the information collected in the Excel document by the LPN/WN was not in or a part of the medical record. The DON again confirmed her expectation was for staff to follow the MD orders and care plans.	M 615		
M 620	45.21.4 Urinary incontinence Urinary incontinence. Residents with urinary incontinence shall be assessed for need of bladder retraining program. An indwelling catheter will not be used unless the resident ' s clinical condition indicates that catheterization is necessary. These residents shall receive	M 620		7/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 620	Continued From page 17 treatment and services to prevent urinary tract infections. Level II Based on facility policy review, record reviews, observations and interviews the facility failed to maintain a urinary catheter in a manner that reduced the risk of recurrent Urinary Tract Infections for one (1) resident, Resident #8, of eight (8) residents in the facility with urinary catheters. Findings Include: The policy "Catheter Care, Suprapubic" dated August 25,2014, did not include the positioning of the catheter tubing off the floor to prevent stagnant flow of urinary output and increased risk of infection. An interview with the Director of Nursing (DON) on 5/23/19 at 9:30 AM, confirmed the policy lacked this standard of practice directive. On 5/20/19 at 1:40 PM, the resident was observed in her wheelchair with her suprapubic catheter tubing on the floor. At 2:30 PM, on the same date, the resident was observed in the dayroom of the South Unit, in the electric wheelchair, with the suprapubic catheter tubing on the floor. On 5/21/19 at 3:05 PM, the resident was observed in her room, in the wheelchair, with the catheter tubing on the floor. Licensed Practical Nurse (LPN) #33 was present at the time of the observation and confirmed the catheter tubing was on the floor and the resident had a history of UTIs. On 5/23/19 at 9:00 AM, the resident was	M 620	1. The charge nurse on the south unit on 5/23/2019 immediately secured the catheter tubing for resident #8. The charge nurse on the south unit on 5/23/2019 provided suprapubic catheter care for Resident #8. The charge nurse on the south unit on 5/23/2019 assessed Resident #8 for signs and symptoms of infection without negative findings. 2. Residents with indwelling catheters have the potential to be affected. A 100% audit was conducted on 6/7/2019 by the Transitional Care Unit Manager and Director of Nursing on all residents with an indwelling catheter, totaling six, to ensure that the catheter tubing was secure and off the floor. Physician orders were obtained by the Director of Nursing and Transitional Care Unit Manager and entered into the medical record for all residents requiring an indwelling catheter to ensure the catheter tubing does not touch the floor completed by June 28, 2019. 3. The Director of Nursing initiated an in-service for all nursing staff on the Suprapubic Catheter Care Policy and Infection Control including the securing tubing, and keeping tubing off of the floor on 6/5/2019 and completed on 6/13/2019. Urinary catheter tubing will be secured and off the floor. 4. Beginning July 15, 2019, the Director of Nursing will observe catheter tubing on three residents a week for three weeks then one resident a week for two weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 620	Continued From page 18 observed in her wheelchair, in the dining room, with the suprapubic catheter tubing on the floor. Review of Resident #8's undated "Face Sheet" (a document with demographic and diagnoses information) revealed the resident was initially admitted to the facility on 12/13/05, and readmitted on 10/4/11, with diagnoses that included Hemiplegia and Hemiparesis affecting the right side, Aphasia, History of Urinary Tract Infections (UTIs) and Pain. Review of the quarterly "Minimum Data Set (MDS)" assessment dated 2/14/19, revealed the resident was cognitively intact, and required extensive assistance with activities of daily living (ADLs). The assessment also documented the resident had an indwelling urinary catheter. Review of the "Physician Orders" dated 10/1/15, revealed the resident had a suprapubic catheter due to Urinary Retention. Review of Resident #8's "Care Plan" dated 9/14/18, revealed the resident had an activities of daily living (ADL) self-care deficit related to physical debility and impaired physical mobility. The care plan also revealed the resident had a suprapubic catheter related to neuromuscular dysfunction and urinary retention. Review of the nursing "Progress Notes" dated 2/2/19, revealed the resident had a urinalysis (lab test) on that date and the lab results prompted new orders for an antibiotic to treat a UTI. Interviews with staff members that routinely care for Resident #8, were conducted on 5/22/19, including: Certified Nurse Aide (CNA) #100 at 9:30 AM, Licensed Practical Nurse (LPN) #65 at	M 620	Negative findings will be reported to the Quality Assurance and Performance Committee monthly by the Director of Nursing, for review and recommendations by the committee revisions, updates, or resolutions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 620	Continued From page 19 9:45 AM, and CNA #84 at 9:50 AM. The interviews revealed an understanding of the need to maintain suprapubic catheter tubing and drainage bag off the floor to maximize urinary output and reduce the risk of recurrent UTIs.	M 620		
M 625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This Statute is not met as evidenced by: Level II Based on observation, record reviews, and interviews, the facility failed to ensure a resident received restorative services and a splint as recommended by therapy. This failure affected one (1) resident, Resident #8, of 19 sampled residents. This had the potential for a decline in function for Resident #8. Findings include: A request was made for a copy of the facility's policy regarding restorative nursing services and the use of splints to prevent/minimize contractures (the condition of shortening and hardening of muscles, tendons, other tissue leading to deformity and rigidity of joints). An interview with the Administrator on 5/23/19 at 10:00 AM, confirmed there was no facility policy on referring residents for restorative services. The Administrator submitted a signed statement indicating there was no facility policy to address these issues.	M 625	1. Resident #8 was assessed for decrease in range of motion from baseline in right arm contracture with no negative findings by the Director of Nursing on 5/23/2019. The Director of Nursing sent a communication form to therapy to screen for a right arm splint for resident #8 on 6/4/2019. 2. This deficient practice has the potential to affect all residents in the building with adaptive equipment. A 100% audit of all residents with physician orders for adaptive equipment was completed by the Medical Records Nurse on 6/21/2019. A 100% audit for all resident tasks with adaptive equipment was completed by the Medical Records Nurse on or before 6/20/19. 3. The Director of Nursing initiated an in-service for all licensed nurses that there was a new communication form to therapy and about the screening process on 6/5/2019 and completed on 6/13/2019.	