STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255289	A. BUILDING _____ B. WING _____	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CHASE VILLAGE	5090 GAUTIER VANCLEAVE ROAD GAUTIER, MS 39553

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F 000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey at the facility from 6/19/23 through 6/22/23. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and deficiencies were cited at F578, F656, F692, F698, F761, and F925. The facility had a census of 59, and held a license for 60 beds.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still	F 578		7/20/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/10/2023

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F 578	Continued From page 1 legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy review, and staff interview, the facility failed to ensure the residents that do not have an Advanced Directive (AD) received information or assistance in formulating an AD for four (4) of 24 resident records reviewed. Resident #1, #8, #44, and #47 Findings include: Record review of the facility policy titled "Advance Directive" dated 2/26/19, revealed information about whether the resident has executed an advance directive shall be maintained in the medical record. The plan of care for each resident will be consistent with his or her documented treatment preference and/or advance directive. Advance directives will be reviewed at least annually with the resident and/or resident's representative by the Social Service Director and/or Registered Nurse to ensure that such advance directives are still the wishes of the resident. The Growth (Care) Plan Team will be	F 578	The following plan of correction is not intended to be an admission of guilt or used for any purpose other than the purpose stated herein. 1. On 6/16/2023 Admission Packet was revised to include Patient Self Determination Act- Mississippi Advanced Health Care Directive with a documented Information Receipt Acknowledgement. On 6/16/2023 Social Service Director implemented the use of an Advanced Directive Care Plan tool to provide Advanced Directive information to residents at the appropriate time. On 6/21/2023 a letter was mailed to residents and resident representatives including Resident #1, Resident #8, Resident #44, and Resident #47 offering assistance with formulating Advanced Directives. Resident #44 has Advanced Directive and Social Service Director placed in medical	

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F 578	Continued From page 2	F 578		

informed of any changes so the appropriate changes can be made in the resident medical record.

Record review of medical records for Resident #1, Resident #8, Resident #44, and Resident #47 revealed no AD or documentation of a denial of use of an AD.

Resident #1

Record review of the "Face Sheet" revealed the facility admitted Resident #31 on 10/3/23 with diagnoses that included Heart Failure and Type 2 Diabetes Mellitus.

Record review of the Minimum Data Set (MDS), with Assessment Reference Date (ARD) 5/16/23, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition.

Resident #8

Record review of Resident #8's "Face Sheet" revealed she was admitted to the facility on 12/18/18 with diagnoses that included Chronic Kidney Disease, stage four (4), Chronic Atrial Fibrillation, and Type II Diabetes.

Record review of Resident #8's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/13/23 and a Brief Interview of Mental Status (BIMS) score of 15 indicating intact cognitive skills for daily decision making.

Resident #44

Record review of Resident #44's Face Sheet

chart on 6/22/2023.
2. All other residents may have the potential to be affected by the deficient practice.
3. On 6/20/2023 the Admissions Coordinator and Social Services Director were in-serviced on Advanced Directives and Resident Rights to Request/Refuse/Discontinue Treatment. On 6/22/2023 an Advanced Directive Audit began to ensure residents that have executed an advance directive is maintained in the medical record. On 6/15/23 a mass text message was sent, and letter mailed 6/21/2023 to residents and resident representatives offering assistance with formulating Advanced Directives. On 6/16/2023 Admission Packet was revised to include Patient Self Determination Act- Mississippi Advanced Health Care Directive with a documented Information Receipt Acknowledgement. On 6/16/2023 Social Service Director implemented the use of an Advanced Directive Care Plan tool to provide Advanced Directive information to residents at the appropriate time.
4. Admission Coordinator and Social Services Director to monitor 5 resident charts weekly times 4 weeks then 5 resident charts monthly times 3 months beginning 6/22/2023. Results of Quality Assessment and Performance Improvement will be taken to Quality Assessment Assurance monthly times three months beginning 7/20/2023 ending 10/23/2023 for review and any systemic changes made as needed. The Quality Assessment and Assurance Committee

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F 578	Continued From page 3	F 578		

revealed she was admitted to the facility on 12/30/20 with diagnoses that included Chronic Kidney Disease, Paroxysmal Atrial Fibrillation, and Cerebral Infarction.

Record review of Resident #44's MDS with an ARD of 5/9/23 and a BIMS score of 3 indicating severely impaired cognition.

