STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255305	A. BUILDING _____ B. WING _____	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PLACE NURSING CENTER	1126 EARL FRYE BOULEVARD, SOUTH AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 4/17/23 through 4/20/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid Services. The SA identified non-compliance and cited F550 for Resident Rights/Exercise of Rights, F583 for Personal Privacy/Confidentiality of Records, F585 for Grievances, F604 for Right To Be Free From Physical Restraints, F636 for Comprehensive Assessments and Timing, F656 for Develop/Implement Comprehensive Care Plan, and F684 for Quality of Care. The census at the time of the survey was 54 with a bed capacity of 60 beds.	F 000		
F 576 SS=F	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail.	F 576		6/9/23

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

Electronically Signed | 05/12/2023

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F 576	Continued From page 1 §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, and facility policy review, the facility failed to promptly deliver postal mail to residents on Saturdays for 54 of 54 residents in the nursing facility that would possibly receive postal mail. Resident #25 Findings include: Review of a document on facility letterhead from the Administrator dated 4/20/23, revealed, "The Policy of (Proper Name of the facility) is to pass mail daily. Activities passes on the weekdays and the Registered Nurse (RN) supervisor or charge nurse is responsible for mail collection on the weekends."	F 576	What corrective action will be accomplished for those residents found to have been affected by to he alleged deficient practice. On May 13th, 2023 Mail will be passed to Resident #25 on Saturday. Beginning May 11th 2023 Mail delivery will occur daily and staff will be educated to ensure this happen. A program involving nursing and front desk was implemented to make sure mail is passed on Saturdays. Steps taken to identify other residents having the potential to be affected by the same alleged practice?	

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F 576	Continued From page 2 Review of the "Resident's Rights" with a copyright date of 2018, revealed, " ...7. Information and communication ... i. The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through means other than a postal service."... An interview on 4/18/23 at 3:45 PM with Resident #25, the Resident Council President, revealed there is no mail delivered to the residents on Saturday. He revealed he saw the staff member that works at the main entrance door bring in mail from the mailbox on a Saturday, could not recall which Saturday, but she refused to go through it to see if he had any mail delivered from the post office. He revealed the nursing staff will bring him his packages and the newspaper, if he tells them to look out for it on the weekend, but the young lady will not give him his Saturday mail. An interview on 4/19/23 at 2:35 PM, with the COVID Check Point Staff, revealed she had gotten the mail out of the mailbox one Saturday and took the mail to the nurse's desk to be placed in the main office to be passed out to the residents on the following Monday. She revealed it was taken to the nurse's desk because she did not have access to a key for the main office. An interview on 4/19/23 at 2:40 PM, with Licensed Practical Nurse (LPN) #2, revealed she has worked on Saturday and reported the mail was brought to the nurse's desk on Saturdays and to be passed out by the Activities Department, if they are working on Saturday. She stated there was not an Activities person at work every Saturday and the mail would then be placed in the main office to be passed on to the residents	F 576	The facility has determined that all residents in the facility have the potential to be affected by this alleged deficient practice. What measures will be put in place or systematic changes made to ensure that the deficient practice will not recur? Administrator conducted an in-service on 5-10-2023 for all Nurses and front desk workers on 5-10-2023 on the procedure for passing mail on Saturdays. Beginning 5-13-2023 The 300-hall cart will receive and sort the mail and give personal letters to the front desk greeter or activity department to be passed to the residents. A log in sheet will be kept at the nurses station and the nurse and greeter will both sign when mail passing has been completed. Administrator or Activities Director will monitor this log weekly for 3 months then monthly for 6 months to ensure compliance. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur? Beginning 5-13-2023 Administrator or Activities Director will monitor this log weekly for 3 months then monthly for 6 months to ensure compliance. Beginning June 9th, 2023 Audit sheets will be brought to the Risk Management/Quality Assurance	