7/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 625	Continued From page 20 On 5/20/19 at 1:40 PM, Resident #8 was observed in her wheelchair. Her right hand and arm were contracted and there were no splints or devices in place. The resident was interviewed at the time of the observation and stated that staff do not apply splints to her right arm. Review of Resident #8's undated "Face Sheet" (a document with demographic and diagnoses information) revealed the resident had diagnoses that included Hemiplegia and Hemiparesis affecting the right side, Cerebrovascular Disease, Aphasia, and Pain. Review of Resident #8's significant change "Minimum Data Set (MDS)" assessment, dated 8/31/18, revealed the resident was cognitively intact and required extensive staff assistance for all activities of daily living (ADLs). The assessment further documented the resident had received Occupational Therapy, five (5) times a week, from 11/29/17 to 8/31/18. Review of Resident #8's most recent quarterly MDS assessment, dated 2/14/19, revealed the resident was cognitively intact; and required extensive assistance with activities of daily living (ADL). The assessment indicated the resident was not currently receiving any therapies. Review of the "Care Plan" dated 9/14/18, for Resident #8, revealed the resident had an activities of daily living (ADL) self-care deficit related to physical debility, and impaired physical mobility. There were no care plans related to restorative programs or the use of a splint to reduce/prevent contractures Review of a "Restorative Referral Form" dated 9/26/18, revealed the resident was recommended	M 625	Physician orders will be reviewed for adaptive equipment Monday through Friday in standup meetings by the Nurse Management Staff. 4. Beginning July 15, 2019, the Director of Nursing will observe two residents that require adaptive equipment once a week for three weeks then one resident that requires adaptive equipment once a week for three weeks to ensure that physician orders for adaptive equipment are being followed. Negative findings will be reported to the Quality Assurance and Performance Committee monthly by the Director of Nursing for review and recommendations by the committee revisions, updates, or resolutions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 625	Continued From page 21 to receive passive range of motion and a splint to the right arm. The purpose/goal of the restorative program was to prevent further contractures of the right elbow and maintain the skin integrity. Passive range of motion to the right elbow and fingers were to be completed, and an elbow splint was to be applied daily. On 5/22/19 at 10:45 AM, an interview with Certified Occupational Therapy Assistant (COTA) #152 confirmed the "Restorative Referral" dated 9/26/18, recommended splints and a restorative nursing program for Resident #8. An interview on 5/22/19 at 3:40 PM, with the Rehab Director verified Resident #8 had a referral for restorative nursing services and a splint that she was not receiving. An interview with the Director of Nursing (DON) on 5/23/19 at 9:30 AM, confirmed there was no documentation that indicated the resident was placed on a restorative nursing program or that the resident was wearing a splint to reduce or prevent contractures as recommended. A review of Resident #8's medical record did not include documented evidence of a functional decline for the right upper extremity. The medical record review revealed no evidence the resident had received restorative services or that a splint was being applied to Resident #8's right elbow, since 8/31/18.	M 625		
M 705	45.24.2 Policies and procedures Policies and procedures. Each facility shall have policies and procedures to assure the following:	M 705		7/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 705	Continued From page 22 1. Accurate acquiring; 2. Receiving; 3. Dispensing; 4. Storage; and 5. Administration of all drugs and biologicals. This Statute is not met as evidenced by: Level II Based on facility policy review, record reviews, and interview, the facility failed to ensure medication was acquired in a timely manner for one (1) resident, Resident #3, of 19 sampled residents whose medications were reviewed. Findings include: The facility's "Medication Administration - General Guidelines" policy and procedure, dated 11/1/08, documented: "Medications are administered as prescribed in accordance with good nursing principles and practices. . ." Review of a "Physician's Order," dated 2/20/19, revealed Resident #3 was to be administered an Atrovent Inhaler (an anticholinergic medication), two (2) puffs orally four (4) times daily, for COPD with acute exacerbation. On 5/20/19 at 11:39 AM, interview with Resident #3 revealed she had not received her Atrovent inhaler for three (3) days because the facility was "out of my inhaler." She stated she had been told "the staff needed to order it." She stated she needed the medication, that she was not a	M 705	1. Physician was notified that Resident #3 prescription inhaler was not administered as ordered. The prescription inhaler was obtained from back up pharmacy by licensed practical nurse on 5/20/19. Resident #3 medication regimen resumed at next scheduled dose. Resident #3 was assessed by Registered nurse and no acute respiratory findings were noted. 2. The Facility recognizes that all residents receiving an inhaler has the potential to be affected by this deficient practice. A 100% audit of all residents receiving inhalers was completed on 6/25/19 by the Transitional Care Manager and the Director of Nursing with no negative findings. 3. One on one in-service with Registered Nurse #90 and LPN #24 for inaccurate documentation in Resident #3 medication administration record. An in-service for all nursing staff was on initiated on 6/5/19 and completed on 6/13/19 on ordering/receiving medication and documentation. Medications not available immediately will be obtained from the back	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 705	Continued From page 23 "responsible person" and that was the reason she was at the nursing home. She stated, "I depend on the staff to have my medications." Review of Resident #3's "Face Sheet," undated, located in the Electronic Health Record (EHR), revealed the resident was admitted to the facility on 2/9/19, with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD) with Acute Exacerbation and Acute and Chronic Respiratory Failure with Hypercapnia. Review of Resident #3's admission "Minimum Data Set," assessment dated 2/16/19, revealed the resident had a "Brief Interview for Mental Status" score of 15, which indicated she was cognitively intact. The assessment documented she required supervision to extensive assistance with activities of daily living (ADLs) and had shortness of breath or trouble breathing with exertion. The "Care Plan" for Resident #3, most recently reviewed/revised on 5/2/19, documented the resident had altered respiratory status related to chronic respiratory failure with hypercapnia and COPD. Interventions included to "administer respiratory treatments as ordered." The "Medication Administration Record (MAR)," dated 5/2019, documented the resident's Atrovent Inhaler was administered/not administered as follows: 5/17/19 - not administered at 12:00 PM or 8:00 PM. Administered at 8:00 AM and 4:00 PM. 5/18/19 - not administered at 8:00 AM or 12:00 PM. Administered at 4:00 PM and 8:00 PM. 5/19/19 - not administered at 8:00 AM, 12:00 PM, 4:00 PM (resident absent from facility) or 8:00 PM.	