STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255114	A. BUILDING _____ B. WING _____	C 06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEVELAND NURSING AND REHABILITATION CENTER	4036 HIGHWAY 8 EAST CLEVELAND, MS 38732

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F 000	INITIAL COMMENTS The State Agency (SA) conducted a complaint investigation CI MS# 21683 at the facility from 6/14/23 through 6/15/23. 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 F580 for CI MS# 21683 for Notification of Changes. The census at the time of the survey was 109 with a bed capacity of 120 beds.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		7/25/23

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

Electronically Signed | 06/29/2023

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F 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to timely notify a family of the death of a resident, for one (1) of five (5) residents reviewed for notification of change in condition. Resident #1 Findings include: Record review of a statement on facility letterhead dated 6/15/23 and signed by the Administrator revealed, "Facility does not have policy that speaks to notification of family regarding significant changes in for resident that	F 580	1. Resident #1 Expired 5/27/2023. Facility failed to notify resident #1 Representative of resident's change in condition/death. 2. All resident's have the potential to be affected. 3. The Director of Nurses in-serviced all licensed nurses on 6/19/2023 regarding notification of change in resident's	

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F 580	Continued From page 2 are their own responsible party." During the entrance conference interview on 6/14/23 at 02:55 PM, with the Administrator revealed the nursing facility did not have access to any contact information for Resident #1's family, that the facility did ask (local funeral home) to pick up Resident #1's body on 5/27/23. She noted she received a call from the funeral home director on 5/30/23, and was told family had called the funeral home upset regarding not being notified but she was not aware of how family was contacted regarding Resident #1's death. A telephone interview on 6/14/23 at 4:20 PM with the Funeral Home Director revealed he was the one who picked up Resident #1's body from the nursing home on Saturday, 5/27/23, at the facility's request. He also revealed that he was informed by the nursing facility that there was no family available nor contact information for family members. He shared information regarding receiving a call from a female family member for Resident #1 on 5/30/23, and the family member stated she had just been informed by the nursing facility that Resident #1 had expired. An interview on 6/15/23 at 10:35 AM, with Social Services, revealed that she only used the Face Sheet to look for family contact numbers for a resident. She also revealed that she did not attempt to read the hospital social worker's notes from the referring facility to attempt to find contact information. She noted she had called the staff member at Resident #1's former placement facility and was told they did not have any contact numbers for family. She denied calling the hospital social worker that referred Resident #1 to	F 580	physical, mental or psychosocial status. The admissions coordinator, Business Office Manager and Social workers were in-serviced on ensuring resident's family contact is added to the face sheet on 6/19/2023. A 100% audit to resident' face sheet was conducted on 6/17/2023 to ensure all resident's have family contact by social service. 4. The Director of Nurses will conduct audits to ensure that notification of Resident's representative were notified timely of any change in condition starting 6/27/2023, five times a week x eight weeks. The Business Office Manager will audit all new admits to ensure family contact listed on face sheet weekly times eight weeks starting 6/27/2023. Any concerns will be addressed immediately by the Director of Nurses. Results of the audit will be forwarded to the Executive Director starting 7/3/2023. The Executive Director will forward results of the audits for notification of resident's representative timely of change in condition and that the family contact was added to the face sheet to the Quality Assurance Committee monthly starting 7/17/2023 times three months.	

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the nursing facility to inquire for family contact information.

A telephone interview on 6/15/23 at 11:15 AM, with the Hospital Social Work Supervisor revealed she had spoken with the Admission Coordinator for the nursing facility and provided contact information for Resident #1's mother prior to Resident #1 leaving the hospital for admission to the nursing facility.

A telephone interview on 6/15/23 at 11:19 AM, with Resident #1's Mother revealed she had spoken with Resident #1 on several occasions while in the nursing facility. She noted she received a call from the nursing facility two (2) weeks after Resident #1 was admitted and she thought it was a social worker who called her. She revealed that the nursing facility called her on the 5/30/23, after Resident #1 passed away on 5/27/23, and told her that the nursing facility had sent her body to the funeral home because they had no telephone number to call family until that day.

