STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255174	A. BUILDING _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINGING RIVER HEALTH AND REHABILITATION CENTER	3401 MAIN STREET MOSS POINT, MS 39563

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F 000	INITIAL COMMENTS State Survey Agency (SA) conducted an annual recertification survey at the facility from 12/03/2018 to 12/06/2018. During the survey, the SA determined the facility was not in compliance with Medicare and Medicaid requirements for participation. The SA cited the regulatory deficiencies F550, F600, F641, F656, F 657, F698, F812, F814, and F880. At the time of survey, the census was 103, and the facility held a license for 160 beds.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		1/9/19

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

Electronically Signed | 01/08/2019

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review and staff interview, the facility failed to treat residents with dignity relating to knocking on doors, before entering the rooms, for four (4) of 27 resident observations. This affected Residents #8, #19, #76, and #91. Findings include: A review of the facility's "Dignity" policy , dated December 2017, revealed the facility must treat each resident with respect and dignity, and care for each resident in a manner and in an environment that promotes maintenance and enhancement of his or her quality of life, recognizing each resident's individuality. The Facility's policy also noted that it is procedure of the facility to treat each resident with respect and dignity with regards to the following: personal care, while assisting with eating and other	F 550	1. On 12/7/18, Director of Nursing in-serviced Licensed Practical Nurse (LPN)#1 and LPN #3 on Residents Rights Policy & Procedure (which included knocking on doors). Social Services Director assessed residents #8, #19, #76, and #91 on 1/7/19 for adverse psychosocial effects with no adverse findings. 2. All residents have the potential to be affected by this deficient practice. On 12/7/18, Social Services Director and Director of Nursing initiated an in-service on Residents Rights Policy and Procedure (which included knocking on doors) with all staff. 3. Starting on 1/9/19, the Social Services Director will perform weekly rounds x three months, then quarterly to ensure that Residents Rights Policy and	

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F 550	Continued From page 2 activities of daily living, during routine interactions, and during medication and treatment opportunities. A review of the facility's "Meals, Serving" policy, dated November 2017, revealed to knock before entering the resident's room. The procedure guide also noted to identify yourself. Resident #19 An observation, made during the initial tour of the facility on 12/03/2018 at 12:30 PM, revealed Licensed Practical Nurse (LPN) #1 failed to knock on the door or announce her entrance before entering the room of Resident #19. LPN #1 was carrying Resident #19's lunch meal tray into the resident's room. Resident #8 An observation, made during the initial tour of the facility on 12/03/2018 at 12:35 PM, revealed LPN #1 failed to knock on the door or announce her entrance before entering the room of Resident #8. Resident #76 An observation, made during the initial tour of the facility on 12/03/2018 at 12:35 PM, revealed LPN #1 failed to knock on the door or announce her entrance before entering the room of Resident #76. Resident #91 An observation, made during medication pass on 12/04/18 at 9:00 AM, revealed LPN #3 failed to knock on the door prior to entering Resident #91's room. On 12/05/18 at 2:51 PM, interview with LPN #3	F 550	Procedure is being followed by all staff through observation and resident interviews. Social Services Director will perform quarterly in-service with all staff on Residents Rights Policy and Procedure (i.e. knocking on doors). 4. Social Services Director will report the results of rounds and status of in-services in monthly Quality Assurance Performance Improvement (QAPI) meeting with recommendations and systemic changes implemented as needed .	

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F 550	Continued From page 3	F 550		

confirmed she failed to knock on the door prior to entering Resident #91's room. She stated she normally knocks on the door, but she was nervous and forgot.

During an interview on 12/06/2018 at 9:50 AM, Registered Nurse (RN) #1 confirmed before entering a resident's room, the correct procedure is to always knock on the door and announce yourself. RN #1 stated there has been recent in-services on Dignity, which included knocking on the resident's doors, within the last 30 days. RN #1 also stated that LPN #2/Staff Development Nurse is the person who usually conducted the in-services, but she had conducted them as well.

During an interview on 12/06/2018 at 10:00 AM, Certified Nursing Assistant (CNA) #1 confirmed that before entering the resident's room, the process is to always knock on the door and tell the resident who you are.

During an interview on 12/06/2018 at 10:05 AM, CNA #2 stated that you should always knock on the resident's door before entering the resident's room.

During an interview, on 12/06/2018 at 11:30 AM, LPN #1 stated, "I know that knocking on the door is what you're supposed to do." LPN #1 stated that she did not realize that she was not knocking on the residents' doors before she entered.

During an interview, on 12/06/2018 at 11:30 AM the Director of Nursing (DON) confirmed that it is the policy of the facility that staff should knock before entering a resident's room to announce their entrance.