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F 576	Continued From page 3 on the following Monday. An interview on 4/19/23 at 2:43 PM, with LPN # 3, revealed mail had been brought to the nurse's desk when she worked on a Saturday and would be placed in the main office to be passed out to residents on the following Monday if no one was working on Saturday from the activities department. An interview on 4/19/23 at 2:50 PM, with the Activities Coordinator revealed she had passed out mail before on a Saturday. But she was not at work this past Saturday, 4/15/23, and was not sure about what happened with the mail. She noted if she is at work, the nurses give the mail to her to pass it out to the residents. An interview on 4/19/23 at 2:55 PM, with the Administrator revealed the weekend RN Supervisors are responsible for getting the Saturday mail from the mailbox and distributing it to the residents. She revealed it was not the responsibility of the Activities department to distribute Saturday mail and was not aware that no staff was delivering Saturday mail to the residents every Saturday. She confirmed all residents should receive their mail the day it is delivered, and Resident #25 had the right to receive his postal mail, if there was some delivered for him, on Saturday. An interview 4/19/23 at 3:01 PM, with Registered Nurse (RN) Supervisor #1, revealed she would look for a newspaper or a package that was delivered on Saturday when Resident #25 would tell her he wanted the newspaper and if had a package coming. She revealed that she would be involved providing resident care and was not	F 576	Committee monthly for 6 months until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident Council June 15th, 2023for comment and suggestions.	

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F 576	Continued From page 4 aware she was responsible to go to the mailbox to get resident mail and distribute it on a Saturday. She confirmed that she had not gotten mail out of the mailbox on any Saturday she had worked. Record review of the Face Sheet revealed that the facility admitted Resident # 25 to the facility on 10/27/21 with diagnoses of Vascular dementia with Sepsis, Unspecified dementia without behaviors, and Benign prostatic hyperplasia. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 3/28/23, revealed that Resident # 25 had a Brief Interview of Mental Status (BIMS) score of 15 which indicated that she was cognitively intact.	F 576		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened	F 583		6/9/23

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F 583	Continued From page 5 mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, and facility policy review the facility failed to protect a resident's right to privacy in her room for one (1) of 54 residents reviewed for resident rights. Resident #39 Findings include: Review of the facility policy titled, "Resident Rights," with a copyright date of 2018, revealed "1. Resident rights. The resident has the right to a dignified existence ... 9. Safe environment. The resident has a right to a safe, clean, comfortable and Homelike environment, including but not limited to receiving treatment and support for daily living safely." An interview on 4/18/23 at 4:00 PM, with Resident #39, during the Resident Council Meeting, revealed Resident #36 had wandered into her room and she did not want uninvited men in her	F 583	1. What corrective action will be accomplished for those residents found to have been affected by to he alleged deficient practice. On 4-18-2023 Social Services Director spoke with resident number 39 and she confirmed no harm had been done by resident number 36. On the day of the event Resident #36 was immediately removed from Resident # 39's room. A stop sign was ordered on 5-11-2023 for Resident #39's door and will be placed once received. 2. Steps taken to identify other residents having the potential to be affected by the same alleged practice? The facility has determined that all residents in the facility have the potential	

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F 583	Continued From page 6 room. She revealed it makes her very uncomfortable for him to be in her room, she feels he was intruding in her private space. She revealed the staff would hear her tell him to get out and would come to convince him to leave. She shared that she would not want to be on the toilet or getting out of her clothes, and he was to come in her room. She revealed that she wanted the staff to assure her that she had the right to her private space, and that she would be comfortable and safe by not having to always watch for him to keep him out of her room. An interview on 4/19/23 at 1:10 PM, with the Registered Nurse (RN) Supervisor confirmed that Resident #36 exhibited wandering behaviors and had wandered in and out of other residents' rooms. She noted that she could not confirm or deny that the male resident had wandered into Resident #39's room before. An interview on 4/19/23 at 1:30 PM, with the Administrator, revealed she had a conversation with Resident #39 some time ago about Resident #36 when he entered her room, and that Resident #39 wanted the Administrator to tell her she would stop Resident #36 from coming in her room. She noted that she informed Resident #39 that she would do all that she could to keep Resident #36 out of her room but could not promise that he would not enter her room again. She confirmed Resident #39 had the right to privacy, that her right to privacy had been violated. An interview on 4/19/23 at 1:45 PM, with Social Services, confirmed Resident #39's complaint that Resident #36 unwantedly entered her room. She revealed that she did not think Resident #39's rights had been violated because Resident	F 583	to be affected by this alleged deficient practice. 3. What measures will be put in place or systematic changes made to ensure that the deficient practice will not recur? An in-service for all staff was conducted by the administrator on 5-11-2023 on the importance of monitoring wandering residents and re - directing as necessary. On 5-11-2023 Social Services placed a sign on the wandering residents door to help him identify his room. Social services identified by interview residents with increased concern about wandering residents and stop signs were ordered on 5-11-2023 and will be placed across the door of those residents rooms once received to help detour wandering residents. This includes the room of Resident #39. 4. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur? Through observation and interviews with residents and Beginning 5-10-2023 The Director of Nursing or Administrator will complete weekly rounds to ensure staff are re directing wandering reseidents this will be done weekly times 4 weeks then monthly times 3 months. Beginning June 9th, 2023 audit records will be reviewed by the Risk Management/Quality Assurance Committee for 6 months or	

