STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255217	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER HEIGHTS HEALTHCARE CENTER	402 ARNOLD AVENUE GREENVILLE, MS 38701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The State Survey Agency (SA) conducted an annual recertification survey at the facility from 5/14/19 - 5/16/19. 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 F582, F623, F625, F641, F645, F656, and F692. At the time of survey, the census was 56, and the facility held a license for 60 beds.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the	F 582		6/19/19

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

Electronically Signed | 06/13/2019

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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F 582	Continued From page 1 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) and Notice of Medicare Non-Coverage (NOMNC) to a resident prior to discharge from skilled services for one (1) of three (3) residents reviewed for Beneficiary Protection Notification Review, Resident #54. Findings include:	F 582	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because is required by the provision of Federal and State law. This plan of correction constitutes the facilities credible	

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F 582	Continued From page 2 Review of the facility's "Available Services" policy, revised August 2011, revealed, "...2. A representative of the business office will inform residents of any change(s) in the cost or availability of services at least five (5) days prior to such change taking effect." Review of the Skilled Nursing Facility Beneficiary Protection Notification Review, Form CMS-20052(11/2017), revealed Resident #54 received Medicare Part A Skilled Services from 1/28/19 - 2/11/19, and the facility initiated a discharge from Medicare Part A Services when benefit days were not exhausted. The facility failed to issue a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) Form CMS-10055 nor a Notice of Medicare Non-coverage (NOMNC), Form CMS-10123 to Resident #54. On 05/16/19 at 2:52 PM, an interview with the Administrator, confirmed Resident #54 was not issued the SNF ABN and NOMNC forms. He stated, that these forms should be issued any time a resident is discharged from skilled services with remaining Medicare days available. During an interview, on 05/16/19 at 3:06 PM, with the Social Services Director (SSD), she revealed, that the SSD is responsible for having the SNF ABN completed and signed. The SSD stated, "I did not have a dollar amount to put on the SNF ABN. I reached out to find out how much it was, so I could put an amount, but did not get a response. I asked the Administrator at that time for the amount but he did not get back with me. I could not ask the Resident to sign an incomplete	F 582	allegation of compliance. No resident suffered any adverse effects from this deficient practice. Resident #54 was discharged from skilled services back in February of 2019 and thus it is not possible to issue and ABN (Advanced Beneficiary Notice or NOMNC (Notice of Medicare Non Coverage) four months later. The facility Social Worker is no longer employed with River Heights and the Acting Social Worker is well aware of what notices are to be provided and when to Medicare Beneficiaries. All Medicare Beneficiaries that receive skilled level services have the potential to be affected by this deficient practice. A 100% audit was completed on 6/11/2019 by the facility Social worker on current Medicare Beneficiaries that are receiving a skilled level of service to ensure that all notifications are in order for these beneficiaries. The audit revealed that one Part A resident and four Part B residents required an ABN be provided and that was completed and given to the beneficiary by the Social Worker. The facility Administrator, Social Worker, and Business Office was provided in-service education on 6/11/2019 by the Chief Operations Officer on the proper use of Advanced Beneficiary Notices and Notice on Medicare Non Coverage for Medicare Beneficiaries. The Social Worker will monitor for the completion of all Medicare required notifications one time a month for six months during monthly Triple Check	

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F 582	Continued From page 3 form. She should have been issued a SNF ABN and I talked with her about it, but did not ask her to sign it. I have never heard of a NOMNC."	F 582	Meetings starting June 2019. The Business Office Manager will monitor for the completion of all Medicare required notifications during monthly Triple Check Meetings ongoing to ensure compliance. Adverse findings will be reported monthly to Quality Assurance Performance Improvement Committee for by the Business Office Manager for further action. Completion Date 06/19/2019	
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623		6/19/19

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F 623	Continued From page 4 resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and	F 623		