Resident #47

Record review of the "Face Sheet" revealed the facility admitted the Resident #47 on 5/24/23 with diagnoses including Type 2 Diabetes Mellitus, Chronic Viral Hepatitis, Dementia, and Malignant Neoplasm of Anal Canal.

Record review of the MDS with an ARD of 6/1/23, revealed the resident had a BIMS score of 12 indicating moderate cognitive impairment.

On 06/20/23 at 10:30 AM, an interview with the facility Social Services (SS) staff confirmed that residents did not have an AD in their charts or in their medical records. The SS revealed she was not aware that she was supposed to get ADs for all residents, have the facility help the resident representative with an AD, if wanted, have a copy of the AD in the chart, or have a signed form that states the family does not want an AD.

On 6/20/23 at 10:45 AM, an interview with the Administrator revealed they do not have ADs for all the residents. The Administrator did not know for sure if during the admission process the staff was asking the new admission or their family if they had or wanted an AD.

On 6/20/23 at 1:43 PM, during an interview with

meets as least quarterly or and more often as needed. The revisions will be developed and approved by the quality assessment and Assurance Committee to ensure the Plan of Correction is achieved and sustained. A quality Assurance meeting will be held 7/21/2023. The next Quality Assurance meeting is tentatively scheduled for 10/23/2023. The Quality Assurance Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Infection Preventionist, and at least 2 members of the facility staff.

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F 578	Continued From page 4 the Admissions Director revealed she is the staff member that does the admissions and would be the one that would discuss a Living Will, Power of Attorney and code status. She confirmed she has not asked or explained to the resident representative or resident about an AD. She revealed she did not know she should discuss an AD, get a copy if they had one, place it on the chart, offer to help develop one if needed and if they did not want to make those decisions, get a signed form of denial.	F 578		
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 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		7/20/23

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F 656	Continued From page 5 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 record review, staff interviews and facility policy review, the facility failed to implement a care plan regarding physician notification, dialysis communication and failed to provide thicken liquids for two (2) of 24 care plans reviewed Resident #6 and Resident #28 Findings Include: Record review of facility policy titled "Comprehensive Care Plans," dated 07/29/19, stated, "The village care plan team, in coordination with the resident, the resident's family members or the resident's representative develops and maintains a comprehensive care plan for each resident which identifies the highest level of functioning the resident is expected to	F 656	The following plan of correction is not intended to be an admission of guilt or used for any purpose other than the purpose stated herein. 1. Care Plans for residents #6 and #28 were reviewed and updated with current plan of care. 2. All other residents may have the potential to be affected by the deficient practice. 3. On 6/26/2023 the Director of Nursing began an in-service training with all nursing staff on following the resident's care plan. 4. Unit Managers and Minimum Data Set Nurse will monitor five (5) residents	

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F 656	Continued From page 6 obtain." Resident #6 Record review of the resident care plan with problem onset date of 10/28/19 revealed a care plan for "Elder lives with ESRD (End Stage Renal Disease) and requires hemodialysis. Goal and target date of 07/14/23 Elder will have no complications due to presence of AV (arterial venous) graft and will remain with minimal overt symptoms of end stage renal disease. Approaches:.. Confer with MD (Medical Doctor)/NP (Nurse Practitioner) as needed and inform family/RP (Responsible Party) of order changes. Attend renal dialysis per current orders... q (every) M,W,F (Monday Wednesday Friday) and that her dialysis communication sheet is filled out and she has it with her before leaving so that dialysis nurse can also document, and upon return from dialysis...Care partners to encourage elder to attend dialysis as scheduled and discuss the negative outcomes of refusal including but not limited to fluid overload, infection, increased s/sx (sign/symptoms) of hypertension, and possible death." Record review of the April, May and June 2023 dialysis communication forms revealed there were seven (7) missing forms out of 26 days of dialysis appointments. The following forms were missing: 04/03/23, 04/12/23, 04/21/23, 05/05/23, 05/10/23, 05/12/23, and 05/29/23. Record review of the physician orders revealed that "Hemodialysis is every MWF with (proper name) dialysis for chair time 10:45-2:15, facility to provide transport."	F 656	weekly times 4 weeks then monthly times 3 months beginning 6/23/2023 to ensure resident plan of care is followed to include but not limited to Dialysis transfer sheets are completed and received timely and hydration being served during resident meals. Results of Quality Assessment and Performance Improvement will be taken to Quality Assessment Assurance monthly times three months beginning 7/20/2023 ending 10/23/2023 for review and any systemic changes made as needed. The Quality Assessment and Assurance Committee meets as least quarterly or and more often as needed. The revisions will be developed and approved by the quality assessment and Assurance Committee to ensure the Plan of Correction is achieved and sustained. A quality Assurance meeting will be held 7/21/2023. The next Quality Assurance meeting is tentatively scheduled for 10/23/2023. The Quality Assurance Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Infection Preventionist, and at least 2 members of the facility staff.	