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F 583	Continued From page 7 #39 did not present the complaint to her in that manner, that it was not a major occurrence with Resident #36 going into her room, and that she informed Resident #39 that Resident #36's mind does not function like hers anymore and he was not aware of what he was doing. An interview on 4/19/23 at 2:34 PM, with Licensed Practical Nurse, (LPN) #2, confirmed that Resident #36 did exhibit wandering behaviors and had been wandering in and out of different residents' rooms. An interview on 4/19/23 at 4:40 PM, with the Director of Nursing (DON), confirmed Resident #36 did wander in and out of other residents' rooms and that there had been residents that did not like him coming into their rooms. Record review of the "Face Sheet" for Resident #39 revealed an admission date of 12/03/21 and a diagnosis of Adjustment disorder with Mixed Anxiety and Depressed Mood. Record review of the "Patient Progress Note," from Resident #36's physician dated 2/10/23, revealed " ... 91-year-old out and about in the facility in his wheelchair ... he's been a little agitated, going in and out of folks room but so far, he's been redirected. ... Impression: ... 2. Dementia." Record review of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 2/14/23, for Resident #39, revealed an interview dated 2/13/23 with a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #39 is cognitively intact.	F 583	until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident Council on June 15th, 2023 for comment and suggestions.	

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F 585	Continued From page 8	F 585		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business	F 585		6/9/23

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F 585	Continued From page 9	F 585		

address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement

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F 585	Continued From page 10 as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, record review, and facility policy review, the facility failed to record, initiate, and resolve a grievance for a resident, for one (1) of five (5) residents reviewed for grievances in Resident Council. Resident #39 Findings include: Review of the facility policy titled, "Resident and Family Grievances," with the date implemented of March 1, 2019, revealed " ... "Prompt efforts to resolve" include facility acknowledgment of a complaint/grievance and actively working toward resolution of that complaint/grievance ... 8. Grievances may be voiced in the following forums: a. Verbal complaint to a staff member or Grievance Official. ... d. Verbal complaint during resident or family council meetings. ... 10. Procedure: ... b. The staff member receiving the grievance will record the nature and specifics of	F 585	1. What corrective action will be accomplished for those residents found to have been affected by to he alleged deficient practice. Grievance was written for Resident #39 on 5-11-2023by the Administrator and Social Services. A Stop sign was ordered on 5-11-2023 for Resident #39's door and will be placed once received. 2. Steps taken to identify other residents having the potential to be affected by the same alleged practice? The facility has determined that all residents in the facility have the potential to be affected by this alleged deficient practice. 3. What measures will be put in place or	

