STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255226	A. BUILDING _____ B. WING _____	05/24/2023

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NATCHEZ REHABILITATION AND HEALTHCARE CENTER	344 ARLINGTON AVENUE NATCHEZ, MS 39120

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey along with a complaint investigation MS CI#20780 from 05/21/2023 through 05/24/2023. During the survey, the SA determined that the facility was not in compliance with the requirements for participation in Medicare and Medicaid.The SA cited deficiencies F656, F677, F684, F695, and F812. The SA did not identify deficient practice related to MS CI#20780 for alleged misappropriation. The facility was licensed for 58 beds and had a census of 52 at the time of the survey.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		7/1/23

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

Electronically Signed | 06/12/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 656	Continued From page 1 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 observation, interview, record review, and facility policy review the facility ailed to implement the comprehensive care plan related to oral hygiene and positioning for one (1) of 15 sampled Residents. Resident #35 Findings Include: Review of the facility policy titled, "Care Plans, Comprehensive Person-Centered," revealed "A comprehensive, person centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented	F 656	Preparation and submission of this plan of correction by Natchez Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws. 1. On 5/23/23, the Director of Nursing revised Resident #35's care plan to	

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F 656	Continued From page 2 for each resident. The facility failed to develop a care plan for hand rolls for a resident with bilateral upper extrememity and hand contractures. Review of the resident's care plan revealed no care plan for hand rolls. Observation on 05/21/23 at 02:54 PM revealed contractures of bilateral upper extremities. The resident's fingers and hand were bent in toward the wrist. Nails were short and not pushing into the hand of the resident. No open areas noted. No hand rolls in hands. Resident nods when asked if she would like to use a hand roll for the contractures in bilateral upper extremities (BUE). Observation with Resident #35, Director of Nurses (DON), and Charge Nurse on 05/22/23 at 01:57 PM revealed Resident was observed with contractures bilaterally. When the resident was asked about hand rolls she nodded yes, she would like hand roles. On 05/23/23 at 09:43 AM, an interview with the occupational therapist (OT) revealed resident wore "hand roles" for a while but that she when she was readmitted from hospital the hand rolls were not restarted. He stated the resident used to wear the hand rolls from late evening through the night. He says she has not been wearing them lately. Review of Resident #35's care plan revealed the facility failed to implement the care plan for personal hygiene. Care Plan review revealed "Resident is at risk for	F 656	include hand rolls for comfort due to contractures. On 5/23/23, the Director of Nursing revised Resident #35's care plan to increase oral care from every shift to every 4 hours. On 5/23/23, Director of Nursing revised Resident #35's care plan to increase grooming to 3 days per week. On 5/24/23, the Director of Nursing in-serviced the Minimum Data Set Nurse on ensuring all changes in resident's care are addressed on the resident specific care plan. Going forward, during the morning clinical meeting the interdisciplinary clinical team will review and revise comprehensive care plans for new admissions to discuss resident specific care needs. 2. 15 residents had the potential to be effected by inaccurate care plans. 3. From 5/25/23 through 5/26/23, the Director of Nursing and Minimum Data Set Nurse conducted an audit of all residents' care plans for accuracy and to ensure all residents' care needs were reflected. Those found not to be accurate were updated immediately. On 5/23/23, the Director of Nursing began in-services with clinical staff on developing/revising care plans to ensure accuracy of cares plan including goals, interventions and implementation. 4. Beginning 6/7/23 the Minimum Data Set Nurse will audit three (3) residents care plans and monitor direct care staff to validate care plan is being updated and implemented. Any deficient practices will be reported to the Director of Nursing immediately and addressed accordingly. Audits and observations will be conducted	

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F 656	Continued From page 3 complications r/t almost totally dependent on staff for all her ADLs (Activities of Daily Living) following CVA (stroke)". Observation on 05/21/23 at 02:49 PM revealed Resident #35 had mouth odor present. Teeth and mouth had build up of white sticky substance. Observation revealed approximate 0.5 inch of hair growth on chin. Interview with Resident #35 on 05/21/23 at 02:49 PM revealed she was interviewable by nodding and shaking head to yes and no questions. The resident nodded yes that she would like her mouth cleaned. On 05/22/23 at 09:50 AM, observation revealed Resident's mouth remained coated with white sticky substance and hairs remained on chin. Resident nodded when asked if she would like her mouth clean. Resident shook her head when asked if she likes to leave hairs on chin. On 05/22/23 at 01:57 PM, observation revealed resident's chin had been shaved. Record review of the Minimum Data Set (MDS) reviewed an Brief Interview for Mental Status score of 99 and was coded as responds adequately to simple direct communication only. Interview with DON revealed care plan should be followed. The DON stated the resident was under PT currently since returning from the hospital. She stated restorative would pick up once the resident comes off the PT schedule.	F 656	weekly for four (4) weeks, then monthly for two (2) months. The Minimum Data Set Nurse will submit a report to Quality Assurance Performance Improvement Committee for review and recommendations on June 27, 2023 and monthly thereafter for three (3) months. The Director of Nursing is responsible for monitoring and compliance.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		7/1/23