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F 600	Continued From page 4	F 600		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to protect residents from resident on resident abuse for two (2) of eight (8) residents reviewed for resident altercations, Residents #24 and #96. Findings include: Review of the facility's "Prevention of Resident Abuse, Neglect, Mistreatment or Misappropriation of Property" policy, dated December 2017, revealed it is the policy of this Center that each resident has the right to be free from verbal, sexual, physical and mental abuse; corporal punishment; involuntary seclusion: mistreatment of any kind, exploitation, and misappropriation of property. Residents will not be subjected to abuse by anyone, including but not limited to, Center staff, other residents, consultant, voluntary staff,	F 600	1. Resident #27 and Resident #24 were immediately separated. A body audit was performed by Licensed Practical Nurse on Resident #24 with no adverse findings/injuries noted. Resident #27 had back scratcher confiscated on 6/3/18. Resident #27 was referred for a Psychiatric evaluation which was performed on 6/13/19 by Psychiatrist. Resident #24 is redirected with diversional activities when exhibiting repetitive verbalizations when wheeling throughout center. Resident #6 and Resident #96 were immediately separated and a body audit was performed by Licensed Practical Nurse on both resident #6 and Resident #96 with no adverse findings/injuries noted. Resident #96 is placed on 1:1 staff observation promptly	1/9/19

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F 600	Continued From page 5 contract staff, family members, friends or others. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. Our residents have the right to be free from resident to resident abuse. Record review of a facility reported incident revealed on 6/4/2018, Resident #24 was propelling herself in her wheelchair in the hallway towards Resident #27's room. Resident #27 was sitting in his wheelchair in the door to his room. Resident #27 started yelling at Resident #24, telling her to turn around. Resident #24 said, "Shut up." Resident #27 struck Resident #24 on the top of her head with a wooden back scratcher. Both residents were separated. Resident #27's back scratcher was confiscated. Both residents were placed on 15 minute checks. Resident #24 was placed back on her unit. Body Audit performed on Resident #24 (with no obvious injury), labs drawn on Resident #27, Psychiatrist, Representatives, Doctors, Director of Nursing, Risk Manager, and Administrator notified of the incident. The facility reported incident also revealed the Risk Manager spoke with Resident #27, and confirmed he struck Resident #24 with his back scratcher. The resident reported saying, "I was tired of her yelling out all the time", "I was trying to sleep and she kept waking me up", "I didn't mean to hurt her", "I just wanted her to go away", and "I won't do it again."	F 600	when noted to be escalating to outburst until it subsides. Resident #6 is redirected with diversional activities when approaching other residents' rooms. Resident #6 does not reside two doors down from Resident #96. Resident #6 resides on West A Wing 6 doors down and through double doors away from Resident #96 that resides on West B Wing. On 12/7/18, the Social Services Director initiated and in-service on Prevention of Abuse and Neglect Policy with all staff. 2. Rounds were made on 12/10/2018 to interview residents regarding abuse. 3. On 1/7/19, the Staff Development Nurse initiated the monthly Hand In Hand Dementia Care video in-service with all staff. Director of Nursing will in-service all staff on How to deal with Behaviors/Dementia Care on 1/9/19. 4. Staff Development Nurse will report in-service completion in Quality Assurance Performance Improvement (QAPI) meeting monthly with recommendations and systemic changes implemented as needed.	

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F 600	Continued From page 6 Resident #24 During an observation and interview on 12/03/2018 at 11:32 AM, Resident #24's husband pushed her around the facility in a wheelchair. Resident #24 was confused, rambling and talking to herself. Resident #24's husband revealed the resident is very confused, and roams in and out of other resident's rooms. Resident #24's husband stated Resident #24 had inappropriate behavior at times such as cursing, hitting pointing her finger, and yelling. The husband stated he visited daily and pushed her around the building because Resident #24 caused confusion with the staff and other residents. Observation on 12/03/18 at 2:10 PM, revealed Resident #24 propelling herself around the building, confused with no behaviors at this time. Observation on 12/04/18 at 12:12 PM, revealed Resident #24 propelling herself around the facility very confused, talking to herself, with no behaviors noted. Record review of the current comprehensive care plan revealed Resident #24 is forgetful, short and long term memory impairment, has a short attention span and can not stay focused on task. The resident is also high risk for inappropriate behavior such as curing, scratching, hitting, spitting, repetitive verbalizations and inappropriate comments sometimes sexual in nature related to Alzheimer's Disease, Major Depressive Disorder and Dementia with Behavioral Disturbance. Interventions: If inappropriate behavior occurs, observe for triggers/root cause and attempt to eliminate, observe for and document any noted episodes of	F 600		