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F 585	Continued From page 11 the grievance on the designated grievance from or assist the resident or family member to complete the form; ... 11. Take any immediate actions needed to prevent further potential violations of any resident right ... d. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions, on the grievance form. ... 12. The facility will make prompt efforts to resolve grievances." During a Resident Council Meeting, on 4/18/23 at 4:00 PM, an interview with Resident #39 revealed that Resident #36 had wandered into her room. She did not want uninvited men in her room. It made her very uncomfortable for him to be in her room and she felt he was intruding in her private space. The staff would hear her tell him to get out, because they would come to her room to convince him to leave. She confirmed that she had spoken to the Administrator and the Social Worker about it, and nothing had been done. She revealed she knew nothing about a grievance being written up for this complaint and no one had come back to her to talk about it. On 4/19/23 at 1:30 PM, during an interview with the Administrator, confirmed that she had a conversation with Resident #39 some time ago about Resident #36 entering her room, and that she did not want an uninvited man coming in her room, and that Resident #39 wanted the Administrator to tell her she would stop Resident #36 from coming in her room. She noted that she had informed Resident #39 that she would do all that she could to keep Resident #36 out of her room but could not promise that he would not enter her room again. She also noted she did not document the conversation she had with	F 585	systematic changes made to ensure that the deficient practice will not recur? An in-service for all staff was conducted by the administrator on 5-11-2023 on the Grievance process and who the Grievance officer is. The corporate nurse also did an in-service with the Administrator and Social Service Director on 5-11-2023 on the Grievance process. 4. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur? Beginning June 2nd, 2023 the previous months Grievances will be reviewed monthly by the administrator and sent to the corporate nurse for 6 months. Beginning in June 9th, 2023 Grievance records will be reviewed by the Risk Management/Quality Assurance Committee for 6 months or until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Council for comment and suggestions.	

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	255305	A. BUILDING _____ B. WING _____	04/20/2023

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Resident #39 and that a formal grievance had not been initiated and resolved for Resident #39's complaint. She confirmed that a formal grievance should have been filed, initiated, and resolved for Resident #39's grievance. The Administrator did confirm that Resident #36 had been confirmed to wander in and out of other residents' rooms.

An interview on 4/19/23 at 1:45 PM with Social Services confirmed there was no formal grievance filed for Resident #39's complaint that Resident #36 unwantedly entered her room. Social Services also confirmed that Resident #36 did wander in and out of other resident's rooms. She noted that Resident #39 did not present the complaint to her in the manner of being bothered by Resident #36 entering her room, so she did not think Resident #39's complaint should have been written up as a grievance. She also noted Resident #39's complaint was not a major occurrence with Resident #36 going into her room. Social Services shared that she informed Resident #39 that Resident #36's mind did not function like hers anymore, and he was not aware of what he was doing.

Record review of the Grievance Log revealed there was no grievance form initiated or resolved for Resident #39's complaint of the resident wandering into her room.

Record review of the "Face Sheet" for Resident #39 revealed an admission date of 12/03/21 and a diagnosis of adjustment disorder with Mixed Anxiety and Depressed Mood.

Record review of the Quarterly Minimum Data Set (MDS) Assessment, with and Assessment Reference Date (ARD) of 2/14/23, for Resident

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F 585	Continued From page 13 #39, revealed an interview dated 2/13/23 with a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #39 is cognitively intact.	F 585		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by:	F 604		6/9/23

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F 604	Continued From page 14 Based on observation, resident interview, staff interview, record review and facility policy review the facility failed to ensure a resident was free of the use of a restraint as evidenced by use of a body alarm that restricted the movements of a resident who could turn and position themselves and they could not easily remove the device for one (1) of 54 residents reviewed. Resident #43 Findings include: A review of the facility's policy titled "SUBJECT: RESTRAINT POLICY", revealed, "POLICY: As per OBRA (Omnibus Budget Reconciliation Act) requirements all residents have the right to be unrestrained. Restraints should be used only as a last alternative and only when other less restrictive measures have been tried and rejected. DEFINITION: "Physical Restraints" are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body...PROCEDURE:..2.) All residents using a restraint are to be evaluated and re-evaluated approximately every quarter..." A review of the facility's policy titled "SUBJECT: PHYSICIAN'S ORDER FOR A PHYSICAL RESTRAINT DEVICE," revealed, "POLICY: "All residents requiring a physical restraint must have a Physician's Order ..." An interview with CNA #4 on 4/17/23 at 11:00 AM, revealed she provides care to Resident #43 at times and confirmed she would fuss when we had to put the alarms on, but we didn't want her to fall.	F 604	1. What corrective action will be accomplished? for those residents found to have been affected by the alleged deficient practice? Clip alarm was immediately removed from Resident #43 on 4-17-2023. Audit was completed by the Director of Nursing on 4-17-2023 to ensure that no other alarms were in the building. Non were found to be in use. 2. Steps taken to identify other residents having the potential to be affected by the same alleged practice? The facility has determined that no other residents in the facility were affected by this alleged practice but do have the potential to be affected. 3. What measures will be put in place or systematic changes made to ensure that the deficient practice will not recur? On 5-12-2023 nursing facility staff including nurses and Certified Nursing Assistants were in -serviced by the DON on the use of fall alarms and restraints. All alarms were disposed of 4-17-2023. 4. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur? Administrator and DON beginning	