M 705	up pharmacy, if unavailable, the practitioner will be notified for additional orders. 4. Beginning July 15, 2019, the Director of Nursing will audit medication carts twice a week for four weeks and then weekly for two months to ensure that any residents with an order for an inhaler has the medication available. Negative findings will be brought to the Quality Assurance and Improvement Committee by the Director of Nursing monthly for review, revision, and resolution of the plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 705	Continued From page 24 5/20/19 - not administered at 8:00 AM. Administered remainder of doses. On 5/21/19 at 4:15 PM, Licensed Practical Nurse (LPN) #102 was asked about Resident #3's Atrovent inhaler administration documentation. She reviewed the MAR and confirmed there were doses documented as not having been administered between 5/17/19 and 5/20/19. She stated the resident reported to her that her Atrovent inhaler had been unavailable last week. On 5/22/19 at 8:44 AM, Resident #3 was interviewed about the missed doses and stated she was in no additional respiratory distress as a result of not receiving her Atrovent inhaler last week. Review of the "Nursing Progress Notes," dated 5/17/19, through 05/20/19, revealed no documentation the resident had experienced respiratory distress as a result of not receiving her Atrovent inhaler. On 5/22/19 at 10:09 AM, LPN #24, who had documented the dose of Atrovent inhaler as having been administered on 5/17/19 at 4:00 PM, was asked if the Atrovent had been administered. She stated she had "charted wrong" and had told the resident there was no Atrovent inhaler in the medication cart. She stated the off-going medication nurse, 5/17/19 at 3:00 PM, had informed her there was no Atrovent inhaler for the resident, but the medication had been ordered. On 5/22/19 at 10:18 AM, LPN #33 was asked why the facility had not acquired an Atrovent inhaler for three (3) days for Resident #3. She stated she called the pharmacy provider and stated authorization to purchase the Atrovent inhaler	M 705		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 705	Continued From page 25 was required, from either the DON or herself, and the provider had not received that authorization. LPN #33 stated she had been told the morning of 5/20/19, the resident still did not have an Atrovent inhaler and at that time she went to the "backup pharmacy" to purchase the medication. When asked if the resident should have had to go three (3) days without her Atrovent inhaler doses, she stated, "No." On 5/22/19 at 05:17 PM, Registered Nurse #90, who had documented the doses of Atrovent inhaler had been administered on 5/18/19 at 4:00 PM and 8:00 PM, was asked if the Atrovent had been administered. She stated she had made an error in charting. She stated there was no Atrovent inhaler in the medication cart and the resident had informed her there was no Atrovent inhaler to administer.	M 705		
M 710	45.24.3 Consultation Consultation. Each facility shall obtain the services of a licensed pharmacist who will be responsible for: 1. Establishing a system of records of receipt and disposition of all controlled drugs and to determine that drug records are in order and that an account of all controlled drugs are maintained and reconciled; 2. Provide drugs regimen review in the facility on each resident every thirty (30) days by a licensed pharmacist; 3. Report any irregularities to the attending physician or nurse practitioner/physician assistant and the director or nursing; and 4. Records must reflect that the consultation pharmacist monthly report is acted upon.	M 710		7/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 710	Continued From page 26 This Statute is not met as evidenced by: Level II Based on facility policy review, record review, and staff interviews, the facility failed to ensure that one (1) resident Resident #12, out of a sample of five (5) residents reviewed for unnecessary medications, was administered an as needed (PRN) antianxiety (Xanax) beyond 14 days without a clinical justification. Findings include: Review of the facility's policy titled, "Psychotropic Medications" undated, revealed, ". . .When any psychotropic medication is ordered the following will occur. . .PRN psychotropic medications will have a 14 day [sic] period of administration time. If prescribing MD/NP orders to continue the medication beyond 14 days, the MD/NP will document rationale and the duration for the medication in the clinical record. . .PRN antipsychotics medications-are limited to a 14 day [sic] period unless. . .The MD /NP evaluates the patient for the appropriateness of the medication, and documents the evaluation and rationale in the clinical record. . ." Review of Resident #12's "Admission Record" indicated the resident was admitted to the facility on 10/30/17, with a diagnosis of Generalized Anxiety Disorder. Review of physician's "Order Recap Report" dated 6/12/18, revealed Resident #12 was ordered to be administer Xanax 0.25 milligrams (mg) one (1) tablet by mouth every 12 hours as needed (PRN) for generalized anxiety.	M 710	1. Psychiatric Mental Health Nurse Practitioner evaluated Resident #12 for anxiety and depression on 05/23/19 with no order changes. Psychiatric Nurse Practitioner stated in progress note on 05/23/19 that she will adjust medication if symptoms increase or become bothersome. Xanax was discontinued on 05/27/19 due to non-use of medication for greater than 14 days by Medical Nurse Practitioner. Resident #12 transferred to a local hospital on 06/17/19 for an unrelated medical condition prior to an additional follow-up visit with Psychiatric Mental Health Nurse Practitioner. 2. Residents receiving an anti-anxiety medication ordered as needed have the potential to be affected by the same deficient practice. The Medical Nurse Practitioner reviewed all residents receiving anti-anxiety medications ordered as needed on 05/30/19 and adjusted medication regimen according to the individual needs of each resident. A 100% audit was completed by the Director of Nursing on 06/28/19 to ensure that residents receiving antianxiety medication ordered as needed have documentation regarding usage timeframe and rationale for use of medication. 3. An individual in-service with Psychiatric Mental Health Nurse Practitioner and Medical Nurse Practitioner was conducted on 06/18/19 by the Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 710	Continued From page 27 The Medication Administration Record (MAR) for January 2019, identified Xanax 0.25 mg was to be administered every 12 hours PRN for Generalized Anxiety. The January MAR indicated Resident #12 was administered the antianxiety medication on the following dates: 1/1/19 at 8:02 AM and 11:00 PM, 1/10/19 at 7:53 AM, 1/12/19 at 8:38 AM, 1/18/19 at 11:30 AM, and on 1/29/19 at 12:45 PM. The MAR showed staff monitored R#12's behavior and side effects. Review of the "Consultant Pharmacist Communication to Physician" dated 1/23/19, indicated Resident #12 was on Xanax, and ". . .continued use is appropriate for no more than 14 days from the original order date and if continued, a duration is required to be added in order to meet the rule. . . Please evaluate and if continued, please add a duration. . ." The physician marked to continue the PRN Xanax for the next three (3) months and signed it 2/21/19. There was no justification documented. The MAR for February 2019 