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F 656	Continued From page 7	F 656		

Interview with the Medical Records Nurse on 06/21/23 at 9:09 AM, stated that she gave the SA what she could find in the medical record for the dialysis communication notes and that if some were missing then the floor nurse that assessed that resident must not have obtained it after the resident's return from dialysis. She confirmed that they keep a "Dialysis Communication Binder" and all communication should be in that binder.

Interview on 06/21/23 at 9:19 AM with Licensed Practical Nurse (LPN) #1 confirmed that there probably were some dialysis communication sheets missing and stated, "They have gotten a little better at sending the communication sheets back but there is a lot of times that she doesn't come back with one." The SA asked how they would know how she did at dialysis and LPN #1 stated, "We wouldn't know." Asked LPN #1 where do you document her vitals, LPN #1 stated, "Well we don't have anywhere that we would put them. I mean it comes up on our computer to check her shunt site every shift, so we mark that. Other than that we don't document her return vitals and where we assessed her for vitals."

Interview with the Director of Nursing (DON) on 06/21/23 at 10:05 AM with the SA confirmed that she was aware that they had missed some dialysis communication sheets and stated that she had recently completed an audit of the dialysis communication binder and confirmed missing communication notes. The DON confirmed that this was their only dialysis resident in the facility.

The DON then returned to the conference room at 10:20 AM on 06/21/23 with the dialysis policy and stated that she had called the dialysis facility

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F 656	Continued From page 8	F 656		

and confirmed that the resident had refused dialysis on 04/21, 05/05 and 05/12 but could not find any nurses's notes or communication notes that the family or physician had been notified.

Interview with the DON at 1:50 PM on 06/21/23 after she did some research in the medical records for documentation and she confirmed that the days that the resident refused to go to dialysis that they did not notify the physician, nor do they document anything into the nurse's note of the medical record and did not notify the family.

Interview with Minimum Data Set (MDS) Registered Nurse (RN) on 06/22/23 at 9:25 AM stated, "I develop the care plans to follow the Medical Director (MD) orders," and confirmed that the lack of dialysis communication and lack of notification of the Physician when the resident refused dialysis was not following the care plan.

Record review of the medical record did not reveal that the facility was checking vital signs for the resident after return from dialysis and confirmed through record review that there was no notification to the physician when the resident refused dialysis and no documentation on the nurse's notes regarding refusal.

Record review of the Face Sheet revealed that the facility admitted the resident on 04/26/19 with diagnosis of End Stage Renal Disease (ESRD).

The most recent Minimum Data Set with an Assessment Reference Date (ARD) of 04/07/23, Section C revealed a Brief Interview of Mental Status Score (BIMS) of 15 revealed that the resident was fully cognitive.

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Resident #28

Record review of the resident's care plan stated, "Elder is at risk for decreased nutritional intake and has a modified diet r/t (related to) dx (diagnosis) of dysphagia." Goal and target date of 09/23/23 stated, "Elder will have adequate PO (by mouth) consumption with no significant weight loss or choking. Approaches: Mechanical Soft Diet Thicken Liquids."

During an observation and interview on 06/20/23 at 8:34 AM, with Resident #28 it was observed that she had eggs and toast for breakfast and did not have anything for hydration on her food tray. Observation revealed that the resident's meal ticket was not on her meal tray.

In an interview with CNA #4 on 06/20/23 at 8:40 AM, revealed that she did not deliver her meal tray to her room and she isn't sure why she did not have anything for hydration on her meal tray but confirmed that the resident did not have anything for hydration on her meal tray.

Interview with MDS RN on 06/22/23 at 9:25 AM, stated, "I develop the care plans to follow the MD orders," and confirmed that the lack of hydration on the resident's meal tray on 06/20/23 was not following the care plan and physicians orders to maintain hydration and prevent choking by not serving the resident anything to drink during her meal.