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F 604	Continued From page 15 An observation and interview on 4/17/23 at 1:43 PM, Resident #43 was asked why she had a body alarm clipped to the back of her blouse, she revealed the staff put it on her because she has had a couple of falls when she came in, but she is in therapy and stronger now. She stated, "I hate the alarm and I feel insulted having to wear it, I can't even bend down to pick something up if I need to without it going off and when I'm in bed I hate to even turn over because the alarm scares me and wakes up the whole hall." She also revealed the staff had showed her how to put the alarm back together so it would stop alarming when she moves to much in the bed and stated, "That's kind of hard to do when its dark or you can't reach it on the back of the chair," and confirmed she had told the staff over and over she wanted it off. Record review of the April 2023 Physician Orders revealed no order for a body alarm. An interview on 04/18/23 at 10:00 AM, with Certified Nurse Aide (CNA) #1, revealed Resident #43 was to wear the chair alarm all the time while up in the wheelchair to deter her from wanting to stand up and risk falling. She noted that each time she had been assigned Resident #43, she had placed the alarm on Resident #43 when she helped her get in the wheelchair. CNA #1 shared that she was told by the nurses the chair alarm had to be clamped onto Resident #43, because she had fallen not long after being admitted to the nursing facility. She stated that Resident #43 was out of her head when she admitted and was not safe to stand up but has not fallen again in a long time. She also confirmed that there was an alarm the CNAs were to place on Resident #43 when	F 604	5-15-2023 will continue to observe and make walking rounds to ensure alarms are not being used on a weekly basis for 3 months. Walking rounds and observations will be done by the Director of Nursing or Registered Nurse Supervisor and findings documented weekly for three months. Beginning in June 9th, 2023 any adverse findings of alarms will be brought to the risk Management / Quality assurance Committee for six months or until such time consistent substantial compliance has been achieved as determined by the committee. audit results will be shared with the Resident Council on 6-15-2023 for comment and suggestions.	

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she was in the bed to deter her from getting up and risk falling at night. She admitted she had not asked Resident #43 if she agreed with wearing the chair alarm or if it bothered her to do so.

An interview with the Director of Nurse (DON) and the Registered Nurse (RN) Supervisor on 4/18/23 at 1:15 PM, both nurses confirmed that Resident #43 had a body alarm on at all times because the resident's granddaughter insisted she have one after a fall on 3/31/23 and related to confusion on admission, not always using the call light, and she would get up unassisted at night but both nurses confirmed that she is much better now. The DON and RN Supervisor stated that the body alarm would be considered a restraint because it does restrict Resident # 43's movement in the chair and the bed. The RN supervisor confirmed Resident # 43 can turn and reposition herself in the bed and chair and confirmed that there was no physician's order for the body alarm, nor had there been a restraint assessment or consent completed. The DON confirmed that the use of a device restricting movement could cause withdrawal from activities or socialization and cause a decrease in the resident assisting herself.

An interview with the Social Services on 4/18/23 at 2:18 PM, revealed that a restraint restricting a resident's movement could cause anxiety, decrease the desire to do things for themselves and they may isolate themselves to their room.

An interview with the DON on 4/19/23 at 1:59 PM, she revealed Resident # 43 sometimes transfers with handheld assistance and other times may need extensive assistance for transfers.