identified the Xanax 0.25 mg was to be administered every 12 hours PRN. The February MAR indicated the resident received the antianxiety medication on the following dates: 2/1/19 at 11:35 AM, 2/12/19 at 11:29 AM, 2/13/19 at 9:00 AM, 2/16/19 at 9:35 AM, 2/17/19 at 10:00 AM, 2/18/19 at 9:04 AM, and on 2/21/19 at 9:30 AM. The MAR noted this order was discontinued on 2/27/19. The MAR showed staff monitored Resident #12's behavior and side effects. The MAR for March 2019, identified the Xanax 0.25 mg was to be administered every 12 hours PRN. The March MAR indicated the resident received the antianxiety medication on the following dates: 3/5/19 at 7:05 PM, 3/10/19 at	M 710	regarding use of psychotropic medication ordered as needed requirements for duration, documentation, and rationale of usage. All Nurses were in-serviced by the Director of Nursing initiated on 06/05/19 and completed on 06/13/19 regarding documentation of non-pharmacological interventions utilized prior to use of psychotropic medication ordered as needed and proper documentation and timeframe regarding use of psychotropic medication ordered as needed. 4. Beginning July 12,2019, the Medical Records Nurse will review new orders five (5) times a week for four (4) weeks for any new psychotropic medications ordered as needed to ensure that limited duration and rationale for use are indicated. Beginning July 15, 2019, the Director of Nursing will perform a weekly audit for two (2) months of psychotropic medication ordered as needed for usage and notify Medical and/or Psychiatric NP of findings for medication review by Nurse Practitioner. Findings will be reported to the Quality Assurance and Performance Committee monthly by the Director of Nursing, for review, revision, and/or resolution of the plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 710	Continued From page 28 3:59 PM, 3/11/19 at 2:00 PM, 3/12/19 at 1:09 PM, 3/13/19 at 6:50 PM, 3/18/19 at 4:00 PM, 3/19/19 5:01 PM, 3/20/19 at 6:00 PM, and on 3/30/19 at 7:00 PM. The MAR noted this order was discontinued on 2/27/19. The MAR showed staff monitored Resident #12's behavior and side effects. The MAR for April 2019, identified the Xanax 0.25 mg to be administered every 12 hours PRN. The April MAR indicted the resident received the psychotropic medication on the following dates: 4/1/19 at 10:45 AM, 4/3/19 at 10:05 AM, 4/6/19 at 11:28 AM, 4/7/19 at 1:35 PM, 4/9/19 at 7:40 PM, 4/11/19 at 7:14 PM, 4/12/19 at 6:54 PM, 4/13/19 at 1:40 PM, 4/14/19 at 7:35 PM, 4/15/19 at 2:04 PM, 4/17/19 at 2:32 AM and again at 4:07 PM, 4/19/19 at 6:00 PM, 4/21/19 at 1:03 AM, 4/22/19 at 7:08 PM, 4/23/19 at 8:02 PM, 4/27/19 at 8:10 PM, and on 4/29/19 at 7:30 PM. The MAR showed staff monitored Resident #12's behavior and side effects. The MAR for May 2019, identified the Xanax 0.25 mg was to be administered every 12 hours PRN. The May MAR indicated the resident received the psychotropic medication on the following dates: 5/1/19 at 5:47 M, 5/5/19 at 9:28 AM, and on 5/11/19 at 8:15 PM. The MAR showed staff monitored Resident #12's behavior and side effects. An interview was conducted with Registered Nurse (RN) #41 on 5/21/19 at 1:59 PM. RN #41 stated the resident was extremely hard of hearing and had very bad anxiety. Telephone interview, on 5/23/19 at 12:11 PM, with Resident #12's attending physician, who was also the facility's Medical Director, revealed the use of	M 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 710	Continued From page 29 psychotropic medications was discussed during the Quality Assurance meetings; however, he was unaware there needed to be a clinical justification to continue the PRN antianxiety medication.	M 710		
M 735	45.25.1 Medical Records Management Medical Records Management. 1. A medical record shall be maintained in accordance with accepted professional standards and practices on all residents admitted to the facility. The medical records shall be completely and accurately documented, readily accessible, and systematically organized to facilitate retrieving and compiling information. 2. A sufficient number of personnel, competent to carry out the functions of the medical record service, shall be employed. 3. The facility shall safeguard medical record information against loss, destruction, or unauthorized use. 4. All medical records shall maintain the following information: identification data and consent form; assessments of the resident's needs by all disciplines involved in the care of the resident; medical history and admission physical exam; annual physical exams; physician or nurse practitioner/physician assistant orders; observation, report of treatment, clinical findings and progress notes; and discharge summary, including the final diagnosis. 5. All entries in the medical record shall be signed and dated by the person making the entry. Authentication may include signatures, written	M 735		7/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 735	Continued From page 30 initials, or computer entry. A list of computer codes and written signatures must be readily available and maintained under adequate safeguards. 6. All clinical information pertaining to the residents stay shall be centralized in the resident's medical records. 7. Medical records of discharged residents shall be completed within sixty (60) days following discharge. 8. Medical records are to be retained for five (5) years from the date of discharge or, in the case of a minor, until the resident reaches the age of twenty-one (21), plus an additional three (3) years. 9. A resident index, including the resident's full name and birth date, shall be maintained. This Statute is not met as evidenced by: Level II Based on facility policy reviews, record reviews, and staff interviews, the facility failed to ensure medical records were complete and accurate for two (2) residents of 19 residents sampled, whose records were reviewed, Residents #54, and #3. Specifically, the facility failed to accurately assess and document the status of a pressure ulcer for Resident #54 and failed to accurately document medication administration in the medical record for Resident #3. Findings include: The facility Administrator submitted a written statement on facility letterhead dated 05/23/19,	M 735	1. Resident #54 Medical record was updated to include missing Weekly Pressure Injury Record dated 3/28/19, 4/4/19, 4/11/19 and 4/18/19 by the Wound Care Nurse on 6/26/19. The Director of Nursing, a Registered Nurse, assessed Resident # 54 pressure injury to the right heel on 5/23/19 and ensured that treatment was current and wound staging current. Resident #3 medication was obtained from back up pharmacy on 5/20/19 and available to the resident medical record was updated by licensed nursing staff to include accurate information. 