STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255327	A. BUILDING _____ B. WING _____	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTHA COKER GREEN HOUSE HOME	2041 GRAND AVE YAZOO CITY, MS 39194

(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 6/26/23 through 6/29/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F641, F656, and F692. The facility held a license for 60 beds, with a census of 57.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy review, the facility failed to accurately complete section N of the Minimum Data Set (MDS) for a resident, as evidence by the incorrect coding of anticoagulant medication use during the 7-day observation look-back period for 1 (one) out of 19 residents sampled for anticoagulant use. Resident #10 Findings include: Review of the facility policy titled "Resident Assessment -RAI" with a revision date of 11/2016 revealed under, "Policy: This facility makes a comprehensive assessment of each resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS." Also revealed under, "Policy Explanation and Compliance Guideline: ... 2. The assessment will	F 641	1. The Minimum Data Set (MDS) assessment for elder #10 was corrected and submitted to the Internet Quality Improvement and Evaluation System (iQIES) on 6/30/2023. 2. The facility determined that all elders have the potential to be affected. 3. Current MDS assessments for all elders were checked by the MDS Coordinator, Clinical Coordinator, and the Director of Nursing to ensure that Section N was coded correctly for all elders. The audit was completed on 7/3/2023. The MDS nurses responsible for the error were educated as to the proper classification of anticoagulant versus antiplatelet medications by the Director of Nursing on 6/30/2023. 4. The Director of Nursing and the MDS Coordinator will monitor accuracy of	8/11/23

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

Electronically Signed | 07/14/2023

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F 641	Continued From page 1 include at least the following: ... n. Special treatments and procedures ...." Record review of the Quarterly MDS with an Assessment Reference Date (ARD) of 6/01/23 revealed under section N, Resident #10 received seven (7) days of Anticoagulant medication for the observation look back period of 5/26/23 through 6/01/23. Record review of the Medication Administration Record (MAR) for the MDS 7 day observation look-back period for anticoagulant medication revealed Resident #10 did not receive anticoagulant medication between 5/26/23 and 6/01/23. An interview with the MDS Coordinator on 6/28/23 at 10:35 AM, confirmed that Resident #10 was coded for receiving 7 days of anticoagulant medication on the MDS. She revealed that Resident #10 received an antiplatelet medication and that the 7 days of anticoagulant medication was coded in error. An interview with the Director of Nursing (DON) on 6/28/23 at 1:55 PM, confirmed that the antiplatelet medication should not be coded under the anticoagulant section of the MDS assessment for Resident #10. Record review of the Admission Record revealed Resident #10 was admitted to the facility on 02/19/23 with diagnoses that included Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, and Encounter for Attention to Gastrostomy and Dysphagia. Record review of the MDS with an ARD of	F 641	section N for all new MDS assessments weekly times 4 weeks beginning 7/3/2023 then monthly for 3 months to ensure proper coding. The results of the report will be reviewed by the quality assurance and performance improvement committee starting on 8/11/2023, and monthly thereafter until a time in which consistent substantial compliance has been achieved as determined by the committee.	

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F 641	Continued From page 2 6/01/23 revealed under section C, a Brief Interview for Mental Status (BIMS) score of 99, indicating Resident #10 was unable to complete the interview.	F 641		
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 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	F 656		8/11/23

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F 656	Continued From page 3 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, resident and staff interview, record review, and facility policy the facility failed to implement a resident's comprehensive care plan for fluid restriction for one (1) of 15 care plans reviewed. Resident #34 Findings include: A review of the facility policy titled "Comprehensive Care Plans," revised 11/2017, revealed "Policy: It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment...." A record review of the care plan titled "Elder has the potential for cardiovascular complications r/t (related to) CHF (Congestive Heart Failure), CAD (Coronary Artery Disease), HTN (Hypertension), AFIB (Atrial Fibrillation), SOB (Shortness of	F 656	1. The plan of care related to the order for fluid restriction for elder #34 was reviewed by the registered dietician on 6/29/2023 to ensure agreement with the physician order for fluid restriction. 2. It was determined that all elders with fluid restrictions have the potential to be affected. 3. All elders with plans of care for fluid restriction were reviewed and clarified by the registered dietician on 6/29/2023. All certified nurse assistants and licensed nurses responsible for providing fluids to the elders were educated on following the physician orders using proper beverage cup sizes and servings to accurately follow the plan of care by the registered dietician ending on 7/14/2023. 4. The Director of Nursing, Registered Dietitian, and Clinical Coordinators will conduct 5 observations of meals and medication passes weekly times four weeks beginning 7/17/2023, then monthly for 3 months to ensure staff are providing	