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F 677	Continued From page 4 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide mouth care for a dependent resident for one (1) of 15 sampled residents. Findings Include: Review of the facility's policy titled, "Activities of Daily Living (ADL), Supporting", revised March 2018, revealed, "Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene." Observation on 05/21/23 at 02:49 PM revealed Resident #35 had mouth odor present. Teeth and mouth were not clean as evidenced by the resident's mouth had build up of white sticky substance. Observation also revealed approximate 0.5 inch of hair growth on chin. Interview with Resident #35 on 05/21/23 at 02:49 PM revealed she was interviewable by nodding and shaking head to yes and no questions. The resident nodded yes that she would like her mouth cleaned. On 05/22/23 at 09:50 AM, observation revealed Resident's mouth remained coated with white sticky substance and hairs remained on chin. Resident nodded when asked if she would like	F 677	1. On 5/22/23, shaving and oral care were provided to Resident #35 by Certified Nursing Assistant assigned to her care. On 5/23/23, the Director of Nursing revised Resident #35's care plan to increase oral care from every shift to every 4 hours. 2. 32 residents had the potential to be effected by this deficient practice. From 5/25/23 through 5/26/23 the Director of Nursing and Mimimum Data Set Nurse audited current residents' care plans and care cards to ensure oral care needs were reflected. Care plans that did not reflect current oral care needs were immediately corrected. On 5/22/23, physical observations were made by the Director of Nursing and RN Charge Nurse on the other 31 dependent residents for grooming and oral care needs. No other issues were noted. 3. On 5/23/23, the Director of Nursing in-serviced nursing staff on ensuring residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living. 4. Beginning 6/7/23 Registered Nurse Supervisors will monitor oral care being performed on two (2) residents per day per unit daily for one (1) week, weekly for	

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F 677	Continued From page 5 her mouth clean. Resident shook her head when asked if she likes to leave hairs on chin. On 05/22/23 at 01:57 PM, observation revealed resident's chin had been shaved. Interview, on 05/22/23 at 01:57 PM, with the Director of Nurses, DON, and Charge Nurse revealed resident's chin had been shaved this morning and mouth care had been provided. The charge nurse nodded that the care had been provided. The DON stated mouth care must be done frequently because the resident drools and requires and towel to prevent the soaking of the resident's clothing. Observation revealed towel present to protect clothing. Record review of the Minimum Data Set (MDS) reviewed an Brief Interview for Mental Status score of 99 and was coded as responds adequately to simple direct communication only.	F 677	one (1) month. Any deficient practices will be reported to the Director of Nursing immediately and addressed accordingly. A report will be submitted to the Quality Assurance Performance Improvement Committee by the Director of Nursing for review and recommendation on June 27, 2023 and then monthly thereafter for three (3) months. The Director of Nursing is responsible for monitoring and compliance.	
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, interview, and record review, the facility failed to provide positioning hand rolls for a dependent resident with	F 684	1. On 5/23/23, hand rolls were placed in Resident #35's bilateral hands by the Certified Occupational Therapist	7/1/23