2. All residents have the potential to be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 735	Continued From page 31 which stated, ". . .we do not have a policy on what goes into the medical records by which a staff member. . .we follow normal standards of practice, who does the care, documents the care. . ." The Administrator signed the document. Resident #54 Review of the "Admission Record," revealed Resident #54 was admitted to the facility on 3/5/19. Review of the resident's "Progress Notes," dated, 3/5/19, the date of the resident's admission, revealed the resident had a right inner and outer suspected deep tissue injury. There was no description of the wound, or where it was located. Review of the "Admission & Readmission Evaluation" dated, 3/5/19, revealed under "Skin Integrity," Resident #54's skin was evaluated as normal, warm, normal turgor, and dusky. Continued review of the evaluation revealed a section that directed clinical staff to document any skin concerns with " ...bilateral heels ..." being documented in the section. Review of Resident #54's clinical record revealed there were missing "Weekly Pressure Injury Records" dated 3/28/19, 4/4/19, 4/11/19, and 4/18/19. The missing notes were confirmed in an interview with the Licensed Practical Nurse/Wound Nurse (LPN/WN) on 5/22/19 at 2:40 PM. The LPN/WN said she had been off work (personal time) during March but was working 3/21/19 through 4/25/19. The LPN/WN stated aloud, "why are there no notes?" The DON was interviewed on 5/23/19 at 8:32 AM, and stated she had two (2) Registered Nurses (RNs) who assist with wounds. The DON was unable to provide evidence the weekly skin assessments were completed as care planned by any of the nurses.	M 735	affected by this deficient practice. A 100% audit was conducted by the Transitional Care Manager and the Director of nursing on Electronic Health Record of all residents with Inhalers to ensure that the medication was available and administered as ordered beginning on 6/20/19 and completed 6/25/19. A 100% audit of all residents with pressure injuries was completed on 6/17/19 by the Medical Record Nurse. The Medical Records were audited to ensure that appropriate documentation including the sizing and staging of pressure areas was included in the medical record. 3. All licensed nursing staff members in-serviced by Director of Nursing beginning on 6/5/19, and completed 6/26/19. A Registered Nurse will completed weekly wound rounds, staging and documentation. Medication Administration Records will be completed to reflect medication administration by the nursing staff. 4. The Director of nursing will audit wound documentation weekly for four weeks, monthly for two months beginning June 20, 2019. The Dir. Of Nursing will audit all physician orders for inhalers weekly for four weeks and monthly for two months beginning June 20, 2019 to ensure that medication is being administered as ordered. Findings will be brought to the Quality Assurance and Improvement Committee monthly for review, revision, and resolution of the plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 735	Continued From page 32 During an interview on 5/22/19 at 2:40 PM, at the desk of the wound nurse, the LPN/WN attempted to retrieve an Excel document kept on her computer. The LPN/WN stated she completes a weekly wound assessment, and that she had an Excel document in which she collected data that was then shared with the Patient at Risk (PAR) team each week. She stated the PAR team included the Director of Nursing (DON). The LPN/WN said that the Excel document was emailed to the Administrator, the DON, Medical Director, and the Minimum Data Set (MDS) Coordinator each week. The LPN/WN stated the Excel document was not part of the electronic medical records. She said she used this document for her wound care notes. On 05/23/19 at 09:45 AM, the Medical Records Supervisor presented the Excel documents, and stated and per their attorney, this cannot be copied. She stated that these documents were the personal notes of the wound nurse and not part of the clinical record. She stated, "this would have been done in a weekly injury pressure form." The Treatment Administration Record (TAR) for March 2019 and April 2019 had missing entries. For March 2019 the missing entries were identified as 3/8/19, 3/11/19, 3/18/19, and 3/21/19. The missing entries on the April 2019 TAR were from 4/6/19 through 4/18/19, which indicated the resident did not receive physician ordered treatment to the pressure ulcer on Resident #54's right heel. In an interview on 5/23/19 at 8:32 AM the DON reviewed the documents and said she would look into it. The DON failed to provide any additional information or evidence the treatments had been provided for Resident #54.	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 735	Continued From page 33 Review of the nursing "Progress Notes" dated 4/12/19, indicated a "Patient at Risk (PAR) meeting was held. The PAR note indicated Resident #54 had a Stage 2 pressure ulcer on her ". . .left heel. . ." and the ". . .right heel has resolved. . ." The PAR note was reviewed with the Licensed Practical Nurse/Wound Nurse (LPN/WN) on 5/22/19, and the LPN/WN confirmed the information in the PAR note was incorrect. The left heel wound had resolved, and the right heel wound had declined. The DON was interviewed on 5/22/19 at 4:19 PM. The DON confirmed the excel document, which contained additional details of Resident 54's wound was not considered part of Resident #54's clinical record. The DON was asked about the missed treatments for Resident #54 and said she would "look into it." The DON failed to provide any additional information or evidence that the treatments had been provided as ordered for Resident #54. The DON, LPN/WN, and the Administrator were interviewed on 5/23/19 at 9:45 AM. The LPN/WN confirmed the "Progress Note" dated 4/12/19, was inaccurate. It was during this interview the LPN/WN stated the medical record computer program (PCC) had discontinued wound care to the right heel in error on 4/12/19, and failed to generate the weekly skin assessments for Resident #54. The DON stated, "We need to make some changes, the nurses have a lot to do." The facility's "Medication Administration - General Guidelines" policy and procedure, dated 11/01/08, documented: ". . .The individual who administers the medication dose records the administration	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 735	Continued From page 34 on the resident's MAR [Medication Administration Record] after the mediation is given. . .If a dose of regularly scheduled medication is withheld, refused, or given at other that the scheduled time,. . .the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation. . ." Resident #3 Review of the electronic health record (EHR) for Resident #3 revealed she had diagnoses that included Chronic Obstructive Pulmonary Disease (COPD) with Acute Exacerbation and Acute and Chronic Respiratory Failure with Hypercapnia. The admission "Minimum Data Set," dated 02/16/19, documented Resident #3 had a "Brief Interview for Mental Status" score of 15, which indicated she was cognitively intact. It documented she required supervision to extensive assistance with activities of daily living and had shortness of breath or trouble breathing with exertion. A "Physician's Order," originally dated 2/20/19, documented the resident was to be administered Atrovent Inhaler two (2) puffs orally four (4) times daily for COPD with acute exacerbation. On 5/20/19 at 11:39 AM, Resident #3 reported she had not received her Atrovent inhaler for three (3) days because the facility was "out of my inhaler." The "Medication Administration Record (MAR)," dated 5/2019, documented the resident's Atrovent Inhaler was administered/not administered as follows:	M 735		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 735	Continued From page 35 5/17/19 - not administered at 12:00 PM or 8:00 PM. Administered at 8:00 AM and 4:00 PM. 5/18/19 - not administered at 8:00 AM or 12:00 PM. Administered at 4:00 PM and 8:00 PM. 5/19/19 - not administered at 8:00 AM, 12:00 PM, 4:00 PM (resident absent from facility) or 8:00 PM. 5/20/19 - not administered at 8:00 AM. Administered remainder of doses. On 5/22/19 at 10:09 AM, LPN #24, who had documented the dose of Atrovent inhaler as having been administered on 5/17/19 at 4:00 PM, was asked if the Atrovent had been administered. She stated she had "charted wrong" and had not documented the error in the nurses' progress notes. On 5/22/19 at 05:17 PM, Registered Nurse #90, who had documented the doses of Atrovent inhaler had been administered on 5/18/19 at 4:00 PM and 8:00 PM, was asked if the Atrovent had been administered. She stated she had made an error in charting and had not documented the error in the nurses' progress notes.	M 735		
