STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255179	A. BUILDING _____ B. WING _____	C 02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEAKESVILLE REHABILITATION AND NURSING CENTER, INC	1300 MELODY LANE LEAKESVILLE, MS 39451

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey and a Complaint Investigation (CI) MS #20373, was conducted by the State Agency (SA) at the facility from 2/15/23 through 2/16/23. The facility was found to be in compliance with infection control regulations and has implemented the Centers for Medicare and Medicaid (CMS) and the Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The complaint was related to facility Administration, equipment not maintained, services not performed per the plan of care/physician, sufficient supplies, and staff improperly qualified. During the survey, the SA determined the facility was not in compliance with the requirements for participation in Medicare and Medicaid and cited F657, F686, and F865. The facility had a license for 60 beds, with a census of 45.	F 000		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		3/31/23

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

Electronically Signed | 02/28/2023

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F 657	Continued From page 1 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and facility policy review, the facility failed to revise the Comprehensive Care Plan for two (2) of three (3) sampled residents. Resident #1 and Resident #2. Findings include: A review of the facility's policy "Care Plans - Comprehensive", revised May 2014, revealed, "...Policy Interpretation and Implementation 1. Our facility's Care Planning/Interdisciplinary Team...maintains a comprehensive care plan for each resident ...8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change ..." Resident #1 A record review of the "Face Sheet" revealed the facility admitted Resident #1 on 7/21/21 and she had a current diagnosis of Pressure Ulcer of Right Heel, Unstageable.	F 657	Leakesville Rehabilitation and Nursing Center - Plan of Correction F657 Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action taken for the resident found to have been affected include: Care Plan of resident's #1 and #2 were reviewed and updated with all current orders on 2/16/23 by the Director of Nursing. 2. Identification of other residents having	

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F 657	Continued From page 2 A record review of "Physician's Telephone Orders", dated 1/13/23, revealed Resident #1 had a Physician's Order to " ... (2) D/C (Discontinue) current tx (Treatment) to R (Right) heel (3) Cleanse pressure ulcer to R heel with NS (Normal Saline), pat dry, apply hydrogel to wound bed, cover with ABD (Abdominal) pad and secure with roll gauze and tape daily and prn (as needed) ..." A record review of Comprehensive Care Plan for Resident #1 with the "Care Plan Description" of "(Proper Name of Resident #1) has a pressure ulcer to right heel ..." revealed an "Intervention" with a start date of 12/13/2022 of "Right heel pressure area cleanse with wound cleanser pat dry apply Collagen Sheet/Powder cover with border gauze dressing daily. Remove dressing at HS (Bedtime) and leave OTA (Open to Air)". The care plan was not revised to discontinue the previous Physician Order and add the current Physician Order dated 1/13/23. Resident #2 A record review of the "Face Sheet" revealed that the facility admitted Resident #2 on 4/7/21 with a diagnosis of Type 2 Diabetes Mellitus. A record review of the "Physician Orders" for Resident #2 "For the month of : January 2023" revealed an order with an order date of 1/13/23 to "Cleanse diabetic ulcer to 2nd toe right foot daily with NS, Pat Dry, Apply Hydrogel to wound bed and cover with dry dressing. Change daily and PRN." A record review of Comprehensive Care Plan for Resident #2 with a "Care Plan Description" of "(Proper Name of Resident #2) has ulcer to right	F 657	the potential to be affected was accomplished by: The facility has determined that all residents have the potential to be affected by the deficient practice. 3. Actions taken and systems put into place to reduce the risk of future occurrences include: Care Plan nurse and interdisciplinary team responsible for writing care plans will be in-serviced by the Director of Nursing designee on the facility policy and procedure for developing Comprehensive Care plans. The Care Plan nurse will update the care plans by 2/16/23 as needed and will be ongoing. The Care plan nurse was educated by the Director of Nursing on developing comprehensive care plans per facility policy to include timing and revision of care plans on 2/16/23. 4. How the corrective actions will be monitored to ensure the practice will not recur: Care plans will be reviewed weekly in accordance with the care plan review schedule by the MDS Coordinator. All care plans will be updated as indicated. The Director of Nursing or designee, will complete random weekly audits of care plans for six consecutive weeks starting 2/25/23. Random audits will be completed to ensure that comprehensive care plans are developed. Audit records will be reviewed by the Quality Assurance Committee on 3/8/23 and monthly until such time consistent	