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F 684	Continued From page 6 contractures for one (1) of 15 residents sampled. Findings Include: Observation on 05/21/23 at 02:54 PM revealed contractures of bilateral upper extremities. The resident's fingers and hand were bent in toward the wrist. Nails were short and not pushing into the hand of the resident. No open areas noted. No hand rolls in hands. Resident nods when asked if she would like to use a hand roll for the contractures in bilateral upper extremities (BUE). Observation with Resident #35, Director of Nurses, and Charge Nurse on 05/22/23 at 01:57 PM revealed Resident was observed with contractures bilaterally. The DON and Charge nurse stated the resident does not want roles placed in hands for positioning. When the resident was asked about hand rolls she nodded yes, she would like hand roles. The DON stated previously she did not like the type of roles in hands but that maybe a different type could be used. The resident nodded. The DON stated she was going to tell PT of the resident's wishes. On 05/23/23 at 09:43 AM, an interview with the occupational therapist (OT) revealed resident wore "hand roles" for a while but that she when she was readmitted from hospital the hand rolls were not restarted. He stated the resident used to wear the hand rolls from late evening through the night. He says she has not been wearing them lately. On 05/23/23 09:48 AM, an interview with Physical Therapist (PT), revealed the facility has a restorative program with the CNAs, The program has check offs for the CNAs to do and stated that	F 684	Assistant. 2. 15 residents had the potential of being effected by this deficient practice. 3. On 5/23/23, the Director of Nursing began in-services with clinical staff on applying positioning devices and checking skin integrity. 4. Beginning 6/7/23 the Director of Nursing and Rehab Director will maintain a contracture managment worksheet to be reviewed in clinical standards each week to ensure residents with splints/contractures have been properly evaluated and screened with a corresponding care plan put in place. Any deficient practices will be reported to Director of Nursing and immediately and addressed accordingly. Observations will be conducted weekly for four (4) weeks, then monthly for two (2) months. The Director of Rehab will submit a report to Quality Assurance Performance Committee for review and recommendations on June 27, 2023 and monthly therefore for three (3) months. The Director of Nursing is responsible for monitoring and compliance.	

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F 684	Continued From page 7 Nursing is over the restorative program. The last restorative training provided by PT for the CNA staff was on 4/20/23 and this is completed annually. When asked if Resident #35 is gotten up out of bed, PT stated they are a awaiting a special wheelchair for her to be able to get up. The chair has been ordered with a Medical Supply. The facility was unable to provide an order request for the wheelchair. On 05/23/23 at 10:00 AM, an observation revealed the resident with hand role "carrot role" in right hand. No role was observed in left hand. Review of the resident's Minimum Data Set (MDS) with assessment reference date (ARD) of 3/17/23 revealed under Section G that resident was extensive assist and totally dependent on staff for positions and mobility. The resident Brief Interview for Mental Status (BIMS) score was 99.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Resident #42	F 695	1. On 5/23/23, Director of Nursing obtained physician order for Resident #42	7/1/23

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F 695	Continued From page 8 Respiratory Care Based on observation, record review, and staff and resident interview, the facility failed to provide respiratory care consistent with professional standards of practice as evidence by a resident receiving oxygen therapy with no physician's order, monitoring or plan of care for one (1) of 15 sampled residents. Resident #43 Findings Include: An observation and interview on 05/22/23 at 03:20 PM revealed Resident #43 lying in bed with bilateral nasal cannula in nares, oxygen concentrator on administered at 2.5 Liters(L). Resident #43 noticed my observation of concentrator setting and commented the setting should be on 1.5L. A record review of Resident # 42's most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 04/23/2023 revealed in Section O regarding O2 use, the resident was marked as not receiving O2 therapy. A record review of Resident #42's cumulative Physician's orders with an order review date of 04/15/2023 revealed the resident did not have an physician's order for the use of O2. A record review of Resident #42's care plan revealed the resident did not have a care plan related to O2 therapy. An Interview on 05/22/23 at 02:20 PM with Resident # 42 revealed she had been using O2 mostly just at night to assist with breathing. Resident #42 stated she believes she has sleep apnea but has never had a sleep study. When	F 695	stating oxygen at 2 liters per minute via nasal cannula at bedtime. Minimum Data Set nurse revised Resident #42's care plan to reflect her use of oxygen at bedtime. 2. 9 residents had the potential to be effected by this deficient practice. 3. On 5/23/23, Corporate Clinical Specialist conducted an Oxygen System Audit to ensure accuracy of all physician orders, care plans, and equipment for residents using oxygen. Any necessary corrections were made immediately.On 5/23/23, Director of Nursing conducted an in-service with all nursing staff on guidelines for safe oxygen administration. 4. Beginning on 6/7/23, the Medical Records Director will conduct an audit by observation of three (3) residents with orders for oxygen therapy, weekly for four (4) weeks, then monthly for two (2) months to validate all residents using oxygen have appropriate order, care plan, and equipment. The Medical Records Director will report findings to the Quality Assurance Performance Improvement Committee on 6/27/23 and monthly thereafter for three (3) months for review and further recommendations. The Director of Nursing is responsible for monitoring and compliance.	