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F 623	Continued From page 5 telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide written notification to the Resident or Resident Representative of transfer to the hospital for four (4) of four (4) residents reviewed for hospitalization; Residents #8, #16, #32, and #54.	F 623	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is	

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F 623	Continued From page 6 Findings include: Review of the facility's statement, dated 5/16/19 and signed by the Administrator, revealed, the facility does not have a Policy and Procedure for notification that a resident is being transferred to the hospital. On 05/15/19 at 2:25 PM, an interview with the Administrator (ADM), revealed, he has been the acting ADM at this facility for two (2) weeks, and is not sure what the process and procedure the facility is using to notify the family and residents when residents are transferred to the hospital. Resident #32 Review of the physicians orders for Resident #32, revealed an order written on 2/26/19 to transfer to (Name of Hospital). Record review of the Minimum Data Set (MDS) assessments for Resident #32, revealed, a Discharge Assessment dated 2/26/19, and a Re-entry Tracking Record dated 3/5/19, which indicated return from the hospital. On 05/15/19 at 11:52 AM, an interview with the Director of Nursing (DON), revealed, the facility notifies the Responsible Parties by phone when transferring a resident to the hospital. On 05/16/19 at 8:11 AM, an interview with the Social Services Director (SSD), revealed, she was unaware the facility should be notifying the Resident and Responsible Party (RR), in writing, of transfers to the hospital and of the bed hold. The SSD revealed, she does contact the	F 623	prepared and/or executed solely because is required by the provision of Federal and State law. This plan of correction constitutes the facilities credible allegation of compliance. No resident suffered adverse effects from this deficient practice. The facility was unable to provide written hospital transfer notifications to the Residents or Residents' Responsible Party for Resident #54, transferred 1/17/2019, Resident #8, transferred 1/26/2019, Resident #32, transferred 2/26/2019, and Resident #16, transferred 3/11/2019, because these hospital transfers were in the past. All residents that are transferred to the hospital are at risk for this deficient practice. A 100% audit was conducted on all residents transferred since 5/16/2019 by Social Services Director on 6/11/2019, to verify a written hospital transfer notification was issued to the Resident or the Resident's Responsible Party. All residents that have been transferred since 05/16/2019 and their Responsible Party, have received written notices of transfer. Resident #54 transferred to the hospital on 6/10/2019 and Resident #16 transferred 06/17/19, both residents received a hospital transfer form. As of 6/19/2019, Resident #8 and Resident #32 have not been transferred to the hospital since survey exit.	

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F 623	Continued From page 7 Ombudsman with resident incidents but has not notified the Ombudsman when a resident is transferred to the hospital. Resident #8 Record review of the nurses notes, dated 1/26/19 at 2:14 PM, revealed, Resident # 8 was transported to (Name of Hospital) via local ambulance due to vomiting. Record review of the MDS assessments for Resident #8, revealed, a Discharge Assessment dated 1/26/19, and a Re-entry Tracking Record dated 2/8/19, which indicated return from the hospital. Resident #16 Record review of the Nurses' Notes dated 3/11/19, at 3:16 PM, revealed, Resident #16 was experiencing weakness and was transported to the local hospital for evaluation via ambulance. Review of the Nurses' Notes dated 3/11/19 at 4:05 PM revealed Resident #16 was admitted to the local hospital's Intensive Care Unit for Hypoxia. Review of the MDS Assessments for Resident #16, revealed, Resident #16 a Discharge Assessment, dated 3/11/19, and a Re-entry Tracking Record, dated 3/19/19, which indicated a return from the hospital. Record review and interview with the SSD, on 5/16/19 at 8:11 AM, revealed, the Resident nor the Resident Representative (RR) was notified of the hospital transfer in writing. The Ombudsman was not notified of hospitalization.	F 623	The Social Worker has been educated by the Administrator on 6/11/2019, on the issuance of written hospital transfer notices to the Resident or Resident's Responsible Party. The Medical Records Clerk will monitor the medical record for proof of written hospital transfer notices weekly for eight weeks starting June 11, 2019. All adverse findings will be forward to the Quality Assurance and Performance Improvement Committee monthly by the Social Worker. The Business Office Manager will monitor the medical record for proof of written hospital transfer notices during monthly Triple Check Meetings. Any adverse findings will be forwarded monthly to the Quality Assurance Performance Improvement for further action by the Social Worker. Completion Date 06/19/2019	