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F 600	Continued From page 7 behavior attempt to redirect in a positive manner, report to medical director, offer diversion activities when appropriate such as snacks, drink, offer resident choices concerning care to promote cooperation with care and wheel resident around facility when anxious, call husband. A review of the facility's face sheet revealed the facility admitted Resident #24 on 10/11/2016, with diagnoses which included Dementia, Alzheimer's Disease, Anxiety and Depressive Disorder. A review of Resident #24's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/06/2018, revealed Resident #24 had a Brief Interview for Mental Status (BIMS) score of 02, which indicated the resident is severely cognitively impaired. Resident #27: Record review of Resident #27's current Comprehensive Care Plan revealed the resident gets agitated when he loses Bingo, refuses ADL care, and has episodes of hollering/screaming/cursing which disrupts others during bingo. The resident is also high risk for altered mood and behavior disorder as evidence by crying during activities, resident cries for not getting his way, or for attention. Resident spits on the floor, pours urine on the floor and in garbage can, refuses baths, and refuses to change clothes. Interventions: investigate and determine reason for crying if able and redirect, praise efforts, pharmacy consult, psych consult, and approach in calm manner. A review of the facility's face sheet revealed the facility admitted Resident #27 on 7/26/2011, with diagnoses, which included Major Depressive	F 600		

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F 600	Continued From page 8 Disorder (Recurrent, Severe with Psychotic Symptoms), End stage renal Disease and Insomnia. A review of Resident #27's Quarterly MDS, with an ARD of 9/08/2018, revealed Resident #27 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment. On 12/04/18 at 9:26 AM, interview with LPN #4 revealed Resident #24 propels herself around the facility and sometimes the resident gets agitated and yells and screams at other residents because of her diagnosis of Dementia. LPN #4 stated when the resident gets loud and starts to act out, the staff tries to redirect her and take her to her unit and notify the nurse. LPN #4 stated that Resident #27 gets agitated easily and wants to isolate in his room. The resident at times yells and screams at staff when he doesn't want to be bothered. LPN #4 said when Resident #27 gets agitated, the staff tries to redirect him and offer a snack or try to find out what's causing the problem and attempt to fix it. During an interview on 12/04/18 at 12:10 PM, RN #1 the Nursing Supervisor, revealed Resident #24 is very confused, propels herself around in wheelchair, and rummages around in and out of resident rooms. RN #1 stated the resident curses at the staff and other residents and is combative at times. She said the staff will redirect her when she become anxious and combative. RN #1 stated the resident's husband visits daily to help keep her calm. RN #1 stated Resident #27 gets agitated at times and yells and screams at staff and other residents and the staff attempts to redirect the resident. During an interview on 12/05/18 at 10:31 AM, the	F 600		

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F 600	Continued From page 9 Director of Nursing (DON) confirmed Resident #27 hit Resident #24 with a back scratcher. The DON stated Resident #24 propels herself around the facility and rummages in and out of other resident rooms. The DON also stated she did not want to keep Resident #24 from traveling around the building. The DON said Resident #27 is simple minded and she did not feel he was trying to hurt Resident #24. During an interview on 12/05/18 at 10:02 AM, LPN #2 the Staff Development Nurse, revealed the facility in-serviced the staff on hire and monthly on Dementia Care through the Hand in Hand videos. The LPN #2 also stated the staff are trained yearly with the behavioral units from the local Hospital. Resident #96 Record review of a facility reported incident, revealed on 11/10/2018 at 12:30 PM, Resident #96 was sitting in the doorway of her room yelling out explicit language. Resident #6 walked up to Resident #96. Resident #96 started yelling and cursing at her. Resident #6 leaned over and struck Resident #96 on her face two (2) times with open hand. Both residents were separated, and the Physician, Resident Representative, Director of Nursing (DON) and the Administrator notified. (No obvious injury). Observation on 12/03/18 at 10:12 AM, revealed Resident #96 sitting in doorway of her room. The resident was non-verbal, and nodded her head to questions. Resident #6 ambulated on the hall without assistance. Resident #6's room was noted two (2) doors down from Resident #96. During an interview on 12/04/18 at 10:15 AM, RN	F 600		

