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MS CARE CENTER OF GREENVILLE	1221 EAST UNION STREET GREENVILLE, MS 38703

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey and a complaint investigation (CI) MS #22085 at the facility from 7/17/23 through 7/20/23. During the survey, the SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M 610, M 650, M 655, and M 1570. The SA determined that the facility was in compliance related to CI MS #22085. The facility held a license for 116 beds at the time of the survey, and the facility census was 74.	M 000		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observations, staff interview, resident interview, record review and facility policy review the facility failed to shave a resident that was dependent on staff for bathing and personal hygiene for one (1) of 74 residents reviewed during initial tour. Resident #26	M 610	1. Resident #26 was shaved on 7/19/23 to remove visible facial hairs. 2. All dependent resident's have the potential to be affected. 3. a. ADL care policy for dependent residents was reviewed by the	8/25/23

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M 610	Continued From page 1 Findings Include: Review of the facility policy titled "Mississippi Care Center-ADL (Activities of Daily Living) Care Provided for Dependent Residents" with a review date of 09/22 revealed, "Residents who are unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene..." An observation on 07/17/23 at 11:39 AM, revealed Resident #26 sitting up in her wheelchair in the day room with a patch of white hair on both sides of her chin that is approximately 1/4 inch wide and approximately 1/4 inch long. An interview and observation on 7/18/23 at 12:45 PM, with Certified Nurse Assistant (CNA) #2 revealed that Resident #26 is in an A bed and those baths are performed on Monday-Wednesday and Friday's. She stated that all personal hygiene care goes along with the resident's baths to include shaving. During an observation of Resident #26, CNA #2 confirmed that Resident #26 had hair on her chin and when the CNA asked the resident if she wanted it shaved off , the resident stated, "If it's there then it needs to be off, I did not even know it was there" CNA #2 confirmed that she should have been shaved and she would take care of it. An interview on 7/18/23 at 1:10 PM, with the Director of Nurses (DON) confirmed that female residents need to be shaved of facial hair when they have their baths unless the resident refuses. Record review of Resident #26's Face Sheet revealed the resident was admitted to the facility	M 610	Administrator and Director of Nurses with no revisions made to policy on 7/24/23. b. Facial hair removal of female residents has been added to the Administrative nurses rounds checklist on 8/8/2023. c. As of 8/1/23 shave facial hair as needed was added to the CNA care task. If refused CNA will report to nurses for documentation. 4. a. Director of Nurses will audit Administrative nurses weekly rounds sheets on all female residents weekly for three months audits began on 8/2/2023. b. Director of Nurses will report audit findings to the Quality Assurance Committee on 8/25/2023 and then monthly for three months to ensure continued compliance has been achieved as determined by the Quality Assurance committee.	

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M 610	Continued From page 2 on 09/24/15 with medical diagnoses that included Unspecified Dementia without Behavioral Disturbance. Record review of Resident #26's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/29/23 revealed in Section G that the resident required total dependence with bathing and in Section C a Brief Interview for Mental Status (BIMS) score of 3, which indicates the resident is severely cognitively impaired.	M 610		
M 650	45.21.10 Hydration Hydration. Each resident shall be provided sufficient fluid intake to maintain proper hydration and health. This Statute is not met as evidenced by: Level II Based on observations, resident and staff interview, record review and facility policy review the facility failed to follow a physician prescribed fluid restriction for (1) one of (4) four residents on dialysis. Resident #69. Findings include: Review of the facility policy titled "Fluid Restriction policy" dated 12/13/2018 revealed, "Fluid restriction orders will be carried out as ordered by the physician by the nursing and dietary departments .... 2. Fluids ordered for the resident will be divided between the Nursing and Dietary departments. 3. Fluids determined to be used by Dietary will be sent out on the meal tray. 4. All fluids given by the aides will be recorded in the resident's room on a fluid intake form. 5. Fluids determined to be used by nursing will be divided	M 650	1. The Director of Nursing and Dietary Manager reassessed the hydration status and fluid needs for Resident #69. All fluids provided on the resident tray at mealtimes by dietary and fluids used by nursing at medication pass and supplement times were reevaluated. Appropriate revisions were made to Resident #69 care plan to reflect current fluid restrictions as order by his physician. The revised care plan was reviewed with staff involved in the care of the resident. 2. The facility has determined that all residents with fluid restrictions have the potential to be affected. 3. a. The hydration policy was reviewed by the Administrator with the Director of Nurses with no revisions made on	8/25/23

