| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 255252 | A. BUILDING _____ B. WING _____ | 07/20/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MS CARE CENTER OF GREENVILLE | 1221 EAST UNION STREET GREENVILLE, MS 38703 |

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| F 000 | INITIAL COMMENTS<br><br>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 Medicare and Medicaid requirements for participation and cited regulatory deficiencies at F656, F658, F677, F690, F692, F695, and F880. The SA found the facility was in compliance related to CI MS #22085 and no deficiencies were cited.<br><br>The census at the time of the survey was 74 and the facility was licensed for 116 beds. | F 000 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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<br>(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). | F 656 | | 8/25/23 |

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

Electronically Signed | 08/10/2023

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| F 656 | Continued From page 1<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interview, record review and facility policy review the facility failed to implement a care plan for shaving for Resident #26, failed to develop a care plan for maintaining a PICC (peripherally inserted central catheter) line for Resident #62, and failed to implement a care plan for fluid restriction for Resident #69. This was for three (3) of 19 care plans reviewed.<br><br>Findings include:<br><br>Review of the facility policy titled "Develop/Implement Comprehensive Care Plan" | F 656 | 1. a. Resident #26 care plan has been reviewed and updated to implement the removal of facial hair on her ADL care plan dated 7/19/23. Resident #26 was shaved on 7/19/2023.<br><br>b. Resident #62 care plan has been reviewed and developed on 7/19/23 to include maintaining a peripherally inserted central catheter line. Resident #62 PICC lined was flushed on 7/19/23<br><br>c. Resident #69 care plan for fluid | |

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| F 656 | Continued From page 2<br>with a revision date of September 2022 revealed, "The facility will develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights and that includes measurable objectives and timeframe's to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - 1. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required ... 4. The resident's goals for admission and desired outcomes ...."<br><br>Resident #26<br><br>Record review revealed the resident had a care plan with problem onset date of 9/24/2015, "Requires assistance with ADL's (Activities of Daily Living) due to DX (diagnoses) of Parkinson, Decreased Muscle Strength, Impaired Mobility, and Decreased Bed Mobility ...Approaches ...Assist with ADL's as needed ..."<br><br>An observation of Resident #26 on 07/17/23 at 11:39 AM revealed she was 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.<br><br>An interview on 7/20/23 at 8:30 AM, with the Administrator and the Corporate Administrator confirmed that the residents Activities of Daily Living (ADL) care plan was not being implemented since the resident had hair on her chin and needed to be shaved. | F 656 | restriction was implemented on his care plan dated 7/19/23. Resident #69 fluid restrictions was added to the orders and cna care task that they check daily on 7/19/23. Nursing is to provide 480cc, dietary is to provide 483cc and supplements include 720cc to total 1200cc as ordered by the physician.<br><br>d. The revised care plans on resident #26, #62 and #69 were reviewed with staff involved in the daily care of these residents.<br><br>2. All residents with a care plan have the potential to be affected.<br><br>3. a. The Care Plan Policy was reviewed by the Administrator and Director of Nurses on 7/24/2023 and no revisions were made to the policy.<br>b. Nursing staff In-serviced was conducted by the staff development nurse on 8/1/23-8/4/23 on development and implementation of care plans.<br>c. Resident #62 PICC line was removed as ordered by Physician on 7/20/23.<br><br>d. Review of Comprehensive Care Plans will be done on each resident's care plan as it is due to be updated by the Care Plan Nurse to ensure their care plan reflects current needs/plan of treatment/services arranged or provided by the facility. Care Plan Audits began on 8/7/23.<br><br>4. a. Director of Nursing or alternating | |