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F 600	Continued From page 10 #1 revealed Resident #96 is very confused, sits in her doorway and yells, screams, and curses at staff and other residents. RN #1 said the resident also propels down the hallway without difficulty. RN #1 stated the staff attempts to redirect her by offering snacks, call her family or just talk to her. RN #1 stated the resident can be combative at times and has had several altercations with other residents but has not hit anybody that she knew about. RN #1 also said Resident #6 ambulates without assistance and is very confused. RN #1 stated that Resident #6 takes care of all the other resident's on her hall. RN #1 stated that Resident #6 can be resistant to care and is combative at times. The staff redirects her with other activities. Observation on 12/04/18 at 11:36 AM, revealed Resident #6 ambulating down hallway without assistance. Resident #6 had a roll of toilet paper in her pants and staff attempted to take the toilet paper to place in the resident's bathroom. Resident #6 was cooperative at this time. During an interview 12/05/18 at 11:43 AM, the DON revealed Resident #96 gets really agitated at times and is hard to redirect. The DON confirmed Resident #6 slapped Resident #96. The DON stated Resident #6 is very territorial and is like a mother figure. The DON said the resident was upset because Resident #96 was cursing at everybody that was passing by her room. The DON stated that she had discussed with the staff that maybe they should remove Resident #96 out of that room, away from the nurses station, but she did not know whether it would cause more damage to that resident because of the resident's Huntington's disease. The DON said she had not considered moving Resident #6; however, she will consider moving	F 600		

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F 600	Continued From page 11 her. Record review of the current comprehensive care plan revealed Resident #96 is at risk for altered mood and behavior related to Huntington's Disease and has inappropriate outburst at times as evidenced by (AEB) cursing, throwing things, hitting staff, paranoia, easily angered, and agitated. Interventions: one to one (1:1) staff observation as needed when escalating to outbursts, back away, maintaining safety of the resident and others. A review of the facility's face sheet revealed the facility admitted Resident #96 on 10/31/2018, with diagnoses which included Mood Disorder, Dementia, Anxiety and Huntington's Disease. A review of Resident #96's Quarterly MDS, with an ARD of 11/03/2018, revealed Resident #96 had a BIMS score of 6, which indicated the resident is severely cognitively impaired. Resident #6: Record Review of Resident #6's current Comprehensive Care Plan revealed Resident #6 is at risk for altered mood and behavior related to she believes that everything she sees is hers and will hit and curse at staff at times and is not easily redirected. She is in and out of other resident's rooms and hoards eating utensils in her room. Interventions: Be attentive and supporting to whatever she has to say, whenever becomes agitated redirect if able with diversonal activities, and conversation. A review of the facility's face sheet revealed the facility admitted Resident #6 on 8/06/2018, with diagnoses which included Alzheimer's/Dementia with behavioral Disturbance, Major Depressive	F 600		

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F 600	Continued From page 12 Disorder and Impulsive Control Disorder. A review of Resident #6's Quarterly MDS, with an ARD of 4/26/2018, revealed Resident #6 had a BIMS score of 3, which indicated the resident has severe cognitive impairment.	F 600		
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 policy review, record review, and staff interview, the facility failed to accurately code a high risk medication on the Minimum Data Set (MDS) for one (1) of 30 resident assessments reviewed, Resident #48. Findings include: A review of the facility's "Resident Assessment" policy, dated November 2017, revealed the facility followed the Resident Assessment Instrument Manual (RAI Manual) for coding the MDS. A review of Resident #48's quarterly MDS, with an Assessment Reference Date (ARD) of 9/24/18, revealed Anticoagulant use over the past seven (7) days was coded for Zero (0) days. A review of Resident #48's September 2018 Physician's Orders revealed that the resident had an order for Eliquis (Apixaban) 2.5 milligram (mg) by mouth twice daily for Atrial Fibrillation. A review of the resident's Medication Administration Record (MAR) for September	F 641	1. On 12/7/18, Minimum Data Set Coordinator (MDS) completed a correction assessment on resident #48 to accurately code the anticoagulant. On 12/7/18, Minimum Data Set Coordinator was in-serviced on Minimum Data Set 3.0 Resident Assessment Instrument Manual, Section N (Medications) requirements. 2. Residents receiving anticoagulants had their medical records audited 12/7/18 to determine if there were any other residents at risk for which there were none. This audit was completed by the MDS Coordinator on residents receiving an anticoagulant to ensure accuracy of MDS, under Section N with no adverse findings. 3. Starting 1/7/19, Perspective Payment System (PPS) Coordinator will complete an audit of completed MDS' monthly x three months, then quarterly to ensure all residents receiving anitcogulants have been accurately coded on the MDS assessment under Section N. 4. PPS Coordinator will report the results	1/9/19

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F 641	Continued From page 13 2018, revealed that the resident had received Eliquis (Apixaban) 2.5 mg twice daily for the entire month of September 2018, which included the days in the ARD. An interview with RN #2, on 12/5/18 at 11:11 AM, confirmed she should have coded Anticoagulants on the 9/24/18 MDS for seven (7) days. RN #2 reported that she just overlooked it. An interview with the DON on 12/5/18 at 11:37 AM, revealed that she would expect the MDS to have the anticoagulant coded on the 9/24/18 MDS, since it was given during the ARD time per the MAR. A review of the facility's face sheet for Resident #48, revealed the facility admitted the resident on 3/22/18, with diagnoses of Chronic Obstructive Pulmonary Disease, Acute Chronic Systolic (Congestive) Heart Failure, Atrioventricular Block Complete, Cerebral Infarction, and Paroxysmal Atrial Fibrillation.	F 641	of MDS audit to the Quality Assurance Performance Improvement (QAPI) meeting monthly with recommendations and systemic changes implemented as needed .	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		1/9/19