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F 604	Continued From page 17 An interview with the Physical Therapist (PT) on 4/19/23 at 2:47 PM, revealed Resident # 43 can walk 150 feet with a rolling walker and that she required a lot of cueing related to left side impairment. PT stated she is riding the new step bike to strengthen her motor control and is extensive assist of one for transfers. An interview with the Speech Therapist (ST) on 4/19/23 at 2:49 PM, revealed Resident # 43 is alert and oriented at this time, and confirmed she was alert and oriented at the time of admission. Record review of the Face Sheet revealed that the facility admitted Resident # 43 to the facility on 2/07/23 with diagnoses of Hemiplegia following cerebral infarction affecting left side, Pulmonary Embolism without acute core pulmonale, Dizziness and giddiness, and Unspecified abnormality of gait. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) on 2/11/23, revealed that Resident # 43 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated that she was cognitively intact.	F 604		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		6/9/23

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F 656	Continued From page 18 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and	F 656	1. What corrective action will be	

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F 656	Continued From page 19 facility policy review the facility failed to develop a care plan for a resident who wanders, failed to develop a care plan for a resident with the use of a body alarm, and failed to implement a positioning care plan for a resident for three (3) of 24 residents reviewed for care plans. Resident #2, Resident #36, and Resident #43. Findings Include: A record review of the facility's policy titled, "Care Plans" updated 2/03/23, revealed "Policy: Each resident will have a person-centered plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care ...Definitions: Care plan- contains resident problems/needs/strengths, Resident goals and interdisciplinary approaches ...Resident Care Summary- part of the Comprehensive Care plan and used as the tool to make staff aware of the resident's care needs as ADL (Activity of Daily Living) care plan ..." Record review of the facility care plan, titled, "TURNING AND POSITIONING POLICY", with no date revealed, "All residents will be ...positioned as per the plan of care..." Resident #2 Observation on 4/17/23 at 2:46 PM, revealed Resident # 2 lying in bed, propped on her left side. Her heels were not elevated and there were no heel booties in place. In an observation and interview on 4/17/23 at 5:30 PM, with Licensed Practical Nurse (LPN) # 1 she verified that Resident #2 should have had her heels floated and heel booties on and that not	F 656	accomplished for those residents found to have been affected by to he alleged deficient practice? Care plan of Resident #36, #43 and #2 were reviewed and corrected as indicated on 5-11-2023 by the Minimum Data Sets coordinator. 2. Steps taken to identify other residents having the potential to be affected by the same alleged practice? The facility has determined that any resident in the facility has the potential to be affected by this alleged practice. 3. What measures will be put in place or systematic changes made to ensure that the deficient practice will not recur? An in-service education was conducted by the Administrator on Care plans to the interdisciplinary team on 5-11-2023 on the policy and procedure regarding care plans. A In-service on 5-11-2023 was also provided to all nursing staff on the importance of following the plan of care as outlined in the residents chart. An audit was completed on 5-15-2023 by the MDS coordinator to ensure all residents have Comprehensive Care Plans. 4. Monitoring the corrective actions (Quality Assurance Program) to ensure. that the alleged deficient practice does not recur? Beginning 5-15-2023 Care plans will be reviewed weekly in accordance with the	

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F 656	Continued From page 20 having them on could result in pressure ulcers. Record review of Resident #2's Care Plan, with a start date of 7/1/2019, revealed "Care Plan Description, PRESSURE: I AM AT RISK FOR PRESSURE ULCER DUE TO INCONTINENCE, DECLINE IN ADL (Activities of Daily Living) FUNCTION, DEMENTIA & ALZHEIMER'S, Care Plan Goal: Skin will remain intact thru the next review date... Intervention ...FLOAT HEELS WHILE IN BED, ENSURE HEEL BOOTIES ARE IN PLACE WHILE IN BED ..." An interview with the DON on 4/19/23 at 1:59 PM, revealed the purpose of the care plan is to guide care for each resident. Record review of Resident #2's Face Sheet revealed, she was admitted to the facility on 8/21/17 with diagnosis included Alzheimer's disease, unspecified, Ankylosing spondylitis of unspecified sites in spine. A record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/27/2023, the Brief Interview for Mental Status (BIMS) score is 9, indicating impaired cognition and Functional Status for bed mobility is extensive assistance of two staff members. Resident #36 An observation on 04/18/23 at 9:15 AM, revealed Resident #36 was sitting in his wheelchair at the exit door to the lobby of the nursing facility informing staff that he needed to go outside to find his car. Staff were observed to redirect Resident #36 away from the main door to the lobby to allow visitors to enter the hallway to the	F 656	care plan review schedule by the MDS Coordinator on an ongoing basis. All care plans will be updated as indicated. The director of Nursing or RN supervisor will complete weekly audits of care plans for 5 residents for 6 consecutive weeks. Audits will be completed to ensure that care plans are developed appropriately for residents. Beginnning June 9th, 2023 Audit records will be reviewed by the Risk Management/Quality Assurance Committee for 6 months or until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident Council on June 15th, 2023 for comment and suggestions.	