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| F 656 | Continued From page 3<br><br>Record review of Resident #26's Admission Record revealed the resident was admitted to the facility on 09/24/15 with medical diagnoses that included Unspecified Dementia without Behavioral Disturbance.<br><br>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 three (3), which indicates the resident is severely cognitively impaired.<br><br>Record review of Resident #62's Care Plans revealed a care plan was not developed for the PICC line maintenance.<br><br>An interview with Registered Nurse (RN) #2 on 7/20/23 at 8:35 AM, confirmed that Resident #62 did not have a care plan for PICC line care. She stated, "No ma'am, it's not in there; That's what I'm working on now." She revealed the purpose of developing and implementing a care plan was to make sure that the care was done and individualized to that resident.<br><br>Record review of Resident #62's Electronic Medication Administration Record (eMAR) revealed an order dated 6/21/23 to flush the PICC line in the left arm with 10 cubic centimeters (CC) of normal saline (NS) before and after each antibiotic.<br><br>Record review of the Face Sheet revealed Resident #62 was admitted to the facility on 4/28/23 with medical diagnoses that included | F 656 | administrative nurse will do Comprehensive care plans audits 4x a week for 4 weeks then 3 times a month for 3 months to make sure changes to resident's care needs/treatments/services are reflected on their current care plan. Audits began on 8/7/23.<br><br>b Director of Nurses will report audit findings to the Quality Assurance Committee on 8/25/2023. A Comprehensive care plan audit be done monthly for three months to ensure continued compliance has been achieved as determined by the Quality Assurance committee.. | |

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| F 656 | Continued From page 4 | F 656 | | |

Benign Prostatic Hyperplasia, Unspecified
Systolic Congestive Heart Failure and
Unspecified Atrial Fibrillation.

Resident #69

Record review of Resident #69's care plan dated 7/13/23 revealed under intervention, "1200 cc (cubic centimeters) fluid restriction. Dietary to provide 720 cc. Nursing to provide 480 cc with med pass."

On 7/18/23 at 4:45 PM, an interview with the DON confirmed that the facility did not monitor or document Resident #69's fluid intake on the Medication Administration Record (MAR) or Activities of Daily Living (ADL's) record.

An interview with RN #2 on 7/19/23 at 2:10 PM, revealed the purpose of the care plan was to tell staff what the problem was with the resident and how to address it. She confirmed that staff did not follow the fluid restriction care plan for Resident #69. She stated, "They wouldn't know the resident was on a fluid restriction."

An interview with the DON on 7/19/23 at 2:30 PM confirmed that Resident #69's care plan was not followed for the fluid restriction and acknowledged that it should have been.

An interview with the Assistant Director of Nursing (ADON) on 7/20/23 at 8:40 AM, revealed the purpose of the care plan was to determine what kind of care the resident was to receive. She confirmed that by not developing or implementing the care plan, the facility may fail to provide the care that was needed.

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| F 656 | Continued From page 5<br>Record review of the Face Sheet for Resident #69 revealed the resident was admitted to the facility on 4/03/23 with medical diagnoses that included Unspecified Systolic Congestive Heart Failure, Hypokalemia, and Major Depressive Disorder. | F 656 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, resident interview, record review and facility policy review the facility failed to flush a residents PICC (peripherally inserted central catheter) line for (1) one of (7) seven residents reviewed during medication observations. Resident #62.<br><br>Findings include:<br><br>Review of the facility policy titled "Central Venous Catheter Procedures PICC/Central Venous Line Dressing and Caps (needleless connector) Change and Care policy" revealed under, "Policies and Guidelines ... Flush PICC line every 12 hours or as ordered by physician" ...<br><br>An observation and interview on 7/19/23 at 10:56 AM, with Resident #62 revealed a PICC line to his left upper arm with a dressing intact. Resident #62 revealed he went to the doctor recently and the device was flushed, but they do not flush it here at the facility. | F 658 | 1. Resident #62 had order obtained on 7/19/23 to flush PICC (peripherally inserted central catheter). The PICC was flushed on 7/19/23.<br><br>2. All residents with PICC lines have the potential to be affected.<br><br>3. a. The policy on PICC (peripherally inserted central catheter) was reviewed by the Administrator with the Director of Nurses on 7/24/23 with no revisions made.<br>b. Staff was inserviced by the staff development on 8/1/23-8/4/23 for services provided to meet professional standards.<br><br>c. Resident #62 PICC line was removed on 7/20/23 per physician's order.<br><br>4. a. Audits on Professional Standards of | 8/25/23 |