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F 656	Continued From page 14 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 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. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, record review, resident interview, and staff interview, the facility failed to develop the care plan related to the resident's refusal of catheter related care for one (1) of four (4) resident care plans with catheters reviewed, Resident #8 Findings include:	F 656	1. On 12/6/18,the Director of Nursing (DON) revised Resident #8's Urinary Care Plan to include/address his noncompliance with the use of catheter drainage bag and dignity bag cover, his noncompliance with maintaining his catheter drainage bag below the level of the bladder while up in wheelchair, and his noncompliance with allowing staff to	

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F 656	Continued From page 15 A review of the facility "Care Plan-Comprehensive" policy, dated November 2017, revealed that a Comprehensive Care Plan that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs shall be developed for each resident. The facility policy also revealed that the Comprehensive Care Plan has been designed to incorporate identified problem areas, incorporate risk factors associated with identified problems, and ensure the Care Plan is individualized and person-centered and reflects the resident's goals for admission and desired outcomes. An observation on 12/03/2018 at 1:00 PM, revealed upon entering Resident #8's room, that his catheter drainage bag was laying on the floor and there was no dignity bag present. Resident #8 was observed placing his catheter drainage bag behind his back after getting into his wheel chair. Resident #8 was observed entering in his bathroom where he emptied his own catheter drainage bag into the toilet. Record review of Resident #8's current care plan, with a review date of 10/11/2018, revealed that a care plan had not been developed to include Resident #8's refusals of staff-assisted catheter care or the refusal of a dignity bag. The care plan did not include Resident #8's refusal to keep the catheter drainage bag below the level of his bladder while in his wheel chair, by placing it behind his back. The care plan did not address that Resident #8 refused to allow the facility staff to emptying his catheter drainage bag to obtain a urine assessment or urine output totals, or that Resident #8 emptied his catheter drainage bag himself.	F 656	empty his catheter drainage bag. On 12/7/18, Director of Nursing performed an in-service with Nurses and Certified Nursing Assistant s (CNA) regarding documentation of resident noncompliance with treatment/care, Refusal of treatment form Policy, and communication to Care Plan Coordinator and Director of Nursing of resident noncompliance as it occurs. 2. Residents with catheters were reviewed/observed to determine if there were any other residents affected. This review/observation occurred on 12/7/18. The Director of Nursing completed this audit of all residents with an indwelling urinary catheter to identify any noncompliance issues through staff/resident interview and observation, completion of Refusal of Treatment forms and review of care plans with no adverse findings. 3. Starting on 1/9/19, the Care Plan Coordinator will complete a monthly audit of all residents with an indwelling urinary catheter to identify noncompliance through staff/resident interview and observation, completed Refusal of Treatment forms and will audit the resident care plan for accuracy to reflect any noted noncompliance. The Care Plan Coordinator will complete an in-service quarterly with Nurses and CNA s on the Refusal of Treatment form Policy. 4. The Care Plan Coordinator will report the results of audits in the Quality Assurance Performance Improvement (QAPI) meeting monthly with recommendations and systemic changes implemented as needed .	

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F 656	Continued From page 16 During an interview, on 12/03/2018 at 1:05 PM, Resident #8 confirmed that he empties his own catheter drainage bag and he refused to use a dignity bag. Resident #8 also stated that he likes to keep his catheter drainage bag behind him while he is up in his wheel chair. During an interview on 12/3/2018 at 3:20 PM, Licensed Practical Nurse (LPN) #1 confirmed that Resident #8 refused to allow the catheter drainage bag to be placed in a dignity bag. LPN #1 confirmed that Resident #8 emptied his catheter drainage bag himself, even though the staff has tried to talk to him about it, but he still refused assistance. LPN #1 stated, "Resident #8 says that he knows he should not be putting his catheter drainage bag in his wheelchair." LPN #1 also stated that Resident #8 continued to put the bag behind him when he's up in his wheelchair or lets it lay on the floor when he is in bed. During an interview, on 12/06/2018 at 11:30 AM, the Director of Nursing (DON), stated the facility does not have a Care Plan Coordinator in place, but that she has been acting in that role. The DON stated that a care plan should have been developed to reflect the resident's refusal of the use of a dignity bag, and his non-compliance of the catheter drainage bag placement. The DON also stated that the care plan should also include that he places the bag in his wheel chair behind his back and that he empties the catheter drainage bag himself. Review of the Face Sheet revealed the facility admitted Resident #8 on 5/20/2015, and re-admitted the resident on 2/03/2016, with diagnoses to include Pressure Ulcer (Stage 4)	F 656		