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F 657	Continued From page 3 foot second toe ..." revealed an "Intervention" with a start date of 10/25/22 to "Cleanse diabetic ulcer to right foot 2nd toe with wound cleanser, pat dry apply Collagen Sheet/Powder, cover with border gauze drsg (Dressing) daily and prn." The care plan was not revised to include the current Physician Order that was dated 1/13/23. On 2/16/23 at 12:09 PM, an interview with the Director of Operations (DOO) revealed that the facility's Care Plan Coordinator had recently resigned. The DOO confirmed that during this transition of staffing, she should have provided the oversight to ensure that resident care plans were current and reflected changes in physician orders. She confirmed that the care plan for Resident #1 and Resident #2 were not revised to reflect the current physician orders for wound care. On 2/16/23 at 12:39 PM, in an interview with the Interim/Director of Nursing (DON), she confirmed that since the facility does not currently have a Care Plan Coordinator, the DON was responsible for completing and revising the comprehensive care plans to include new physician's orders that are written for residents.	F 657	substantial compliance has been achieved as determined by the committee. Completed by 3/31/2023	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 686		3/31/23

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F 686	Continued From page 4 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide care and services consistent with professional standards of practice as evidenced by not completing weekly wound assessments to include wound measurements for one (1) of one (1) pressure injuries reviewed. Resident #1 Findings include: Review of the facility policy, "Prevention of Pressure Ulcers/Injuries", revised July 2017, revealed, " ...The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors ..." A record review of a facility letter signed by the Director of Operations (DOO), dated 2/17/23, revealed, "Leakesville Rehabilitation and Nursing Center measures and records wounds weekly or as needed per the standards of care ..." A record review of the "Face Sheet" revealed the facility admitted Resident #1 on 7/21/21 and she had a current diagnosis of Pressure Ulcer of Right Heel, Unstageable. A record review of the facility's "Wound Healing Progress Report", for Resident #1, dated 2/16/23, revealed, "Type of Wound/Location" as "Pressure	F 686	Leakesville Rehabilitation and Nursing Center F0686 Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action taken for the resident found to have been affected include: The Wound measurements were completed 2/15/23 and documented on the Wound Healing Progress Report report 2/15/23 by the Director of Nursing. The Registered Nurse Care Manager was educated by the Director of Nursing on 2/16/23 on wound measuring and on completing the Wound Healing Progress Report. 2. Identification of other residents having the potential to be affected was accomplished by: All residents receiving wound treatments have the potential to be	

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F 686	Continued From page 5 Ulcer Right Heel". The dates in which measurements were recorded were 12/14/22, 12/21/22, and 1/26/23. There were no recorded measurements for 12/28/22, 1/4/23, 1/11/23, or 1/23/23. There was only one (1) measurement documented for January 2023 (1/26/23) and there were no measurements documented for February 2023 prior to the State Agency (SA) entry on 2/15/23. On 2/15/23 at 1:33 PM, in an interview with Registered Nurse (RN) #1, she confirmed that she works at the facility on weekends as the RN Supervisor. She stated that she had not been completing weekly wound assessments or measuring the wounds and the previous Director of Nursing (DON) was aware that the wounds were not being assessed or measured. On 2/16/23 at 10:39 AM, in an interview with the Nurse Practitioner (NP), she confirmed that she expected the facility to assess the wounds weekly as per the standards of care, to be notified of any changes, and updated weekly on her rounds. The NP stated that she thought the facility was assessing the wounds because there had not been any negative outcomes. On 2/16/23 at 12:09 PM, in an interview with the DOO, she stated that the facility had undergone staff changes. She also stated that RN #1 had been instructed to perform the weekly wound assessments and measurements. The DOO confirmed that it was her responsibility to oversee that the wounds were being assessed weekly. On 2/16/23 at 12:39 PM, in an interview with the current Interim DON, she confirmed that the weekly wound assessments were not completed	F 686	affected. 3. Actions taken/systems put into place to reduce the risk of future occurrences include: The Wound Healing Progress Report will be audited weekly by the Director of Nursing beginning 2/16/23 for 6 weeks and ongoing. The audits of the Wound Healing Progress Report will be reviewed at the monthly QAPI meeting on 3/8/23 and ongoing. 4. How the corrective actions will be monitored to ensure the practice will not recur: The Registered Nurse supervisor or designee will monitor documentation of treatments weekly for 6 weeks starting 2/25/23, then ongoing. Discrepancies will be promptly reported to the Director of Nursing. Findings of the audit will be discussed at the QA meetings starting 3/8/23 x 3 months, ongoing. The Registered Nurse Care Manager will measure the wounds weekly beginning 2/15/23 and document the wounds on the Wound Healing Progress Report weekly by 2/25/23; ongoing. This plan of correction will be monitored at the monthly QA meeting until such time consistent substantial compliance has been met. Completion date 3/31/23.	