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F 656	Continued From page 4 Breath) with exertion," with a revision date of 1/4/23, revealed Interventions: ...1000ml fluid restrictions..." A review of the medication record by for June 2023, revealed Resident #34 received more then the physician prescribed, 1000 mm fluid restriction, on 21 days from June 1st-26th. On 6/26/23 at 2:05 PM, an interview with Resident #34 revealed he had Congestive Heart Failure and was on fluid restriction. State Agency (SA) observed a glass of water with measurements on the side of the glass. SA observed 240 millimeters/mm of water in the glass. Resident revealed he was unsure of how much fluids he can have but he drinks what he is given. A review of the comprehensive care plans for Resident #34 with the Director of Nursing (DON) on 6/27/23 at 10:55 AM, she confirmed staff were not following the care plan for fluid restriction and revealed the purpose of the care plan is to direct the personalized care for each resident. An interview with the Registered Dietician (RD) on 6/27/23 at 3:07 PM, confirmed after looking at the record Resident #34 was receiving a lot more fluids daily than the physician recommended amount. A record review of the care guide for Resident #34 for June 2023 revealed "How much fluid did the resident drink? revealed no directions related to fluid restrictions. Record review of the Admission Record revealed that the facility admitted Resident #34 to the	F 656	the appropriate amount of fluid to elder with fluid restriction diets. The observation reports will be reviewed by the quality assurance and performance improvement committee starting on 8/11/2023, and monthly thereafter, until a time in which consistent substantial compliance has been achieved as determined by the committee.	

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F 656	Continued From page 5 facility on 7/12/2021 with diagnoses of Acute on Chronic Combined Systolic and Diastolic Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) of 6/15/23, revealed that Resident #34 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated that he was cognitively intact.	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, resident and staff	F 692	1. The fluid restriction order for elder #	8/11/23

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F 692	Continued From page 6 interview, record review, and facility policy the facility failed to follow a resident's physician prescribed fluid restriction for one (1) of 15 resident records reviewed. Resident #34 Findings include: A review of the facility policy titled, "Fluid Restriction, "revised 03/23/23, revealed, "Policy: It is the policy of the facility to ensure that fluid restrictions will be followed in accordance to physician's orders....Compliance Guidelines: 1.) The nurse will obtain and verify the physician's order for the fluid restriction and an order written to include the breakdown of the amount of fluid per 24 hours...." An interview with Resident #34 on 6/26/23 at 2:05 PM, he revealed he had Congestive Heart Failure and was on fluid restriction. State Agency (SA) observed a glass of water with measurements on the side of the glass. SA observed 240 milliliters (ml) of water in the glass. Resident #34 revealed he was unsure of how much fluids he can have but confirmed he drinks what is given to him. An interview with Certified Nursing Assistance (CNA) #1 on 6/27/23 at 10:40 AM, revealed Resident #34 was on a fluid restriction and she believed it was 1500 milliliter (ml) a day. CNA #1 revealed Resident #34 is served a 360 ml glass and a 240 ml glass of fluids with each meal. CNA #1 revealed Resident #34 has not ever been angered or non-compliant with his fluid restrictions. CNA #1 revealed she was unsure of how she knew Resident #34 was on fluid restrictions. An interview and record review of Resident #34's	F 692	34 was evaluated and clarified by the registered dietician on 6/29/2023. 2. All elders with fluid restrictions have the potential to be affected. 3. All elders with fluid restriction□s orders were reviewed and clarified by the registered dietician on 6/29/2023. All licensed staff responsible for providing fluids to the elders were in-serviced on following the physician orders using proper beverage cup sizes and servings to accurately follow those orders by the registered dietician ending on 7/14/2023. 4. The Director of Nursing and Registered Dietitian, Clinical Coordinators will conduct 5 observations of meals and medication passes weekly times four weeks beginning 7/17/2023, then monthly for 3 months to ensure staff are providing the appropriate amount of fluid to elder with fluid restriction diets. The observation reports will be reviewed by the quality assurance and performance improvement plan committee starting on 8/11/2023, and thereafter quarterly times two to ensure substantial compliance has been achieved as determined by the committee.	