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F 656	Continued From page 17 and Generalized Anxiety Disorder. Review of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/23/2018, revealed Resident #8 had a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		1/9/19

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F 657	Continued From page 18 by: Based on facility policy review, record review, and staff interview, the facility failed to revise the care plan related to recommendations for nutritional support for one (1) of (5) resident nutritional care plans reviewed, for Resident #73. Findings Include: Review of the facility's "Care Plan-Comprehensive" policy, dated November 2017, revealed that a Comprehensive Care Plan that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs shall be developed for each resident. The facility policy also revealed that care plans are revised as changes in the resident's conditions dictate. Reviews are made at least quarterly. Record review of Resident #73's current care plan, with a review date of 08/28/2018, revealed that the care plan was not revised to include the physician's orders on 10/12/2018, when the resident was to begin receiving four (4) ounces (oz.) of a high calorie protein supplement two (2) times per day by mouth (PO) as a supplement, nor revised when the Ready Care was increased to three (3) times daily on 10/25/18. Record review of Resident #73's Nutrition Quarterly Update note, dated 10/12/2018, signed by the Dietary Consultant, revealed that Resident #73 will be started on a high calorie protein supplement, at four (4) ounces twice a day, to prevent further rapid weight loss. Record review of Resident #73's Nutrition Quarterly Update note, dated 10/25/2018, signed	F 657	1. On 12/6/18, the Director of Nursing (DON) revised Resident #73's care plan to include Ready Care 4 ounces by mouth three times a day. 2. Residents receiving nutritional supplements were reviewed/observed to determine if the care plan was accurate with regard to their nutritional supplement. This audit was completed on 12/7/18 by the Director of Nursing who completed the audit of all residents receiving a dietary supplement to ensure it is reflected in the resident care plan with no adverse findings. 3. Starting on 1/9/19, the Care Plan Coordinator will complete a daily audit of all new orders for Dietary supplements and ensure that it is added to the resident care plan as ordered. Starting on 1/9/19, the Director of Nursing will perform a monthly audit of all care plans for residents receiving dietary supplements x three months, then quarterly to ensure that the resident care plan has been revised timely as ordered. 4. The Care Plan Coordinator will report the results of audits in Quality Assurance Performance Improvement (QAPI) meeting monthly with recommendations and systemic changes implemented as needed.	

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F 657	Continued From page 19 by the Dietary Consultant, revealed that Resident #73 will receive a high calorie protein supplement, at four (4) ounces three (3) times a day, related to his weight loss. Record review of Resident #73's Physician's Orders, revealed a telephone order dated 10/12/2018, which noted that the resident was to receive four (4) ounces of a high calorie protein supplement two (2) times per day by mouth (PO), as a supplement. A physician's order, dated 10/25/2018, noted the resident was to receive four (4) ounces of a high calorie protein supplement to be increased to three (3) times per day PO. During an interview, on 12/06/2018 at 11:30 AM, the Director of Nursing (DON), revealed the Care Plan for Resident #73 should have been revised to include the high calorie protein supplement ordered by the resident's physician, due to the resident's weight loss. Review of the Face Sheet revealed the facility admitted Resident #73 on 10/11/2016, and re-admitted the resident on 12/19/2016, with diagnoses to include Dysphagia and a Vitamin B12 Deficiency.	F 657		
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	F 698		1/9/19