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M 650	Continued From page 3 between their medication passes. 6. Fluids given by the nurses on medication passes are to be recorded on the eMAR (electronic medication administration record). 7. Fluid intake sheet will be totaled, and a 24-hour total entered on the eTAR (electronic treatment administration record)." An observation and interview with Resident #69 on 7/18/23 3:15 PM, revealed that he did not have a water pitcher in his room. The resident revealed that he goes by his fluid restriction. He stated, "Pretty much, I drink only what they bring me." Record review of the July 2023 Physician Orders revealed an order dated 6/06/23, "1200 cc (cubic centimeter) fluid restriction R/T (related to) ESRD (End Stage Renal Disease)".... Record review of the July 2023 Medication Administration Record (MAR) revealed Resident #69 did not have an order listed for fluid restriction or a monitoring tool to track fluid intake within a 24-hour period. An interview with the Director of Nursing (DON) on 7/18/23 at 4:15 PM, revealed that the aides would know not to give Resident #69 any fluids because he doesn't have a water pitcher in his room. An interview on 7/18/23 at 4:30 PM with Medical Records revealed that Resident #69's fluid restriction was not added on the Activities of Daily Living (ADL) task for the aides to document. An interview with the DON on 7/18/23 at 4:45 PM, confirmed that the facility did not monitor or document Resident #69's fluid intake on the MAR	M 650	7/24/2023. b. All staff was IN-serviced on the hydration policy by staff development Nurse on 8/1/23-8/4/23. c. The Directory of Nursing in-serviced nursing staff on 7/26/23 on following physician orders on fluid restrictions, the significance of accurately reporting of fluids consumed daily and updating resident care plan to reflect current fluid restrictions as ordered. 4. a. The Director of Nurses and/or alternating administrative nurses will complete weekly chart audits On Sufficient fluid intake for 3 months and review fluid intake records to ensure physician orders are being followed as ordered, daily totals are accurate and the care plan remains updated to reflect current physician fluid restriction orders. Sufficient fluid intake Audits began on 8/7/23. b. Director of Nurses will report audit findings to the Quality Assurance Committee on 8/25/2023 and then monthly for 3 months to ensure continued compliance has been achieved as determined by the committee.	

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M 650	Continued From page 4	M 650		

or ADL's. She confirmed that this should have been done, and that this could cause the resident to be in fluid volume overload. She also confirmed that they did not provide a breakdown of the total number of fluids that the resident should receive between nursing and the dietary department in a 24 -hour period. She stated, "No, we didn't do it."

An interview with Certified Nurse Aide (CNA) #3 on 7/19/23 at 8:00 AM, revealed she was able to identify if a resident was on a fluid restriction because the resident will not have a water pitcher in their room. She stated, "The fluid restriction will be on their meal slip." She revealed that Resident #69 does go by his ordered fluid restriction. She stated, "He may ask for 1/2 (one-half) cup of coffee in the mornings, and we have to check with the nurse before getting it."

An interview with Registered Nurse (RN) #2 on 7/19/23 at 2:10 PM, revealed Resident #69 did not have an order for a fluid restriction on the MAR or ADL. She stated, "They (the staff) wouldn't know the resident was on a fluid restriction because it's not on there" (the ADL or MAR).

An observation of Resident #69's Medical Record with the Minimum Data Set (MDS) on 7/20/23 at 9:15 AM, confirmed that the resident did not have a fluid restriction task on the ADL's.

Record review of the Face Sheet for Resident #69 revealed he was admitted to the facility on 4/03/23 with medical diagnoses that included Unspecified Systolic Congestive Heart Failure, Hypokalemia, Gastro-Esophageal Reflux Disease Without Esophagitis, and ESRD.

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M 650	Continued From page 5 Record review of the Quarterly MDS with an Assessment Reference Date (ARD) of 7/07/23 revealed under section C a Brief Interview for Mental Status (BIMS) score of 99, indicating Resident #69 was unable to complete the BIMS.	M 650		
M 655	45.21.11 Special needs Special needs. Each resident with special needs shall receive proper treatment and care. These special needs shall include, but are not limited to injections; parenteral and enteral fluids; colostomy, ureterostomy, ileostomy care; tracheostomy care; tracheal suction; respiratory care; foot care; and prostheses. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interviews, record review, and facility policy review the facility failed to post an oxygen in use sign outside the door and to label oxygen tubing and a humidifier bottle for one (1) of four (4) residents reviewed that were receiving oxygen. Resident #21. Findings include: Record review of a procedure "Nursing Department Infection Control" undated, revealed " ...Respiratory Equipment: ...Oxygen tubing...When not in use, store the mask/cannula in a plastic bag labeled with the resident's name and date ..." An observation on 07/17/23 at 11:11 AM, revealed, Resident #21's oxygen tubing and	M 655	1. Resident #21 oxygen signage was placed on the door on 7/19/23 by Nurse Supervisor. Resident #21 oxygen setup was assessed and changed, labeled, dated and stored per facility policy on 7/19/23 by Nurse Supervisor. 2. All residents who use oxygen have the potential to be affected. 3. a. Nursing staff was in-serviced on 7/19/23 on how to properly set up oxygen when not in use. b. ALL Staff was in-serviced on respiratory care related to tag 695 by staff development on 8/1/23-8/4/23 c Nursing staff was in-serviced on new Oxygen Policy changes on 7/26/23 by Director of nurses.	8/25/23