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| F 658 | Continued From page 6<br><br>Record review of the July 2023 Medication Administration Record (MAR) for Resident #62 revealed an order dated 6/21/23, "Normal Saline Flush 1 ML (milliliter) SYR (syringe) flush PICC (peripherally inserted central catheter) line left arm with 10 cc (cubic centimeters) normal saline before and after each antibiotic" with a stop date of 7/04/23.<br><br>Record review of the Physician Orders for the month of July 2023 revealed an order dated 6/22/23, "PICC (peripherally inserted central catheter) line left arm sterile dressing change every 7 days: Sterile gloves clean gloves; mask; 4×4's; alcohol swabs occlusive dressing; Barrier for sterile field;"<br><br>An interview with the Assistant Director of Nursing (ADON) on 7/19/23 at 11:00 AM, revealed the resident was recently sent to the hospital for a blood transfusion. She revealed the Nurse Practitioner (NP) was waiting to see if the resident would require any further blood work or transfusions before removing the PICC line and she revealed that the resident had a follow-up appointment with the urologist on 7/17/23 and the NP wanted to leave the PICC line in place until that appointment.<br><br>An interview with the ADON on 7/19/23 at 1:15 PM, revealed she was not aware that Resident #62's PICC line was not being flushed. She stated, "We were flushing it." She revealed that the resident was receiving antibiotics for a UTI (urinary tract infection) and the PICC line flush order must have stopped when the antibiotic was completed on 7/04/23. She confirmed that they should be flushing it every day to maintain | F 658 | Quality were started on 8/7/23 by Director of Nurses and/or alternating administrative nurses on care plans to make sure all services provided or arranged by the facility is reflected on their current care plan. Audits will be done on 2 residents 3x a week for 4 weeks then 3 times a month for 3 months.<br><br>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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| F 658 | Continued From page 7<br>patency and prevent occlusion.<br><br>An interview with the Director of Nursing (DON) on 7/19/23 at 1:30 PM, revealed she was not aware that Resident #62's PICC line was not being flushed every day. She stated, "The order was entered with a stop date for when the IV antibiotic was completed." She revealed the NP wanted the line left in until he followed up with the Urologist.<br><br>An interview with the NP on 7/19/23 at 1:45 PM, revealed the PICC line should still be flushed, and she stated, "Yes, I didn't know that it wasn't, I can re-order that." She confirmed that flushing the PICC line could prevent the line from occluding.<br><br>An interview with the DON on 7/19/23 at 2:00 PM, confirmed that Resident #62 should have an order to flush his PICC line and confirmed that by not doing this, the line could clot off.<br><br>Record review of the Face Sheet revealed Resident #62 was admitted to the facility on 4/28/23 with medical diagnoses that included Benign Prostatic Hyperplasia, Unspecified Systolic Congestive Heart Failure and Unspecified Atrial Fibrillation.<br><br>Record review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/5/23 revealed under section C a Brief Interview for Mental Status (BIMS) score of 12, indicating resident #62 is moderately cognitively impaired. | F 658 | | |
| F 677 SS=D | ADL Care Provided for Dependent Residents<br>CFR(s): 483.24(a)(2) | F 677 | | 8/25/23 |

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| F 677 | Continued From page 8<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br>This REQUIREMENT is not met as evidenced by:<br>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<br><br>Findings Include:<br><br>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..."<br><br>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.<br><br>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 | F 677 | 1. Resident #26 was shaved on 7/19/23 to remove visible facial hairs.<br><br>2. All dependent resident's have the potential to be affected.<br><br>3. a. ADL care policy for dependent residents was reviewed by the Administrator and Director of Nurses with no revisions made to policy. on 7/24/23.<br><br>b. Facial hair removal of female residents has been added to the Administrative nurses rounds checklist on 8/8/2023.<br>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.<br><br>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.<br><br>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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| F 677 | Continued From page 9<br>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.<br><br>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.<br><br>Record review of Resident #26's Face Sheet revealed the resident was admitted to the facility on 09/24/15 with medical diagnoses that included Unspecified Dementia without Behavioral Disturbance.<br><br>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. | F 677 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must | F 690 | | 8/25/23 |