Record review Physician Orders for June 2023 revealed an order dated 12/02/22 "Mechanical Soft Diet Thicken Liquids."

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F 656	Continued From page 10 Record review of the Face Sheet revealed that the resident was admitted to the facility on 11/03/22 with diagnoses of Metabolic encephalopathy, Type 2 diabetes, Dysphagia. Record review of the MDS with an Assessment Reference Date (ARD) of 03/20/23 revealed a Brief Interview for Mental Status Score (BIMS) of 10 indicating that the resident had mild cognitive impairment.	F 656		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, and facility policy reviews, the facility	F 692	The following plan of correction is not intended to be an admission of guilt or	7/20/23

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F 692	Continued From page 11 failed to provide hydration during a meal to a resident who was a choking risk, for one (1) of three (3) residents reviewed for nutrition Resident #28. Findings Include: Record review on facility letterhead dated 06/20/23 and signed by the Administrator stated, "Our home does not currently have policies regarding checking tray accuracy, preparing trays, and communication with the Registered Dietician (RD)." On 06/19/23 at 12:10 PM an observation was made of Resident #28 laying in her bed, eyes open, soft speech, able to shake head yes/no to questions appropriately that was asked of her. Certified Nursing Assistant (CNA) #3 entered the room and placed the residents meal tray on the bedside table and moved the bedside table over to the resident and began meal set up. Resident is observed served boiled carrots, beef stroganoff, bread stick, cake and a 5-6 ounce glass of thickened water. Review of resident's meal ticket revealed resident is on a mechanical soft diet with Ensure Plus to be served at meals. Ensure Plus was not observed on the resident's meal tray. Interview at this same time revealed that the CNA #3 confirmed that the resident is not served an Ensure Plus with her meal and stated, "Sometimes I look to see if it (meal ticket) matches what they get but usually it is the kitchens responsibility. The last time I remember seeing her get an Ensure with her meal was a couple of weeks ago." Observation and interview on 06/20/23 at 8:34 AM, with the resident observed that she had eggs	F 692	used for any purpose other than the purpose stated herein. 1. Elder #28 was assessed for signs of dehydration by the Nurse Practitioner on 6/20/2023 with no evidence of dehydration noted and was assessed again on 6/26/2023 by the attending physician for signs of dehydration with no evidence of dehydration noted. 2. All other Elders may have the potential to be affected by the deficient practice. On 6/20/23, all other Elders were assessed for signs of dehydration by the Director of Nursing and Nurse Managers with no evidence of dehydration noted. 3. On 6/20/2023, each Nurse Manager was assigned by the Director of Nursing to check tray cards for accuracy at breakfast and lunch meals Monday through Friday for requested fluids per Elder. The Lead Certified Nurses Assistant was assigned to check tray cards for accuracy at dinner meal Monday through Sunday for requested fluids per Elder. The weekend Supervisor was assigned to check tray cards for accuracy at breakfast and lunch on weekends for requested fluids per Elder. On 6/20/2023 all nursing staff were in-serviced on ensuring that fluids are served at each meal as requested per the Elders. 4. The Dietary Manager and Director of Nursing will monitor 5 tray cards for accuracy for 4 weeks then monthly times 3 months beginning 6/23/2023. Results of Quality Assessment and Performance Improvement will be taken to Quality Assessment Assurance monthly times	

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F 692	Continued From page 12 and toast for breakfast and did not have anything for hydration on her food tray. Observation revealed that the resident's meal ticket was not on her meal tray. Interview with CNA #4 on 06/20/23 at 8:40 AM, revealed that she did not deliver her meal tray to her room and she isn't sure why she did not have anything for hydration on her meal tray but confirmed that the resident did not have anything for hydration on her meal tray. Interview on 06/20/23 at 8:45 AM, with two other CNAs #5 and #6 stated that they didn't deliver the meal tray to the resident either. Interview with the Dietary Manager (DM) on 06/20/23 at 8:50 AM, stated that "We don't have regular ensure, we only have ensure clear (non-dairy) and we have never had ensure plus to give to the resident's so I'm not sure why that is even on her meal ticket." The DM confirmed that he wasn't aware that Ensure was on her meal ticket and he guessed he had just missed it when he audited the meal tickets for accuracy. DM then stated, "We wouldn't give Ensure anyway, that is something the nurse's would give to the residents." The DM printed off the resident's meal ticket and it revealed that the resident's meal was ordered to have Ensure Plus and it was not on her meal tray. Interview on 06/20/23 at 9:05 AM with Registered Nurse (RN) #1 confirmed that she does not give the resident her Ensure Plus and confirmed that it is not on her orders to give so she would not give her Ensure. Interview with the DON on 06/20/23 at 2:00 PM	F 692	three months beginning 7/20/2023 ending 10/23/2023 for review and any systemic changes made as needed. The Quality Assessment and Assurance Committee meets as least quarterly or and more often as needed. The revisions will be developed and approved by the quality assessment and Assurance Committee to ensure the Plan of Correction is achieved and sustained. A quality Assurance meeting will be held 7/21/2023. The next Quality Assurance meeting is tentatively scheduled for 10/23/2023. The Quality Assurance Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Infection Preventionist, and at least 2 members of the facility staff.	