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M 655	Continued From page 6 humidifier bottle were not labeled and dated. The cannula was laying on the floor underneath the overbed table. No oxygen in use signage was on the door. An observation and interview on 07/19/23 at 8:16 AM, with the Director of Nursing (DON) confirmed, Resident #21's oxygen tubing was laying on the floor and the oxygen tubing and humidifier water bottle was not labeled. The DON stated that the procedure should be to change tubing every seven days and that tubing should be labeled with time, date and initials. The DON stated that the water bottle on the concentrator should be changed every thirty days and should be labeled with time, date, and initials. The DON stated that the tubing should be stored in a plastic bag when not in use and should not be laying on the floor to prevent infection. The DON confirmed that there was not an oxygen sign on the door. A record review of the Physician Orders dated 07/17/23 revealed "Oxygen at two (2) liters per minute by nasal cannula as needed." An observation and interview with Resident #21 on 07/19/23 at 04:30 PM, revealed the oxygen tubing and humidifier bottle remained unlabeled and the tubing was laying on the floor. Resident #21 stated she doesn't use it all the time, just when she thinks she needs it. A review of the facility Face Sheet revealed Resident #21 was admitted to the facility on 12/01/21 with diagnoses that included Congestive Heart Failure, Human Immunodeficiency Virus, Essential Hypertension and Cough. A review of the Minimum Data Set (MDS) with an	M 655	d. The policy for oxygen use/storage was reviewed by the Administrator with the Director of Nurses on 7/19/23 and revision were made to the policy on 7/20/2023 with revisions listed as 1.Masks should be replaced and dated every 7 days. 2.Cannulas should be replaced and dated every 7 days. 3.When not in use, store the mask/cannula in a plastic bag clearly labeled with the resident□s name and date. 4.Pre-filled humidifiers are to be dated and replaced when the water level is insufficient to provide humidification, but not less than once per month. 5.Filter should be cleaned weekly with soap and water. 6.Concentrators will be serviced monthly. 4. a. Oxygen Audit began on 8/7/23 by Director of Nurses or Administrative nurses. Oxygen Audit will initially be done on all residents on oxygen then 5 residents per week for two weeks and then 4 residents per week for three months. b. Director of Nurses will report audit finding to the Quality Assurance Committee on 8/25/23 and then monthly for four months to ensure continued compliance has been achieved as determined by the QA committee.	

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M 655	Continued From page 7 Assessment Reference Date (ARD) of 04/17/23 revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated Resident #21 was cognitively intact.	M 655		
M1570	48.58.1 Infection Control The following infection control standards shall be met: 1. The facility must maintain and document an effective infection control program that protects patients, families, visitors, and facility personnel by preventing and controlling infections and communicable diseases. 2. The facility must have an active surveillance program that includes specific measures for prevention, early detection, control, education, and investigation of infections and communicable diseases in the facility. There must be a mechanism to evaluate the effectiveness of the program(s) and take corrective action when necessary. The program must include implementation of nationally recognized systems of infection control guidelines to avoid sources and transmission of infections and communicable diseases. 3. The facility must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. This Statute is not met as evidenced by: Level II Based on observations, staff interviews, record review and facility policy review the facility failed	M1570	1. a. CNA #1 was immediately in-serviced on 7/19/23 by infection control nurse on the proper procedures to prevent the spread of infection by using the proper	8/25/23