M 780	45.27.2 Activity Program Activity Program. Provisions shall be made for suitable recreational and entertainment activities for resident according to their needs and interests. These activities are an important adjunct to daily living and are to encourage restoration to self-care and resumption of normal activities. Variety in planning shall include some outdoor activities in suitable weather. Level II Based on facility policy review, observation, staff	M 780	1) A radio was provided for resident #74 5/22/19 by the Life Connections Coordinator. A radio was provided for	7/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 780	Continued From page 36 interviews, and record review, the facility failed to provide an ongoing program of activities based on the identified preferences/interests of two (2) residents, Residents #74 and #46, out of a sample of 19 residents. Findings include: Review of the facility's policy titled, "Activity Program," dated 10/26/09, revealed: It is the policy of this facility than [sic] an ongoing program of activities be designed to meet the needs of each resident. . .Activity Programs consist of individual, small and large group activities that are deigned [sic] to meet the needs and interests of each resident and include, as a minimum. Resident #74 On 5/20/19 at 1:41 PM, Resident #74 was observed in his room and in bed. There was no radio observed in his room with music playing and the resident's television was powered off. On 5/20/19 at 4:04 PM, Resident #74 was observed in his room, in bed, and again, there was no radio with music playing and the resident's television was off. An annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 8/17/18, identified Resident #74 enjoyed listening to music. The quarterly "MDS" with an ARD of 4/24/19, revealed a Brief Interview for Mental Status (BIMS) was not able to be completed; however, the facility assessed Resident #74 as being severely cognitively impaired. Review of Resident #74's care plan, revised 5/16/17, revealed the resident was visually impaired; however, he still enjoyed involvement in singing and spiritual programs. Continued review	M 780	Resident # 46 on 5/22/19 by the Life Connections Coordinator. The Life Connections Coordinator was educated to document all one on one activities by the administrator on 6/19/19. The care task were updated for Resident #74 and Resident #46 on 6/25/19 by the Life Connections Coordinator to include turning on the radio and/or television. The Activity Coordinator was in-serviced by the Administrator on June 19, 2019 regarding the facility policies for care plans. 2) Residents who require in room activities have the potential to be affected. The Life Connections Coordinator reviewed all residents for the need of in room activities to develop and implement weekly in room activity program on 6/28/19. 3) All resident care plans and care task were audited and/or updated by the Life Connections Coordinator completed by 6/28/19 to ensure they reflect information to meet resident's activity needs. The Life Connections Coordinator will update the care plan for new residents and with changes to reflect residents activity needs. All facility nursing staff were in serviced beginning on June 19,2019 and completed on June 20, 2019 by the Administrator regarding reviewing the care plan and/or care task and providing activities. Life Connections Coordinator will document all activities on activity logs. In room activities will be provided to resident's who are unable to or chose not to participate in group activities. 4) Beginning July 15, 2019, the Activity	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 780	Continued From page 37 of the care plan specifically identified Resident #74 as blind and a need for in room visits. The intervention documented on the resident's care plan included Resident #74 enjoyed music, specifically the blues. Review of progress notes titled, "Life Connections," dated 11/9/18, 2/12/19, and 4/26/19, revealed Resident #74 enjoyed listening to music. Continued review of the progress notes revealed the Activities Coordinator completed the progress notes; however, she was not available for interview during the survey process. A review was conducted of documents titled, "In Room/1:1 Activities," dated February 2019, March 2019, and April 2019. The form dated February 2019 revealed Resident #74 received in room music for 10 minutes on 2/6/19 and on 2/26/19. The form dated March 2019 revealed Resident #74 listened to music for 10 minutes on 3/5/19. The form dated April 2019 revealed Resident #74 listened to music for 10 minutes on 4/8/19. Certified Nursing Assistant (CNA) #84 was interviewed on 5/20/19 at 4:04 PM. CNA #84 stated she had worked at the facility since February 2019. The CNA further stated there was no radio in Resident #74's room and the television was turned on periodically, but not on any specific channel. On 5/21/19 at 9:32 AM, Resident #74 was observed in his room and in bed, with no radio observed in his room playing music and the television was off. An interview was conducted with CNA #109 on 5/21/19 at 12:30 PM. The CNA stated she had worked at the facility for the past year and had	M 780	logs will be reviewed weekly for 6 weeks by the Administrator to ensure that all residents have routine activities documented. The Medical Records Nurse and the Minimum Data Set Nurse will review residents care plans and care task with each comprehensive assessment to ensure it reflects current activity information. Beginning July 15, 2019, Activities observations will be conducted 2 x weekly x 4 weeks then weekly for 6 weeks by the Administrator to ensure resident activities meet residents needs. Findings will be brought to the Quality Assurance and Improvement Committee monthly by the Activities Director for review, revision, and/ or resolution of the plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 780	Continued From page 38 never been directed to turn a radio on or to turn the television on for Resident #74 to listen to music. The Administrator was interviewed on 5/21/19 at 2:54 PM. The Administrator stated his expectation was staff would provide a resident with in room activities. The Director of Nursing (DON) was interviewed on 5/22/19 at 4:15 PM. The DON stated it was her expectation that residents were provided activities that they were interested in. The DON further stated the facility was going to provide the resident with a radio today. Resident #46 Review of Resident #46's admission MDS assessment, dated 8/17/18, revealed the resident had severely impaired cognition, and communications