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stated, "I think it's an error, I can't find where she was ever ordered to have Ensure." DON was informed that the resident did not have any hydration on her meal tray at breakfast and she stated, "I heard that she didn't have anything to drink but I can't find out who took her tray into her room this morning and I can assure you that this won't happen again."

Interview and record review with Licensed Practical Nurse (LPN) #2 on 06/20/23 at 2:50 PM, looked through the thinned out medical record and discovered that the resident was admitted to the facility on 11/03/22 and was admitted with hospice services. The family wanted to change hospice providers and changed on 12/16/22 and also ordered to discontinue the Ensure Plus. Ensure plus was initially written as an order on 12/02/22 and then discontinued on 12/16/22 and the LPN confirmed that it was not taken off of the dietary orders.

The DM confirmed in an interview on 06/20/23 at 8:50 AM, that he was not aware that it had been ordered nor was he aware if it had been discontinued and he didn't know why the resident did not get hydration on her meal tray. "The CNAs take the meal tickets and go to each room and they circle what the residents want for each meal and they bring it back to us in the kitchen and we assembly the trays."

Record review revealed that it was circled on the meal ticket dated 6/20/23 for scrambled egg, ground sausage, toast. Jelly and water were written in by hand on the meal ticket.

Interview with the DM on 06/21/23 at 11:40 AM stated that he did some investigating into what

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F 692	Continued From page 14 happened as to why the resident did not get a drink with her breakfast meal and he stated, "All I can say is we missed it. I just had a meeting with my staff this morning and I told them to make sure that not one single tray goes out of here without some kind of drink on it." Record review of a "Nurse request visit," dated 06/20/23 electronically signed by Nurse Practitioner stated, "72 year old female patient presents for visit. It was reported that the (resident's name) did not receive fluids with her breakfast." Record review revealed an order dated 12/02/22 "Mechanical Soft Diet Thicken Liquids." Record review of the Face Sheet revealed that the resident was admitted to the facility on 11/03/22 with diagnoses of Metabolic encephalopathy, Type 2 diabetes, and Dysphagia. Record review of the most recent Minimum Data Set with an Assessment Reference Date (ARD) of 03/20/23 with a Brief Interview for Mental Status Score (BIMS) of 10 indicated that the resident had mild cognitive impairment.	F 692		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 698		7/20/23

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F 698	Continued From page 15 Based on observation, record review, staff interviews and facility policy review, the facility failed to maintain communication with the physician and maintain dialysis communication sheets for a resident who receives dialysis services for seven (7) of 34 days that Resident #6 attended or refused dialysis. Findings include: Review of the facility policy titled, "Dialysis," with revision date of 01/27/22 stated, "The village will utilize the Dialysis Communication Form which includes: vital signs, weight if ordered, and any signs and symptoms of infection to central venous catheter (CVC), shunt, fistula, graft, and other vascular access catheter. This form will be completed prior to dialysis and sent with resident and dialysis facility will return post dialysis and include any additional comments or concerns to the village. The village will also monitor for.....ongoing monitoring and care of the resident's vascular access.....related to complications (i.e., hypotension) and with notification of concerns to Doctor and Responsible Party as needed." On 06/20/23 at 8:25 AM, an interview with Resident #6 in her room stated that she attends dialysis every Monday, Wednesday and Friday (MWF). The State Agency (SA) asked the resident if the staff assessed her and checked her vitals when she returned and she stated, "Sometimes they do, but not every time." Record review of the Physician Orders revealed that "Hemodialysis is every MWF with (proper name) dialysis for chair time 10:45-2:15, facility to provide transport."	F 698	The following plan of correction is not intended to be an admission of guilt or used for any purpose other than the purpose stated herein. 1. 6/20/2023 medical information was obtained from the Dialysis unit for the dates 4/3/2023, 4/12/2023, and 5/10/2023 on resident #6 and placed in medical record. 2. No other resident was potentially affected by the deficient practice as there were no other elders receiving Dialysis at that time. 3. On 6/23/2023 all nurses were in-serviced by the Director of Nursing on completion of Dialysis Communication forms and ensuring that all from return from the Dialysis Unit. Nurses will call the Dialysis Unit to request any dialysis Communication Form not returned to the facility the day of scheduled Dialysis and report to the Director of Nursing any Communication Form that does not return from the Dialysis on the day of scheduled Dialysis. On 6/20/2023 the Director of Nursing contacted the Dialysis Unit requesting that all Dialysis Communication Forms be completed and sent back to the facility the scheduled day of Dialysis. 4. The Director of Nursing will audit the Dialysis Communication Forms weekly beginning 6/22/2023 for four weeks and then monthly thereafter. Results of Quality Assessment and Performance Improvement will be taken to Quality Assessment Assurance monthly times three months beginning 7/20/2023 ending 10/23/2023 for review and any systemic	