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F 698	Continued From page 20 by: Based on record review and staff interview the facility failed to ensure on-going assessments were completed during and after dialysis for one (1) of three (3) residents with dialysis, Resident #78 Findings include: Review of Resident #78's "Admission Record", dated 9/18/18, revealed the diagnoses included but were not limited to End Stage Renal Disease and Diabetes Mellitus. Review of Resident #78's "Physicians Orders Summary" dated 12/3/18, revealed the resident received dialysis on Tuesday, Thursday, and Saturday. Review of the "Dialysis Transfer Forms" dated 10/20/18, 10/25/18,10/27/18, 10/30/18,11/08/18, 11/10/18, and 11/21/18, lacked documentation to be completed by the dialysis unit and returned with the resident for the following areas: "the pre and post dialysis weights, problems during dialysis, medications administered during dialysis, amount of fluid pulled off resident, vital signs, any dietician recommendations, food and fluid consumed during dialysis, and medications sent by center which were given during dialysis." Review of the "Dialysis Transfer Form," dated 10/25/18, 10/30/18,11/06/18, 11/10/18, 11/19/18, and 11/21/18, lacked documentation of the assessment to be completed by the facility staff, upon a resident's return from dialysis appointments. The following information was missing: "bruit/thrill present, signs and symptoms of infection, and signs of bleeding at the site."	F 698	1. On 12/7/18, Director of Nursing in-serviced Nurses on Dialysis Policy (which included assessment of resident before/after dialysis and completion of dialysis unit section upon return to center) and accurate completion of Resident #78 Dialysis Transfer Form with each dialysis visit. 2. All other residents receiving dialysis have the potential to be affected by this deficient practice. On 12/7/18, Assistant Director of Nursing and Nurse Supervisor on the first shift (7a-3p)completed an audit of Dialysis transfer Forms on all residents receiving Dialysis services to ensure accurate completion of forms for all Dialysis visits with no negative findings. 3. Assistant Director of Nursing and Nurse Supervisor on day shift will perform daily audit of Dialysis Transfer forms on dialysis days upon residents return to the center to ensure accurate completion of forms x one month, then monthly. Beginning 3/7/19, the Director of Nursing will perform quarterly in-service on Dialysis Policy. 4. Assistant Director of Nursing will report the results of audit in Quality Assurance Performance Improvement (QAPI) meeting monthly with recommendations and systemic changes implemented as needed.	

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F 698	Continued From page 21 During an interview on 12/05/18 10:00 AM, the Licensed Practical Nurse Staff Coordinator confirmed the dialysis transfer forms should be completed by both the dialysis staff, and the facility nurse, when the resident returns from dialysis. The facility nurse should call if the forms have not been completed by the dialysis center when the resident returns from dialysis.	F 698		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to prepare and distribute food under sanitary conditions. Dishes available for resident use were observed to be dirty with food particles remaining after the dinnerware was washed.	F 812	1.On 12/5/18 Dietary Manager cleaned the mixer and ensured it was free of any food/batter splattering, all dishes were cleaned by dietary staff and free of any food particles and were stored dry.	1/9/19

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F 812	Continued From page 22 Additionally, a kitchen mixer used for resident food preparation wasn't properly cleaned. This had the potential to affect 99 of 103 residents who reside in the facility. Findings include: During the kitchen tour on 12/5/18 at 10:56 AM through 11:37 AM, with the Dietary Manager (DM), observations were made of the following: The mixer had yellow food/batter splattered underneath where the beaters attach, on the right side, on top of the mixer, and on the back of the base. The Dietary Manager stated the mixer needed to be cleaned at the time of the observation. Continued observations during the kitchen tour on 12/05/18, revealed the dishes were found to have food particulate remaining on the them, after the dishes had been washed and stored for staff to use to serve the resident's meals. There were food particles found on nine of 10 bowls, and 31 of 35 divided plates had been either stored wet (increased risk of contamination) and/or had food particles left on the dinnerware after it had been washed and stored. The DM confirmed the plates and bowls needed to be rewashed, at the time of the observations. Observation of the plate warmer during the kitchen tour revealed 17 of 24 plates stored in the plate warmer had food particulate on them and had not been placed in the warmer clean. DM stated the plates needed to be rewashed at the time of the observation. The dishwasher was observed during the survey and was in working order. No concerns were	F 812	2. All residents who are served meals prepared in the kitchen have the potential to be affected by this deficient practice. 3.On 12/5/18 an in-service was given to all dietary staff by Dietary Manager on Food Procurement, Storage, Preparation/Service/Sanitation including "all utensils, counters, shelves and equipment shall be kept clean." The Dietary Manager initiated a daily log on 12/5/18 to inspect dishes and equipment to ensure it is clean and free of food particles. This will be completed by assigned dietary staff. Registered Dietician will perform monthly audits of the inspection logs x three months and then Quarterly. 4. Dietary Manager will report the results of daily inspection log/audits/observations to the Quality Assurance Performance Improvement (QAPI) meeting monthly with recommendations and systemic changes implemented as needed.	