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M1570	Continued From page 8 to prevent the possibility of infection as evidenced by failing to perform hand hygiene, provide a clean workspace, change gloves and keeping oxygen tubing off the floor and in a plastic bag for one (1) of four (4) resident care observations. Resident #21 Findings include: A review of the facility policy titled "Infection Control", revised September 2022, revealed: Staff involved in direct resident contact will perform hand hygiene (even if gloves are used). Hand hygiene is performed: After removing personal protective equipment (e.g., gloves, gown, facemask). Gloves changed and hand hygiene performed before moving from a contaminated body site to a clean body site during resident care. Oxygen tubing, when not in use, store the mask/cannula in a plastic bag labeled with the resident's name and date. An observation, on 07/17/23 at 11:11 AM, revealed Resident #21's oxygen tubing and humidifier bottle were not labeled and dated. The cannula was laying on the floor underneath the overbed table. , An observation and interview on 07/19/23 at 8:16 AM, with the Director of Nursing (DON) confirmed, Resident #21's oxygen tubing was laying on the floor. The DON stated that the tubing should be stored in a plastic bag when not in use and should not be laying on the floor to prevent infection. An observation on 07/19/23 at 08:24 AM, of incontinent care with Certified Nursing Assistant (CNA) #1 revealed, she set up a wash basin on the overbed table of Resident #21. There was an	M1570	hand hygiene when required, providing a clean workspace as needed, changing gloves as procedure requires. b. Oxygen tubing and nasal canula was changed on 7/19/23 by Nurse Supervisor to a new set up that has the tubing and nasal canula stored in a plastic bag to prevent the spread of infection. Set up was labeled, dated and secured on top of the concentrator. Oxygen was not in use at the time prn order for oxygen. 2. All residents that require direct care and use oxygen concentrators have the potential to be affected. 3. a. The policy on Infection Control was reviewed by the Administrator with the Director of Nurses with no revisions on 7/24/2023. b. The policy on appropriate labeling and storage of oxygen equipment at bedside was reviewed by the Administrator with the Director of Nurses 7/24/2023. c. In-service was done by the Director of Nursing and infection control with nursing staff on Hand Hygiene/standard precautions on 7/26/23. d. In-service was done with nursing staff by Staff Development Nurse on labeling and storage of oxygen equipment at bedside on 8/1/23. e. Labeling and storage of oxygen equipment has been added to the Administrative nurses weekly room round	

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M1570	Continued From page 9 open container of juice, toothpaste, a comb, jewelry, and a contact case on the same table with the wash basin. CNA #1 did not change gloves after setting up the wash basin. CNA #1 wet a bath cloth and wiped across the resident's lower abdomen and groin areas and placed the contaminated bath cloth back in clean water basin and reused it. CNA #1 wiped more than once with the same area of the bath cloth and left the dirty bath cloth on the bed. CNA #1 positioned Resident #21 on her right side. CNA #1 then got a new bath cloth and did not change gloves. CNA #1 looked over resident #21's room for briefs in drawers, touching furniture, bed and privacy curtain. CNA #1 then put on clean gloves without performing hand hygiene. CNA #1 then applied skin protectant, did not change gloves and then applied a clean brief to Resident #21. An interview on 07/19/23 at 09:45 AM, with Registered Nurse (RN)#1 and Licensed Practical Nurse (LPN) #1 regarding incontinent care process revealed, LPN #1 stated that gloves should be changed frequently, and staff's hands should be washed each time gloves are changed. LPN #1 stated that the staff should clean with a different area of the bath cloth from top to bottom with one swipe with each different location. RN #1 stated that CNA #1 should have used two wash basins. An interview on 07/19/23 at 10:00 AM, with CNA #1 confirmed she put the dirty bath cloth back into the clean water and contaminated the clean water. CNA #1 stated that there should not have been anything on the table with the basin and confirmed there was open apple juice and other items on the table. She stated that having the items on the table was an infection control problem.	M1570	sheets for continuing checks during rounds on 8/2/23. 4. a. Director of Nurses and/or administrative nurses will do 5 infection control audits weekly for two weeks and then 4 residents a week for 3 months to verify the oxygen equipment is stored correctly starting on 8/7/2023. b. Director of Nurses and/or administrative nurses will do 5 infection control audits weekly for two weeks and then 4 residents a week for 3 months on hygiene, clean workspace, and gloves. Director of Nurses will report findings to the Quality Assurance Committee on 8/25/23 and then monthly for three months to ensure continued compliance has been achieved as determined by the QA committee	

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M1570	Continued From page 10 An interview on 7/20/23 at 9:50 AM, with the DON confirmed staff does annual competency check offs, but the staff does get nervous. Record review of the Face Sheet for Resident #21 revealed Resident #21 was admitted to the facility on 12/01/21 with diagnoses that included Congestive Heart Failure, Human Immunodeficiency Virus, Essential Hypertension and Cough. A review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/17/23 revealed a Brief Interview for Mental Status (BIMS) score of 14 which indicated Resident #21 was cognitively intact.	M1570		