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F 698	Continued From page 16 Record review of dialysis communication notes for last three (3) months revealed lack of a communication note between the dialysis unit and the facility for 04/03/23, 04/12/23, 04/21/23, 05/05/23, 05/10/23, 05/12/23, 05/29/23. Interview on 06/21/23 at 9:09 AM, with the Medical Records Nurse stated that she gave the SA what she could find in the medical record for the dialysis communication notes and that if some were missing then the floor nurse that assessed that resident must not have obtained it after the resident's return from dialysis. She confirmed that they keep a "Dialysis Communication Binder" and all communication should be in that binder. During an interview on 06/21/23 at 9:19 AM, with Licensed Practical Nurse (LPN) #1 confirmed that there probably were some dialysis communication sheets missing and stated, "They have gotten a little better at sending the communication sheets back but there is a lot of times that she doesn't come back with one." The SA asked how they would know how she did at dialysis and LPN #1 stated, "We wouldn't know." SA asked LPN #1 where do you document her vitals, LPN #1 stated, "Well we don't have anywhere that we would put them. I mean it comes up on our computer to check her shunt site every shift, so we mark that. Other than that we don't document her return vitals and where we assessed her for vitals." On 06/21/23 at 10:05 AM, during an interview with the Director of Nursing (DON) , with the SA confirmed that she was aware that they had missed some dialysis communication sheets and	F 698	changes made as needed. The Quality Assessment and Assurance Committee meets as least quarterly or and more often as needed. The revisions will be developed and approved by the quality assessment and Assurance Committee to ensure the Plan of Correction is achieved and sustained. A quality Assurance meeting will be held 7/21/2023. The next Quality Assurance meeting is tentatively scheduled for 10/23/2023. The Quality Assurance Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Infection Preventionist, and at least 2 members of the facility staff.	

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stated that she had recently completed an audit of the dialysis communication binder and confirmed missing communication notes. The DON confirmed that this was their only dialysis resident in the facility.

During an interview at 10:20 AM on 06/21/23 the DON stated that she had called the dialysis facility and confirmed that the resident had refused dialysis on 04/21, 05/05 and 05/12 but could not find any nurses's notes or communication notes that the family or physician had been notified.

During an interview with the DON at 1:50 PM on 06/21/23, after she did some research in the medical records for documentation and she confirmed that the days that the resident refused to go to dialysis that they do not notify the physician, nor do they document anything into the nurse's note of the medical record and did not notify the family.

On 06/21/23 at 2:12 PM, interview with the Dialysis Nurse stated that the facility had called them yesterday afternoon because they were missing some dialysis communication forms so they faxed them over to them at the facility. The Dialysis Nurse confirmed that the resident did not come to dialysis on 04/21, 05/05, 05/12 and 05/29. The Dialysis Nurse stated that the pre and post dialysis vital signs are completed by the dialysis center and sent back with the resident to the nursing home.