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F 656	Continued From page 21	F 656		

nursing facility.

An observation on 4/18/23 at 9:30 AM, revealed Resident #36 was in his wheelchair wandering aimlessly throughout the building and was observed to make two (2) trips, back-to-back, from the nurse's desk, and back up the hall to one of the side exit doors to sit and look outside.

An interview on 4/19/23 at 1:45 PM, with Social Services revealed she did not do a care plan for the resident being a wanderer. She confirmed that she did not think he should have been care planned as a wanderer because he did not exhibit exit seeking behaviors while wandering.

An interview on 4/19/23 at 3:01 PM, with the Registered Nurse (RN) Supervisor revealed , that she did not think that a care plan had been developed for his wandering behavior.

Record review of the care plan for Resident #36 revealed there was not a care plan for wandering behaviors.

An interview on 4/19/23 at 4:40 PM, with the Director of Nursing (DON), revealed Resident #36 did wander aimlessly daily. She also revealed that he should have a had a wandering care plan done to ensure all staff were aware of his behaviors and need for staff to monitor him for his safety.

Record review of the "Face Sheet" for Resident #36 revealed an admission date of 12/19/17 and diagnoses of Unspecified Dementia, Unspecified Severity, with Behavioral Disturbance, Anxiety Disorder, Unspecified, Restlessness and Agitation.

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Record review of the Minimum Date Set (MDS) with an ARD of 2/22/23 revealed a BIMS score of 10 indicating Resident #36 had moderate cognitive impairment.

Resident #43

During an interview and observation with Resident #43 on 4/17/23 at 1:43 PM, the State Agency (SA) asked the resident why she had a body alarm clipped to the back of her blouse. She revealed the staff put it on her because she had a couple of falls when she came into the facility.

An interview on 4/18/23 at 10:00 AM, with Certified Nurse Aide (CNA)#1, revealed Resident # 43 was to wear the chair alarm all the time while up in the wheelchair to detour her from wanting to stand up and risk falling.

An interview with the Director of Nurse (DON) and the Registered Nurse (RN) Supervisor on 4/18/23 at 1:15 PM, both nurses confirmed that Resident #43 has a body alarm on.

An interview with the DON on 4/19/23 at 1:59 PM, revealed the purpose of the care plan is to guide care for each resident and revealed the alarm device should have been on the fall care plan and confirmed that a care plan had not been developed for the chair alarm device.

A review of Resident #43's care plan titled, "I HAD A FALL ON 02/23/23, 03/31/23" with a start date of 2/23/23, revealed no documentation of a body alarm, and further review of all care plans also revealed no use of a body alarm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255305	A. BUILDING _____ B. WING _____	04/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER PLACE NURSING CENTER	1126 EARL FRYE BOULEVARD, SOUTH AMORY, MS 38821

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 23 Record review of the Face Sheet revealed that the facility admitted Resident # 43 to the facility on 2/07/23 with diagnoses that included Hemiplegia following cerebral infarction affecting left side and Dizziness and giddiness unspecified abnormality of gait. Record review of the Minimum Data Set (MDS) Section C with an ARD on 2/11/23, revealed that Resident # 43 had a BIMS score of 14 which indicated that she was cognitively intact.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to apply heel booties and float heels while in bed for one (1) of 24 residents reviewed. Resident #2 Findings include: Record review of the facility policy, "TURNING AND POSITIONING POLICY", with no date, revealed "All residents will be...positioned as per the plan of care...Procedure:...2. Charge Nurse is responsible for visually observing...positioning as needed..."	F 684	1. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? The facility failed to ensure that staff placed heel booties or floated heels of resident # 2. Certified Nursing Assistand immediately placed heel booties on Resident #2. Resident #2 was assessed by the	6/9/23