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| F 690 | Continued From page 10<br>ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident and staff interview, record review and facility policy review the facility failed to provide appropriate incontinent care treatment to prevent the potential for infection for one (1) of four (4) residents observed for care observations. Resident #21.<br><br>Findings include:<br><br>A review of the facility policy titled "Incontinence", revised September 2022, revealed based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. The Policy | F 690 | 1. CNA #1 was in-serviced on the correct way to complete peri-care on a dependent resident on 7/19/23 by Infection control nurse.<br><br>2. All dependent care residents that require peri-care have the potential to be affected.<br><br>3. a. The policy for peri-care on a dependent resident was reviewed by the Administrator with the Director of Nurses with no revisions made on 7/24/2023. | |

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| | 255252 | A. BUILDING _____ B. WING _____ | 07/20/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MS CARE CENTER OF GREENVILLE | 1221 EAST UNION STREET GREENVILLE, MS 38703 |

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| F 690 | Continued From page 11<br>Explanation and Compliance Guidelines revealed: Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible.<br><br>An interview on 07/17/23 at 11:13 AM, with Resident #21 revealed she doesn't feel like they clean her good.<br><br>On 7/19/23 at 8:02 AM, an observation of Resident #21's incontinent care with Certified Nursing Assistant (CNA) #1 revealed that she did not change gloves after setting up the wash basin. CNA #1 wet a bath cloth, wiped across the resident's lower abdomen and groin areas. She then placed the contaminated bath cloth back in the clean water basin and wiped more than one area with the same area of the bath cloth.<br><br>An interview on 07/19/23 at 09:45 AM, with Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1 regarding the incontinent care process, 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 basins.<br><br>An interview on 07/19/23 at 10:00 AM, with CNA #1 regarding incontinent care confirmed that she put the dirty bath cloth back into clean water and contaminated the clean water and she should not wipe more than once with the same area of the bath cloth.<br><br>An interview on 7/20/23 at 9:50 AM, with the Director of Nursing (DON) confirmed staff does annual competency check offs but the staff does | F 690 | b. All staff was inserviced on Incontinent care for dependent residents on 8/1/2023-8/4/2023 by Staff Development.<br><br>c. CNA #1 was successfully checked off on peri-care on a dependent resident after completing the training check off on 8/1/23 by Infection control nurse.<br><br>d. Skills check offs were performed on all CNA staff for peri-care for a dependent resident starting on 7/27/23-8/10/23 by Infection Control Nurse, Staff Development Nurse, and Assistant Director of Nursing.<br><br>4. a. Check offs will be conducted by Infection Control Nurse on 5 CNA's performing peri-care on dependent resident's a week for 6 weeks and then 6 residents requiring peri-care will be audited each month for four months starting on 8/14/2023.<br><br>b. Director of Nurses will report audit 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 Quality Assurance committee.. | |

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| F 690 | Continued From page 12<br>get nervous.<br><br>A review of facility in-service records revealed that CNA #1 attended an in-service on incontinent care on 01/30/23 and successfully performed skills check off for incontinent care on 07/20/22.<br><br>A review of the facility Face Sheet for Resident #21 revealed she was admitted to the facility on 12/01/21 with diagnoses that included Diabetes Mellitus, Intracerebral Hemorrhage, and Needs assistance with personal care.<br><br>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. | F 690 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§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-<br><br>§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;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; | F 692 | | 8/25/23 |