Record review of the medical record did not reveal that the facility was checking vital signs for the resident after return from dialysis and confirmed through record review that there was

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F 698	Continued From page 18 no notification to the physician when the resident refused dialysis and no documentation on the nurse's notes regarding refusal. Record review of the Face Sheet revealed that the facility admitted the resident on 04/26/19 with a diagnosis of End Stage Renal Disease (ESRD). Record review of the most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/07/23 revealed a Brief Interview for Mental Status Score (BIMS) of 15 indicating Resident #6 was cognitively intact.	F 698		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		7/20/23

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F 761	Continued From page 19 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record reviews and facility policy review, the facility failed to store medications in a locked medication cart for one (1) of three (3) medication carts reviewed. Medication Cart on Back Hall Findings Include: Record review of the facility policy titled "Medication Storage," dated 05/31/23, revealed " ...Policy Explanation and Compliance Guidelines: 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms). b. Only authorized personnel will have access to the keys to locked compartments ..." On 06/19/23 at 12:15 PM, an observation was made of medications sitting on the bedside table of Resident #6. The resident was out to dialysis and not in her room. Observed medications of Refresh eye drops, Advair Disk inhaler and Astepro nasal spray. All medications were in the manufacturers packages with resident's name on the outside of each box with instructions for administration. Record review of Resident #6's Electronic Medication Record (EMAR) for June 2023, revealed physician's orders for "Refresh Tears 0.5% eye drop insert 1 drop into both eyes 3 times daily. Advair 500-50 Diskus inhale one puff into the lungs two times daily. Azelastine 0.15%	F 761	The following plan of correction is not intended to be an admission of guilt or used for any purpose other than the purpose stated herein. 1. On 6/20/2023 medications were removed from the bedside table of Resident #6. 2. All other residents may have been affected by the deficient practice. 3. On 6/20/2023 rounds were made by the managers to ensure no other medications were left at bedside with no other infractions noted. On 6/29/2023 RN (Registered Nurse) #1 was provided a one-on-one in-service by the Director of Nursing regarding proper storage of medications and biologicals. On 6/29/2023 an in-service was completed on all nurses by Director of Nursing regarding the proper storage of medications and biologicals. 4. Rounds will be made by the Nurse Managers twice weekly for 4 weeks and as needed beginning 6/19/2023 and ending 7/20/23 then bi-weekly for 8 weeks to ensure no medications and/or biologicals are stored at bedside. Results of Quality Assessment and Performance Improvement will be taken to Quality Assessment Assurance monthly times three months beginning 7/20/2023 ending 10/23/2023 for review and any systemic changes made as needed. The Quality	

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F 761	Continued From page 20 nasal spray, spray 2 puffs into each nostril 2 times a day." The State Agency (SA) made an observation that Registered Nurse (RN) #1 was the nurse assigned to Resident #6 for 06/19/23 on the 7AM-7PM shift. Interview with RN #1 on 06/20/23 at 8:30 AM, confirmed that she had forgotten and left the resident's medications in her room the previous day and stated, "I put them in there yesterday to administer to her and she was about to go to dialysis and she wanted her dialysis communication sheet to take with her. I sat the medications down and ran to get the sheet and forgot and left her medications in there." RN #1 confirmed that the medications were Advair Disk Inhaler, Astepro nasal spray, and Refresh eye drops. RN #1 stated that she remembered later that day that she had left them in Resident #6's room and she went back to get the medication and stated, "I had to go back and get them and put them back in the medication cart because I would have needed them later to give her because they are ordered for twice a day. RN #1 confirmed that she just "messed up" and that medications are to be locked in the medication cart at all times. Interview with the Director of Nursing (DON) on 06/20/23 at 2:00 PM, confirmed that all medications should be secured and locked in the medication cart and stated that RN #1 had told her what she had done and that she had left the medications in the residents room on her bedside table. Record review revealed that the facility admitted	F 761	Assessment and Assurance Committee meets as least quarterly or and more often as needed. The revisions will be developed and approved by the quality assessment and Assurance Committee to ensure the Plan of Correction is achieved and sustained. A quality Assurance meeting will be held 7/21/2023. The next Quality Assurance meeting is tentatively scheduled for 10/23/2023. The Quality Assurance Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Infection Preventionist, and at least 2 members of the facility staff.	