deficits described as "rarely/never understood." The assessment documented the resident was dependent on staff for all activities of daily living (ADLs). The MDS documented that the resident indicated it was "very important" for him to keep up with the daily news and listen to music in the activity/routine preferences section of the assessment. Review of Resident #46's undated "Face Sheet" (a document with demographic and diagnoses information) revealed a readmission date of 5/8/19, with diagnoses including Pressure Ulcers and Quadriplegia. Interview with the Medical Records Nurse on 05/21/19 at 3:38 PM, revealed Resident #46 does not have a page in the activity participation book, and there is no documentation that activities of any kind had been provided since Resident #46's	M 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 780	Continued From page 39 readmission on 5/08/19. The Activities Coordinator was not in the facility during the survey and was unavailable for interviews. An interview with the Administrator on 5/22/19 at 3:00 PM confirmed the facility lacked evidence one-to-one or group activities had been provided for Resident #46 since his readmission to the facility on 5/8/19.	M 780		
M 810	45.28.1 Direction and Supervision Direction and Supervision. Food service is one of the basic services provided by the facility to its residents. Careful attention to adequate nutrition and prescribed modified diets contribute appreciably to the health and comfort to the resident and stimulate his desire to achieve and maintain a higher level of self-care. The facility shall provide residents with well-planned, attractive, and satisfying meals which will meet their nutritional, social, emotional, and therapeutic needs. The dietary department of a facility shall be directed by a Registered Dietitian, a certified dietary manager, or a qualified dietary manager. If a qualified dietary manager is the director, he/she must receive frequent, regularly scheduled consultation from a licensed dietitian, or a registered dietitian exempted from licensure by statute. This Statute is not met as evidenced by: Level II Based on facility policy review, record review, and interview, the facility failed to ensure the Dietary Manager (DM) had an active certification. This failure affected 89 residents who received their	M 810	1. The District Manager, a Certified Dietary Manager, started serving as the Interim Certified Dietary Manager as of June 20, 2019. 2. All residents have the potential to be	7/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 810	Continued From page 40 meals from the kitchen, of the 90 residents residing in the facility. Findings include: Review of the facility policy entitled "Professional Staffing" dated May 2014, revealed a "qualified food services director" was employed by the facility and was responsible for insuring all dietary practices were in full compliance with applicable regulatory requirements. The certified DM was qualified based on educational requirements and/or experience as defined by the state requirements. During an interview with the DM on 5/21/19 at 9:40 AM, during the kitchen tour, she confirmed her certification had expired 4/14/19, and was not current. An interview on 5/23/19 at 10:00 AM, with the DON and the Administrator, confirmed staff certifications and licenses must be kept current.	M 810	affected by this deficient practice. The Nursing Home Administrator ensured that the facility had a Certified Dietary Manager as of 6/20/19 and has audited the Dietary manager and Registered Dietician personnel files as of 6/20/19 to ensure they have current and appropriate credentials. Copies of Certified Dietary manager and Registered Dietician respective certifications are on file in the facility. 3. The Nursing Home Administrator in-serviced the Dietary manager and the District Dietary Manager regarding the certification requirements for the Dietary Manager on June 20, 2019. A permanent Certified Dietary Manager started on June 26, 2019. The Nursing Home Administrator will ensure that the Dietary Department has a qualified Dietary Manager at all times. 4. Beginning July 1, 2019, the facility Nursing Home Administrator will audit monthly to ensure that the facility has a qualified Dietary Manager, at all times, and upon changes in personnel. District Dietary Manager will report to the facility Administrator quarterly confirmation that Dietary Manager qualification remains active and any upcoming expirations prior to occurring. This audit will be conducted monthly for 3 months and the results brought to the monthly Quality Assurance Committee by the Nursing Home Administrator for review, revisions, and/or resolution.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 815	Continued From page 41	M 815		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Based on facility policy review, observations, record review, and interview, the facility failed to ensure the dishwasher was functioning with sanitizer, and the kitchen remained clean and sanitary. This affected 89 of 90 residents residing in the facility, who received dietary services. Findings include: The facility's policy titled "Warewashing" revised 9/2017, indicated all dishware, service-ware and utensils would be cleaned and sanitized after each use. The facility's policy titled "Environment" revised 9/2017, indicated all food preparation areas, food service areas, and dining areas would be maintained in a clean and sanitary condition. During the initial kitchen tour that began on 5/20/19 at 9:45 AM, the dishwasher was operated by Dietary Aide (DA) #6 and assisted by DA #11. There were six (6) racks of dishes, trays and glasses that had been run through the dishwasher. DA #6 was requested to test the sanitizer in the dishwasher. She stated the dishwasher was a low temperature machine that used sanitizer. When DA #6 used a test strip in the dishwasher it indicated there was no sanitizer	M 815	1. The chemical containers for the dish machine were immediately replaced on 5/20/2019 with new containers by the acting Dietary Manager. Chemical levels were verified to ensure proper sanitization on 5/20/2019 by the acting Dietary Manager. The oven doors and the vent under the doors were cleaned on 6/21/2019 by the acting Dietary Manager. The grease was changed out on 6/21/2019 by the acting Dietary Manager. The top of the fryer and the bottom shelf of the table next to the fryer were cleaned by the acting Dietary Manager on 6/21/2019. The three- steel bowls and the colander on the bottom shelf of the table were cleaned by the acting Dietary Manager on6/21/2019. The bottom shelf of the prep table was cleaned by the acting Dietary Manager on 6/21/2019. Two loaf pans, five full pans, three ¿ pans and three 1/3 pans were cleaned by the acting Dietary Manager on 6/21/2019. The floor fan was cleaned on 6/21/2019 by the acting Dietary Manager. Two freezers were cleaned on 6/21/2019 by the acting Dietary Manager. The bins with the serving pieces and the thirty- nine serving pieces in the bins were cleaned on 6/21/2019 by the acting Dietary Manager.	7/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 815	Continued From page 42 present. At 10:00 AM, the Dietary Manager (DM) joined the conversation and confirmed the test strips indicated no sanitizer present in the dishwasher. She instructed dietary staff to stop using the dishwasher until it could be checked. The kitchen tour continued with the DM present, and revealed the following: 1. The inside of the oven doors and the vent under the oven doors had a large amount of sediment and spillage build-up. 2. The grease in the fryer had a large amount of sediment. 