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F 623	Continued From page 8 Resident #54 Review of Nurses' Notes for Resident #54, dated 1/17/19 at 2:43 PM, revealed, the resident was transferred to (Name of Hospital) for scheduled surgery. Review of the MDS Assessments for Resident #54, revealed a Discharge Assessment dated 1/17/19 and a Re-entry Tracking Record, dated 1/28/19, which indicated a return from the hospital. Record review and interview, on 05/15/19 at 8:11 AM, with the Social Services Director, revealed that the Resident nor the Resident Representative (RR) was notified of the hospital transfer in writing. The Ombudsman was not notified of hospitalization. The Bed Hold Agreement was not given to the Resident/RR following transfer to the hospital.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 625		6/19/19

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F 625	Continued From page 9 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to issue a Notice of Bed Hold Policy to the Resident or Resident Representative upon transfer to the hospital for four (4) or four (4) residents reviewed for hospitalization; Resident #8, #16, #32, and # 54. Findings include: Review of the facility's "Bed-Holds and Returns" policy, dated March 2017, revealed, prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: b. The reserve bed payment policy as indicated by the state plan (Medicaid residents); c. The facility per diem rate required to hold a bed (non-Medicaid residents), or to hold a bed beyond the state bed-hold period (Medicaid residents); and d. the details of transfer.	F 625	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because is required by the provision of Federal and State law. This plan of correction constitutes the facilities credible allegation of compliance. No resident suffered any adverse effects from this deficient practice. Resident #32 was transferred to the hospital on 02/26/2019 and did not receive a bed-hold and return policy. Resident #8 was transferred to the hospital on 01/26/2019 and did not receive a bed-hold and return policy. Resident #16 was transferred to the hospital on 03/11/2019 and did not receive a bed hold and return policy. Resident #54 was transferred on	

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F 625	Continued From page 10 Resident #32 Record review of the Physician's orders for Resident #32, revealed an order written on 2/26/19, to transfer to (Name of Hospital). Record review of the Minimum Data Set (MDS) assessments for Resident #32, revealed, a Discharge Assessment dated 2/26/19, and a Re-Entry Tracking Record dated 3/5/19, which indicated a return from the hospital. Resident #8 Record review of the Nurses Notes, dated 1/26/19 at 2:14 PM, revealed, Resident # 8 was transported to (Name of Hospital) via local ambulance due to vomiting. Record review of the MDS assessments for Resident #8, revealed, a Discharge Assessment dated 1/26/19, and a Re-entry Tracking Record, dated 2/8/19, which indicated a return from the hospital. On 5/15/19 at 11:52 AM, an interview with the Director of Nursing (DON), revealed, the facility notifies the Resident's Responsible Party (RP) by phone when transferring a resident to the hospital. On 5/15/19 at 2:25 PM, an interview with the Administrator revealed, he has been the acting administrator for two (2) weeks at this facility and is not sure what the facility is doing for transfers. The Administrator revealed, he has a form at his facility, which is owned by the same corporation, that is mailed to the RP and includes where, why	F 625	01/17/2019 and did not receive a bed-hold and return policy. All residents that are transferred to the hospital have the potential to be affected by this deficient practice. A 100% audit was completed on the 06/11/2019 by the Business Office Manager to ensure that all residents that are currently in the hospital received a bed-hold and return policy. The audit revealed that all residents received a bed-hold and return policy. The facility Administrator, Social Worker, Director of Nursing, Business Office Manager, and Licensed Nurses will be provided in-service education on 06/11/2019 by the Chief Operations Officer on the issuing the Bed-hold and return policy when a resident is transferred to the hospital. The Business Office Manager will monitor beginning 6/11/2019 all residents transferred to the hospital weekly times twelve weeks, to ensure a bed-hold and return policy and one mailed to the Responsible Party. Resident #54 transferred to the hospital on 6/10/2019 and Resident #16 transferred 06/17/19, both residents received a bed-hold and return form. As of 6/19/2019, Resident #8 and Resident #32 have not been transferred to the hospital since survey exit. The Administrator will monitor to ensure a bed-hold and return policy is given to the	