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F 761	Continued From page 21 the Resident #6 on 04/26/19 with diagnoses of End Stage Renal Disease (ESRD), Chronic Obstructive Pulmonary Disease (COPD), Unspecified asthma, emphysema, and Dry eye syndrome. Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/07/23 revealed a Brief Interview for Mental Status Score (BIMS) of 15 indicating Resident #6 was fully cognitive.	F 761		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and record review, the facility failed to ensure an effective pest control program was maintained as evidenced by multiple flies observed throughout the facility for three (3) of four (4) days of survey. Findings include: Record review of a document on facility letterhead dated 6/21/23 and signed by the Administrator revealed the facility does not have a pest control policy on "flies". On 06/19/23 at 11:51 AM, an observation and interview with Resident #8 sitting at a table in the dining room with two (2) other residents revealed 4 flies flying around the table and landing on the resident's food. Resident #8 revealed she had not	F 925	The following plan of correction is not intended to be an admission of guilt or used for any purpose other than the purpose stated herein. 1. On 6/16/2023 the Maintenance Director placed fly lamps, disposable fly traps, UV light indoor fly traps with additional traps purchased and installed on 6/19/2023 and 6/20/2023. On 6/19/2023 additional housekeeping staff were added by the Administrator to assist with monitoring and eradicating flies in the facility including the dining room and resident rooms. On 6/19/2023 the Administrator notified Activities Director to ensure that door to courtyard remain closed when not used for entering/exiting. On 6/21/2023 Service agreement with pest control company for all-inclusive pest	7/20/23

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F 925	Continued From page 22 eaten her soup because "she is letting the flies have it". Resident #8 confirmed the flies had been bad lately and she thinks it is because people leave the door open to the patio so the residents could come in and out and that's when the flies come in. On 06/20/23 at 9:10 AM, an interview with the Administrator revealed he was aware of the issue with the flies and felt like it was because the door is left open to the courtyard. The Administrator revealed the flies landing on the resident's food could potentially cause them to not eat. On 06/20/23 at 11:45 AM, an interview with in the dining room Resident #39 revealed the flies are better right now but they were terrible this morning. They were all over our food. On 06/21/23 at 11:00 AM, an observation of 2 flies in the therapy room during the resident council meeting. On 06/21/23 at 11:25 AM, an interview with Certified Nursing Assistant (CNA) #1 revealed she believed the flies are coming in from the door being left open. CNA #1 revealed it has been so hard to try and keep the flies off of the food, they are everywhere. On 06/21/23 at 11:50 AM, an interview with CNA #2 revealed the residents have been complaining about the flies on their food and she would not want to eat any food that flies had been on. On 06/21/23 at 12:00 PM, an interview with an unsampled resident, while she was sitting in the dining room at a table, revealed the flies have been a real problem. She stated they have been	F 925	service including inspections, monthly treatments, and as needed services. 2. All other residents may have had the potential to have been affected by the deficient practice. 3. On 6/19/2023 ongoing monitoring of the facility for pest including flies began by Maintenance Director and Housekeeping staff. On 6/28/2023 an in-service with Maintenance Director and Housekeeping staff was conducted by the Administrator regarding maintaining an effective pest control program. On 6/29/2023 pest control performed inspection, installed 2 fly lights in Kitchen and 1 fly light in the Service Hall, treated the perimeter of facility, kitchen, all resident rooms, offices, baseboards, and all cracks and crevices for flies and 24 other targeted pests. 4. A pest control log was implemented to communicate pest related concerns including flies to Maintenance Director and pest control company beginning on 6/29/2023 monthly times 3 months and monthly thereafter . Results of Quality Assessment and Performance Improvement will be taken to Quality Assessment Assurance monthly times three months beginning 7/20/2023 ending 10/23/2023 for review and any systemic changes made as needed. The Quality Assessment and Assurance Committee meets as least quarterly or and more often as needed. The revisions will be developed and approved by the quality assessment and Assurance Committee to ensure the Plan of Correction is achieved and sustained. A quality Assurance meeting will be held 7/21/2023. The next	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255289	A. BUILDING _____ B. WING _____	06/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CHASE VILLAGE	5090 GAUTIER VANCLEAVE ROAD GAUTIER, MS 39553

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F 925	Continued From page 23 around so much that she named them Tom, Dick, and Harry. During the interview observed 2 gnats flying and landing on the dining table. On 06/21/23 at 12:15 PM, an interview with Resident #18 revealed she ate lunch in the front lobby yesterday with visitors and 2 flies were all over them, she would just pick the part of the food off and put it to the side when a fly landed on it.	F 925	Quality Assurance meeting is tentatively scheduled for 10/23/2023. The Quality Assurance Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Infection Preventionist, and at least 2 members of the facility staff.	