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| F 692 | Continued From page 13<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>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<br><br>Findings include:<br><br>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 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)."<br><br>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." | F 692 | 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.<br><br>2. The facility has determined that all residents with fluid restrictions have the potential to be affected.<br><br>3. a. The hydration policy was reviewed by the Administrator with the Director of Nurses with no revisions made on 7/24/2023.<br>b. All staff was IN-serviced on the hydration policy by staff development Nurse on 8/1/23-8/4/23.<br><br>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. | |

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| F 692 | Continued From page 14<br><br>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)"....<br><br>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.<br><br>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.<br><br>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.<br><br>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 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."<br><br>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 | F 692 | 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.<br>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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| F 692 | Continued From page 15<br>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."<br><br>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).<br><br>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.<br><br>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.<br><br>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. | F 692 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who | F 695 | | 8/25/23 |

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| F 695 | Continued From page 16<br>needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>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.<br><br>Findings include:<br><br>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 ..."<br><br>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. No oxygen in use signage was on the door.<br><br>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 | F 695 | 1. Resident #21 oxygen signage was placed on the door on 7/19/23 by Nurse Supervisor.<br><br>Resident #21 oxygen setup was assessed and changed, labeled, dated and stored per facility policy on 7/19/23 by Nurse Supervisor.<br><br>2. All residents who use oxygen have the potential to be affected.<br><br>3. a. Nursing staff was in-serviced on 7/19/23 on how to properly set up oxygen when not in use.<br>b. ALL Staff was in-serviced on respiratory care related to tag 695 by staff development on 8/1/23-8/4/23<br>c Nursing staff was in-serviced on new Oxygen Policy changes on 7/26/23 by Director of nurses.<br>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<br>1.Masks should be replaced and dated every 7 days.<br>2.Cannulas should be replaced and dated every 7 days. | |

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| F 695 | Continued From page 17<br>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.<br><br>A record review of the Physician Orders dated 07/17/23 revealed "Oxygen at two (2) liters per minute by nasal cannula as needed."<br><br>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.<br><br>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.<br><br>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. | F 695 | 3.When not in use, store the mask/cannula in a plastic bag clearly labeled with the resident□s name and date.<br>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.<br>5.Filter should be cleaned weekly with soap and water.<br>6.Concentrators will be serviced monthly.<br><br>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.<br><br>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. | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program | F 880 | | 8/25/23 |

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| F 880 | Continued From page 18 | F 880 | | |

designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

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| F 880 | Continued From page 19<br>least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, record review and facility policy review the facility failed to prevent the possibility of infection as evidenced by failing to perform hand hygiene, provide a clean workspace, change gloves and keep oxygen tubing off the floor and in a plastic bag for one (1) of four (4) resident care observations. Resident #21<br><br>Findings include:<br><br>A review of the facility policy titled "Infection Control", revised September 2022, revealed:<br>Staff involved in direct resident contact will perform hand hygiene (even if gloves are used). | F 880 | 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 hand hygiene when required, providing a clean workspace as needed, changing gloves as procedure requires.<br><br>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 | |

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| F 880 | Continued From page 20<br>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.<br><br>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.<br>,<br>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.<br><br>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 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 | F 880 | at the time prn order for oxygen.<br><br>2. All residents that require direct care and use oxygen concentrators have the potential to be affected.<br><br>3. a. The policy on Infection Control was reviewed by the Administrator with the Director of Nurses with no revisions on 7/24/2023.<br><br>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.<br><br>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.<br><br>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.<br><br>e. Labeling and storage of oxygen equipment has been added to the Administrative nurses weekly room round sheets for continuing checks during rounds on 8/2/23.<br><br>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. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 255252 | A. BUILDING _____ B. WING _____ | 07/20/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MS CARE CENTER OF GREENVILLE | 1221 EAST UNION STREET GREENVILLE, MS 38703 |

| (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 |
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| F 880 | Continued From page 21<br>#1 looked over resident #21's room for briefs touching items in drawers, touching furniture, the bed and the 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 | F 880 | 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.<br><br>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 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 880 | Continued From page 22<br>and Cough.<br><br>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. | F 880 | | |