3. The top of the fryer and the bottom shelf of a table next to the fryer, had a large amount of grease spillage and sediment. There were three (3) clean, steel bowls and a colander being stored on the bottom shelf with the grease spillage. 4. The bottom shelf of the prep table had a large amount of sediment. 5. Stored pans were wet and dirty, including: two (2) 1/4 loaf pans, five full pans, three (3) 1/2 pans, and three (3) 1/3 pans. 6. The floor fan in the kitchen had a large amount of dirt build up. 7. Two (2) of the freezers had spillage and garbage on the bottom. 8. The bins with the serving pieces had sediment and spillage. There were 39 dirty serving pieces in the bins and available for resident use. All of the above findings were confirmed by the DM, at the time of the observations, during the kitchen tour with the Dietary Manager.	M 815	2. This deficient practice has the potential to affect all facility residents. The Registered Dietician conducted a sanitation check in the kitchen on 6/27/2019 to ensure that proper sanitation techniques are being utilized in the kitchen at the pot sink and in the dish room. 3. The acting Dietary Manager in-serviced all dietary staff as of June 20,2019 on the cleaning policy and procedures including the cleaning schedule, and the sanitation system. The kitchen staff were in-serviced by the Dish Washer Service Company on June 21st, 2019 regarding the food contract service policies and procedures for utilization of the dish machine. Kitchen staff members not completing the required education were not allowed to be scheduled to work until the education has been complete. The facility began a cleaning schedule as of 6/21/19 and will be monitored Monday through Friday by the Dietary Manager. The staff members responsible for following the cleaning schedule assigned by the acting dietary manager received additional education as of 6/28/19 to complete assignments outlined in the cleaning schedule. 4. The Registered Dietician will conduct monthly sanitation checks in the kitchen to ensure compliance with the requirements. The Dietary Manager will ensure the monthly Registered Dietician sanitation audit is completed on a monthly basis for 3 months. The Dietary Manager will audit weekly to ensure the cleaning schedule log is complete and the chemical	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 815	Continued From page 43	M 815	sanitation logs are complete and of proper levels for 12 weeks. These audits will begin as of July 11, 2019. The Dietary Manager will bring the results of these audits to the monthly Quality Assurance Committee for review, revisions, and/or resolution.	
M 865	45.30.9 Serving of Meals Serving of Meals. 1. Table should be of a type to seat not more than four (4) or six (6) residents. Residents who are not able to go to the dining room shall be provided sturdy tables (not TV trays) of proper heights. For those who are bedfast or infirm tray service shall be provided in their rooms with the tray resting on a firm support. 2. Personnel eating meals or snacks on the premises shall be provided facilities separate from and outside of food preparation, tray service, and dishwashing areas. 3. Foods shall be attractively and neatly served. All foods shall be served at proper temperature. Effective equipment shall be provided and procedures established to maintain food at proper temperature during serving. 4. All trays, tables, utensils and supplies such as china, glassware, flatware, linens and paper placemats, or tray covers used for meal service shall be appropriate, sufficient in quantity and in compliance with the applicable sanitation standard. 5. Food Service personnel. A competent person	M 865		7/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 865	Continued From page 44 shall be designated by the administrator to be responsible for the total food service of the home. Sufficient staff shall be employed to meet the established standards of food service. Provisions should be made for adequate supervision and training of the employees. This Statute is not met as evidenced by: Level II Based on facility policy review, observations, and group interviews, the facility failed to ensure food was served at palatable temperatures. This affected the 36 residents on the North Unit who ate in their rooms of 89 residents who received their meals from dietary services in the facility. Findings include: Review of the facility's undated policy entitled "Food: Preparation", included direction for the cook to insure all foods were held at appropriate temperatures. During the resident group meeting on 5/21/19 at 9:30 AM, the residents revealed the room meal trays served on the North Unit had cold food. On 5/22/19 at 11:50 AM, the food on the tray line was observed, and temperature checks were conducted by Cook #1. The corn was 160 degrees Fahrenheit (F), mixed vegetables were 165 degrees F, the fish was 150 degrees, the fortified mashed potatoes were 170 degrees F, the pureed pinto beans were 165 degrees F, pureed chicken was 165 degrees F, the pureed chili was 165 degrees F, the chicken breasts were 170 degrees F, the pinto beans were 180 degrees F, the chili was 185 degrees F and the corn bread was 160	M 865	1) Meal trays had been delivered and were consumed before the results of the test trays were known. 2) Residents who receive meals from the kitchen have the potential to be affected by this deficient practice. 3) All dietary staff members were inserviced by the acting Dietary Manager on or before June 20, 2019 and will be re-inserviced by the Regional Dietary Manager on or before June 21, 2019 regarding meal serving temperatures and to notify the nursing staff of when trays are taken to the halls. 4) The Dietary manager or Regional Dietary Manager will sample one tray 5x week for 4 weeks then weekly for 4 weeks, beginning the week of July 11, 2019, to test food temperatures on hall trays to ensure warm foods are at or above 120 degrees. Findings will be brought to the Quality Assurance and Improvement Team for review, revision and/or resolution of the plan.	

MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30PL	A. BUILDING: _____ B. WING _____	05/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAZA COMMUNITY LIVING CENTER	4403 HOSPITAL ROAD PASCAGOULA, MS 39581

(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) COMPLETE DATE
M 865	Continued From page 45 degrees. A test tray audit was conducted on 5/22/19. The test tray was placed on the second, and last, food cart that went to the North Unit. The cart left the kitchen at 12:40 PM, and arrived on the North Unit at 12:42 PM. At 12:50 PM, all the lunch trays had been delivered to the residents on the North Unit. The temperatures and tasting were completed with the Dietary Manager (DM) present when the last resident's tray had been delivered. The pureed chicken was 109.5 degrees F and was not hot. The pureed chili was 116.8 degrees F and was not hot. The pureed pinto beans were 108.7 degrees F and were not hot. The food taste was palatable. The DM confirmed the food was not hot enough when it was served on the North Unit.	M 865		