A telephone interview on 6/16/23 at 11:59 AM, with Resident #1's Sister revealed she had spoken with Licensed Practical Nurse (LPN) #1 on 5/30/23, after Resident #1 passed away. She revealed LPN#1 told her there were no contact numbers in the chart for family and that she had just gotten a contact number for the mother on that day. She also noted there had also been family calls made to the nursing facility to follow up on how Resident #1 was doing. She shared that LPN#1 told her that Resident #1 had been sent to the funeral home. The Sister revealed she did talk with the funeral home director, and he told her the funeral home had Resident #1's body

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because they were called by the nursing facility to provide the funeral services, due to there being no family available.

An interview and record review on 6/15/23 at 11:35 AM, with the Admission Coordinator revealed she had spoken with the Hospital Social Work Supervisor, and she did not give her a contact number for the mother of Resident #1. She noted she was informed by the Hospital Social Work Supervisor that they had not spoken to any family members and had no way of calling any family for Resident #1. SA reviewed a copy of the documentation for the social worker from the hospital's medical record with the Admission Coordinator and she confirmed she had received it in the referral packet for Resident #1. The record review revealed the hospital social worker had spoken with Resident #1's mother twice over the telephone regarding discharge planning. The Admission Coordinator confirmed the she did not know that information was in the medical record and that she did not review the documentation when the referral was submitted.

An interview on 6/15/23 at 12:00 PM, with Licensed Practical Nurse (LPN)#1 revealed she spoke with Resident #1's mother and sister on 5/30/23, and informed them that Resident #1 expired on 5/27/23, and she was transported to the funeral home on that date. She noted there was no contact information for family members in the medical record and had received the telephone number, for Resident #1's mother, on 5/30/23, from the Business Office Manager (BOM).

An interview on 6/15/23 at 01:16 PM, with the BOM revealed she had obtained Resident #1's

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mother's telephone number from Resident #1 prior to Resident #1's death. She noted she did not add the telephone number to the medical record because she did not ask for Resident #1's permission to do so. She also noted she did not communicate having the telephone number with the Social Worker to allow her to assist in getting the telephone number added to the medical record.

An interview on 6/15/23 at 1:30 PM, with the Administrator confirmed she was aware on 5/30/23 that the BOM provided Resident #1's mother's telephone number to LPN #1, that LPN #1 had contacted the family to inform them of Resident #1's death and transport of her body to the funeral home on 5/27/23. She confirmed the BOM did not communicate having the contact number to any other staff members. The Administrator confirmed the facility failed to timely notify Resident #1's family of her death.

Record review of the "Billing Notes" for Resident #1 revealed "5/17/23 ... Noted by: (BOM)...I have spoken with (Resident #1) and she gave me the mother's number ... I called and spoke with (Resident #1's mother)."

Record review of the "Departmental Notes" for Resident #1 revealed "5/27/23 3:03 PM ... 2:36 PM CPR (cardio-pulmonary resuscitation) STOPPED BY EMS (Emergency Medical Services). 2:40 MD (Medical Doctor) NOTIFIED OF RESIDENT EXPIRED ... UNABLE TO REACH RP (Responsible Party) DUE TO NO FAMILY LISTED ... INFORMATION GIVEN TO TRANSFER BODY TO FUNERAL HOME ... FUNERAL HOME HERE TO TRANSPORT BODY."

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F 580	Continued From page 6 Record of the "MORTICIAN RECORD/RECORD OF DEATH" dated 5/27/23, for Resident #1, revealed "Date of Death: 5/27/23 ... Name of Person Notified/Relationship: Unable to Reach. No RP (Responsible Party) listed ..." Record review of the "Face Sheet" for Resident #1 revealed an admission date of 1/10/23 and diagnoses of Human Immunodeficiency Virus (HIV) Disease, Hyperlipidemia, Unspecified, Hyperkalemia, and Essential (Primary) Hypertension.	F 580		