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F 812	Continued From page 23 identified related to the dishwashing equipment.	F 812		
F 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based observation, staff interview, and review of facility policy, the facility failed to ensure garbage was disposed of properly for two (2) of two (2) dumpsters. Specifically, the dumpsters were not closed, and were overflowing with garbage, with garbage on the ground around the dumpsters. Findings include: Review of a facility's "Garbage and Rubbish Disposal" policy, dated November 2017, specified " Outside dumpsters provided by garbage pick-up services must be kept closed and free of litter around the dumpster area." On 12/03/18 at 10:20 AM, during the initial kitchen tour with the Dietary Manager, two (2) outside dumpsters used for facility refuse were observed. One (1) dumpster was observed with the lid down, but not closed, because it was overflowing with garbage. The second dumpster was observed with the lid open, and garbage spilling over the top of the dumpster. There were five (5) bags of garbage and a discarded box on the ground next to the dumpsters. The Dietary Manager stated they had been having trouble with the waste company at the	F 814	1. On 12/3/18 the dumpster was emptied by the contracted waste disposal company. All bags and trash were cleaned and removed in surrounding areas by dietary and maintenance staff. 2. No residents were affected by this issue. No residents reported any symptoms of illness due to this issue. 3. On 12/3/18 Dietary Manager in-serviced all staff on the Garbage and Rubbish Disposal policy including "outside dumpsters provided by garbage pick-up services must be kept closed and free of litter around the dumpster area." On 12/7/18 a daily inspection log was initiated to be completed by assigned dietary staff. Registered Dietician will perform monthly audit of inspection log x three months and then quarterly. 4. Dietary Manager will report results of daily inspection log and audits to the Quality Assurance Performance Improvement (QAPI) meeting monthly with recommendations and systemic changes implemented as needed.	1/9/19

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	255174	A. BUILDING _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINGING RIVER HEALTH AND REHABILITATION CENTER	3401 MAIN STREET MOSS POINT, MS 39563

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F 814	Continued From page 24 time of the observations.	F 814		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program 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	F 880		1/9/19

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F 880	Continued From page 25 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 least restrictive possible for the resident under the circumstances. (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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, record review, and staff interview, the facility failed to prevent the possible spread of infection by staff pulling gloves and eye ointment from a pocket, prior to resident care, for one (1) of four (4) residents observed during medication administration, Resident #91.	F 880	1. On 12/7/18, Resident #91 was placed on 72 hour observation for signs and symptoms of infection with no adverse findings. On 12/7/18, Director of Nursing in-serviced Licensed Practical Nurse #3 on Infection Control Policy (which included not storing items in pockets due to contamination) and performed written	

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F 880	Continued From page 26 Findings include: A review of the facility's "Infection Control Monitoring" policy, dated November 2017, revealed it is the policy of the center to investigate the cause of infections (nosocomial and community and hospital acquired) and the manner of spread. The objectives of the facilities Infection Control Policies and Practices are to prevent, identify, report and control infections and other communicable diseases. Designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections, establish guidelines to follow in the implementation of isolation precautions, Maintain records of incidents and corrective actions related to infections, establish guidelines to follow in implementing standard precautions/universal precautions of the handling of blood/body fluids, antibiotic Stewardship Program. During an observation of medication administration on 12/04/2018 at 9:00 AM, Licensed Practical Nurse (LPN) #3 pulled gloves out of her pocket prior to administering medication via Resident #91's Gastrostomy tube. LPN #3 also removed "ultra fresh ointment" out of her pocket and applied it to the resident's bilateral eye lids. During an interview on 12/05/18 at 9:31 AM, LPN #3 confirmed she pulled the gloves and the eye ointment out of her pocket. LPN #3 said she was nervous and did not realized she had put the gloves and eye medication in her pocket and took it out until after she left the room. During an interview on 12/06/18 at 12:08 PM,	F 880	verbal counseling. 2. All residents receiving medications, especially eye ointment, have the potential to be affected by this deficient practice. 3. On 12/7/18 Director of Nursing initiated an in-service on Infection Control Policy (which included practicing standard/universal precautions when caring for residents)with all staff. Staff Development Nurse will perform in-service on Infection Control Policy with all staff monthly x three months, then quarterly. Assistant Director of Nursing and Nurse Supervisor on the day shift (7a-3p) will perform random weekly Medication Pass Observations x three months, then monthly x three months, then quarterly. 4. Assistant Director of Nursing will report the results of medication pass observations in Quality Assurance Performance Improvement meeting monthly with recommendations and systemic changes implemented as needed.	

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F 880	Continued From page 27 LPN #2/Staff Development Nurse, stated that infection control training is done upon hire and annually. LPN #2 stated that the nurse, LPN #3, failed to follow the facility policy by pulling the gloves and eye ointment out of the her pocket. She said the nurse could cause infection by pulling gloves and the eye ointment out of her pocket, then provide care to the resident.	F 880		

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	255174	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/05/2018**

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility meets the applicable provisions of the 2012 (existing) Edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA). There were no LSC deficiencies cited during this survey.	K 000		

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

Electronically Signed | 01/03/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 000	Initial Comments *EMERGENCY PREPAREDNESS* Survey conducted on 12/5/18 revealed the above facility meets all applicable Federal, State and local emergency preparedness requirements. No deficiencies were identified.	E 000		

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

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