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F 686	Continued From page 6 weekly. She stated that it was the responsibility of the DON to track the wounds at the facility and to make sure they are assessed and measured to ascertain if the wounds are deteriorating.	F 686		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and	F 865		3/31/23

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F 865	Continued From page 7	F 865		

evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

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F 865	Continued From page 8 §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility's Quality Assurance and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place in 12/2/22. The facility's continued failure during this and the previous survey in November 2022	F 865	Leakesville Rehabilitation and Nursing Center F0865 Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a	

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F 865	Continued From page 9 on an annual recertification survey indicates a pattern of the facility's inability to sustain an effective QAPI Committee. Findings include: Review of the facility's policy, "Quality Assurance and Performance Improvement (QAPI) Committee," dated July 2016, revealed, "The facility shall establish and maintain a Quality Assurance and Performance Improvement (QAPI) Committee that oversees the implementation of the QAPI Program ... The primary goals of the QAPI Committee are to: 1. Establish, maintain and oversee facility systems and processes to support the delivery of quality of care and services... 6. Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals ..." F657: Based on staff interview, record review, and facility policy review, the facility failed to revise the Comprehensive Care Plan for two (2) of three (3) sampled residents. Resident #1 and #2. On 02/16/23, at 12:50 PM, in an interview and record review of the facility's Quality Assurance Program, the Administrator explained the team had been meeting monthly and the previous care plan citation had been on the agenda. The Administrator revealed, she was unaware of ongoing issues related to care plan revisions and thought the facility was in compliance.	F 865	deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action taken: The facility's Quality Assurance and Performance Improvement (QAPI) Committee met on 2/24/23 and implemented procedures and monitoring of the interventions put into place on 2/16/23 for Care Plans and Wound Measurements and the Wound Healing Progress Report. The QAPI Committee will meet again on 3/8/23 and will meet monthly and ongoing to identify and correct quality deficiencies. 2. Identification of other residents having the potential to be affected was accomplished by: All residents have the potential to be affected. 3. Actions taken/systems put into place to reduce the risk of future occurrences include: The Director of Nursing will in-service the QAPI committee on the facility QAPI policy and procedures by 2/24/23. The QAPI Committee will meet monthly to address and evaluate for effectiveness of the Care Plan interventions, the Wound Measurement interventions and the Wound Healing Progress Report interventions and plans on 2/24/23, 3/8/23 and monthly for 3 months.	

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F 865	Continued From page 10	F 865	4. How the corrective actions will be monitored to ensure the practice will not recur: The Director of Nursing will audit Care Plan audit, Wound Care audit and Wound Healing Progress Report audit of the QAPI committee 2/24/23 and again on 3/8/23 and monthly x 3 months to ensure the auditing of Care Plans and the Wound Measurement and Wound Healing Progress Report is being monitored monthly at the QAPI meeting and ongoing. Discrepancies will be promptly reported to the Administrator. The QAPI Committee will meet monthly to address and evaluate for effectiveness of the Care Plan interventions, the Wound Measurement interventions and the Wound Healing Progress Report interventions and plans on 2/24/23, 3/8/23 and monthly for 3 months; ongoing. This plan of correction will be monitored at the monthly Quality Assurance meeting until such time consistent substantial compliance has been met.	