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F 692	Continued From page 7	F 692		

Order Summary Report with Licensed Practical Nurse (LPN) #1 on 6/27/23 at 10:50 AM, revealed an order for fluid restriction dated 1/2/23 revealed she had obtained the order for the fluid restriction and revealed the order is for "1000 ml Fluid Restriction Intake Q (every) Shift" and confirmed the restriction is supposed to be 1000 ml every 24 hours.

An interview and record review of the physician's order for fluid restriction for Resident #34 with the Director of Nursing (DON) on 6/27/23 at 10:55 AM, confirmed the order reads to her "1000 ml fluid restriction intake Q (every) shift" and she confirmed that a nurse reading the order would think that Resident #34 was allowed 1000 ml every shift equaling 3000 ml daily. The DON also revealed the dietary order read "Regular texture, Regular/Thin consistency, 1000 ml FLUID RESTRICTION." The DON confirmed the fluid restriction order should have been written in a way easy for staff to understand and confirmed staff were not following the physician's specific fluid restrictions order correctly for Resident #34 and this placed Resident #34 at risk for fluid overload related to his congestive heart failure.

A review of the progress notes for Resident #34 with the DON for the Months of May and June 2023 on 6/27/23 at 11:03 AM, revealed she could find no documentation of non-compliance with fluid restriction by resident.

A review of the medication record by for June 2023, revealed "1000 ml fluid restriction Q SHIFT (every shift)" no breakdown of the amount of fluids per 24 hours. A continued review revealed Resident #34 received more that the physician prescribed 1000 ml fluid restriction on 21 days

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from June 1st-26th.

An interview with the Registered Dietician (RD) on 6/27/23 at 3:07 PM, he revealed Resident #34 is drinking 1000-1100 ml fluid at meals and is on a 1000 ml fluid restriction every 24 hours. After review of the medication record with the RD he revealed he had no idea the nurses documented the fluid intake on the medication record and confirmed he gets the average amount of fluid intake from the care guide that the CNA's document on. The RD confirmed after looking at the medication record Resident #34 was receiving a lot more fluids daily than the physician recommended amount.

A review of the care guide for June 2023 revealed "How much fluid did the resident drink?" revealed no directions related to fluid restrictions.

An interview with LPN #2 on 6/27/23 at 3:15 PM, revealed that Resident #34 is on a 1200 ml fluid restriction every 24 hours. SA asked how she knew how much fluid she was to give the Resident; LPN #2 revealed the amount should be on the medication record. LPN #2 then revealed the amount of fluid given is documented on the medication record and confirmed she gets the total for the shift she works from the amount of fluids the CNA gives Resident #34 and the amount of fluids given with medication administration.

Record review of the Admission Record revealed Resident #34 was admitted to the facility on 7/12/2021 with diagnoses of Acute on Chronic Combined Systolic and Diastolic Congestive Heart Failure and Chronic Obstructive Pulmonary Disease.

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F 692	Continued From page 9 Record review of the Minimum Data Set (MDS) Section C with an Assessment Reference Date (ARD) on 6/15/23, revealed that Resident #34 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated that he was cognitively intact.	F 692		