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F 684	Continued From page 24 An observation on 4/17/23 at 2:46 PM, revealed Resident # 2 lying in bed, propped on her left side. Her heels were not elevated and there were no heel booties in place. In an observation and interview with Certified Nursing Assistant (CNA) # 2 on 4/17/23 at 5:26 PM, she verified that Resident #2 did not have her heels floating or have heel booties in place. CNA #2 verified that Resident # 2 should have had heels floating and have heel booties in place. She stated that Resident #2's right heel "bothered" her and if Resident #2 did not have the heel booties in place she could get a sore. CNA # 2 stated that she used the kiosk to know what interventions the residents need. In an observation and interview on 4/17/23 at 5:30 PM, with Licensed Practical Nurse (LPN) # 1 she verified that Resident #2 should have had her heels floated and heel booties on and that not having them on could result in pressure ulcers. She stated that the CNAs were responsible for ensuring these interventions were in place. LPN # 1 stated that the interventions trigger on the electronic Treatment Administration Record (eTAR) for the nurse to check to be sure that they are in place. She stated that the treatment nurse checks on day shift, and the floor nurses check during the evening and night. In an interview with the Director of Nursing (DON) on 4/17/23 at 5:35 PM, she stated that the CNA who put the resident back to bed should have made sure the heel booties were in place. An interview with Treatment Nurse on 4/19/22 at 8:15 AM, verified that she checks the residents	F 684	Nursing Supervisor on 4-17-2023. There were no adverse outcomes identified By this alleged deficient practice. 2. Steps taken to identify other residents having the potential to be affected by the same alleged practice? The facility has determined that all residents that have movement limitations have the potential to be affected. 3. What measures will be put in place or systematic changes made to ensure that the deficient practice will not recur? On 5-12-2023 facility nursing staff including Nurses and CNA's was in -serviced by the DON and RN supervisor on the facility policy of prevention of pressure ulcers and the importance of placing heel booties on residents to prevent pressure ulcer. 4. Monitoring the corrective actions (Quality Assurance Program) to ensure that the alleged deficient practice does not recur? Beginning 5-15-2023 The Director of Nurses, Staff development nurse or RN supervisor will complete weekly checks of residents requiring heel booties ensuring booties are in place. This will be done twice weekly for 4 weeks, weekly	

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F 684	Continued From page 25 when she comes in in the morning to make sure that heels are floated, and heel booties are in use. She stated that she signs off the eTAR for the day shift and the floor nurses check them and signs off the eTAR for the evening and night shift. She stated that floating heels and use of heel booties were used to prevent pressure ulcers. An interview with the DON on 4/19/23 at 2:45 PM, she verified that failure to provide these interventions could result in a pressure ulcer. Record review of the April 2023 Physician Orders revealed an order dated 9/2/22 "Float heels in bed." Record review of Resident #2's eTAR revealed FLOAT HEELS IN BED, with an onset date of 9/2/22, and ENSURE HEEL BOOTIES ARE IN PLACE WHILE IN BED, with an onset date of 11/13/22. The AM shift was initialed indicating the heel booties were in place and heels were floated. Record review of Resident #2's Face Sheet revealed, she was admitted to the facility on 8/21/17 with diagnoses that included Alzheimer's disease, unspecified, Ankylosing spondylitis of unspecified sites in spine. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/27/2023 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of nine (9), indicating impaired cognition and review of Section G indicated functional status for bed mobility is extensive assistance of two staff.	F 684	for 4 weeks and monthly for three months to ensure compliance. Beginning June 9th, 2023 Audit records will be reviewed by the Risk Management/Quality Assurance Committee for 6 months until such time consistent substantial compliance has been achieved as determined by the committee. Audit results will be shared with the Resident/Family Group Council for comment and suggestions.	