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F 695	Continued From page 9 asked about who puts the O2 on and sets the concentrator rate, Resident #42 stated she does it herself and uses every night to help her sleep. An Interview on 05/23/23 at 11:20 AM with LPN #1 revealed she was aware Resident utilizes O2 at night when she has shortness of breath and it helps her sleep. An Interview on 05/23/23 at 11:42 AM with Registered Nurse (RN) #2 and the Director of Nursing (DON) revealed they were unaware the resident was using O2. The DON stated the resident's order for O2 was discontinued. Neither were aware the resident continued to use the O2. Both agreed there were no orders for the use of O2 and the resident was not being monitored for use of O2. Interview on 05/23/23 at 11:55 PM with the MDS nurse confirmed the resident was not assessed as using O2 and no care plan was developed for the use of O2. A record review of Resident # 42's most recent quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 04/23/2023 revealed the resident had a brief interview for mental status (BIMS) score of 15 and the resident was admitted by the facility on 01/03/2023 with active diagnoses including Morbid (SEVERE) Obesity with Alveolar Hypoventilation and Peripheral Vascular Disease.	F 695		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		7/1/23

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F 812	Continued From page 10 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: FACILITY Kitchen Based on observation, interview, and facility policy review, the facility failed to ensure supplemental nutritional shakes were thawed in a manner to prevent potential foodborne illness. This deficient practice had potential to affect four (4) of 4 residents who received nutritional shake supplements of 52 residents in the facility. Findings Include: A review of the Facility's Policy titled "Food: Preparation" states the cook(s) will thaw frozen items using one of the following methods: thawing in the refrigerator, in a drip-proof container, and in a manner that prevents cross-contamination; thawing the item in a microwave oven then transferring immediately to	F 812	1. On 5/21/23, Dietary Staff/Manager immediately discarded all improperly stored Mighty Shakes. 2. The only residents with the potential to be affected were the four (4) residents with orders for Mighty Shakes. 3. Beginning 5/22/23, the Dietary Manager and District Manager in-serviced all dietary staff on proper procedure for preparation and storage of foods and house shakes. 4. Effective 6/7/23, Dietary Manager will conduct audits on kitchen proper procedure for preparation and storage of foods and house shakes. (3) times a week for (4) weeks, Then once (1) a week for (4) weeks, then monthly thereafter for (3) months. The report of the audits will be reviewed by the Administrator and brought to the Quality Assurance Performance	

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	255226	A. BUILDING _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATCHEZ REHABILITATION AND HEALTHCARE CENTER	344 ARLINGTON AVENUE NATCHEZ, MS 39120

(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 812	Continued From page 11	F 812		

conventional cooking equipment; completely submerging the item under cold water (at a temp of 70 degrees Fahrenheit) or below that is running fast enough to agitate and float off loose ice particles; cooking directly from the frozen state, when directed.

An observation on 05/21/23 at 02:35 PM during the Initial Brief Tour of the kitchen revealed approximately 24 tray of supplemental shakes, strawberry flavor, on a tray on a shelf in kitchen. The shakes were thawed and sitting at room temperature, about 84 degrees as read on thermometer.

An interview with Dietary Staff (DS) #1 at 2:55 PM revealed another dietary staff person (DS #2) had pulled the shakes out to thaw and placed them on the tray prior to her leaving after the lunch meal. DS #1 stated he was supposed to put them in the refrigerator and forgot. DS #1 calibrated thermometer to 32 and tested temperature of one the shakes. The shake temperature was 69 degrees. DS #1 stated he was going to throw the shakes out as the temperature was too high for them to be served. He again stated they should have been in the refrigerator until serving time.

A review of facility listing of therapeutic diets revealed four of 52 residents in the facility were prescribed supplemental Mighty Shakes.

An interview on 05/22/23 @ 3:00PM with DS #2 confirmed she was the person who took the Mighty shakes out freezer to thaw. DS #2 states she put them on a tray and told DS #1 to put the tray in the refrigerator to thaw. DS#2 stated the normal way they thaw shakes is by putting them on a tray in the refrigerator and the milkshakes

Improvement Committee on 6/27/23 for review and then once (1) monthly for (4) months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255226	A. BUILDING _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NATCHEZ REHABILITATION AND HEALTHCARE CENTER	344 ARLINGTON AVENUE NATCHEZ, MS 39120

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F 812	Continued From page 12 should be stored in refrigerator until time to serve. DS #2 , stated if shakes were too warm they may cause residents to have stomach upset, or could make them sick. DS #2 estimated the shakes were taken out between 11:30AM to 12:00PM DS #2 stated shakes should not have temp above 41 as they contain milk.	F 812		