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F 625	Continued From page 11 and when residents are transferred. The Administrator was not sure if the facility had been notifying families of the bed hold status of residents when they are transferred to the hospital in writing. On 5/16/19 at 8:11 AM, an interview with the Social Services Director (SSD), revealed, she was unaware the facility should be notifying the Resident and Responsible Party of transfers to the hospital and of the bed hold. The SSD revealed, she has the resident representatives sign a bed hold policy in the admission packet, but does not notify them unless she is told their days for bed hold are about up. Resident #16 Record review of the Nurses' Notes for Resident #16, dated 3/11/19 at 3:16 PM, revealed, Resident #16 was experiencing weakness and was transported to the local hospital for evaluation via ambulance. Review of the Nurses' Notes, dated 3/11/19 at 4:05 PM, revealed Resident #16 was admitted to the local hospital's Intensive Care Unit for Hypoxia. Record review and interview with the SSD, on 5/16/19 at 8:11 AM, revealed, that the Resident nor the Resident Representative (RR) was issued an updated Bed Hold Agreement. Resident #54 Review of Nurses' Notes for Resident #54, dated 1/17/19 at 2:43 PM, revealed, Resident #54 was transferred to (Name of Hospital) for scheduled surgery.	F 625	resident and mailed to the Responsible Party when a resident is transferred to the hospital bi-weekly time three months. Any adverse finding will be forwarded monthly to the Quality Assurance Performance Improvement Committee by the Administrator for further action. Completion date 06/19/2019	

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	255217	A. BUILDING _____ B. WING _____	05/16/2019

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F 625	Continued From page 12 On 5/16/19 at 8:11 AM, a record review and interview with the SSD, revealed, that an updated Bed Hold Agreement was not given to the Resident/RR following transfer to the hospital.	F 625		
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 record review, staff interview and facility policy review, the facility failed to accurately code a Minimum Data Set (MDS) Assessment for one (1) of 19 resident MDS assessments reviewed; Resident #3. Findings include: Review of the facility's "Certifying Accuracy of the Resident Assessment" policy, revised December 2009, revealed, "All personnel who complete any portion of the Resident Assessment (MDS) must sign and certify the accuracy of that portion of the assessment." Record review of the Quarterly MDS for Resident #3, dated 2/12/19, revealed Item J1900C (Number of Falls Since Admission/Entry or Re-entry or Prior Assessment), was coded to indicate the resident had one fall with Major Injury. Review of Incident Report dated 1/21/19, at 10:30 AM, revealed the "Certified Nursing Assistant (CNA) stated when she was putting lotion on	F 641	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because is required by the provision of Federal and State law. This plan of correction constitutes the facilities credible allegation of compliance. No resident suffered adverse effects from this deficient practice. Resident #3's Minimum Data Set Assessment dated 02/12/2019 was corrected on 05/15/2019 by the Minimum Data Set Nurse to remove the fall with major injury to ensure Minimum Data Set was coded accurately. All residents that had a Minimum Data Set assessment were at risk for this deficient practice. On 05/15/2019, Minimum Data Set Nurse	6/19/19

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F 641	Continued From page 13 Resident, the Resident stated that it hurts and was making grimaces faces. Upon assessment of Resident's left hand noted guarding left hand and noted dark discoloration to hand and tender to touch. No edema noted per the Director of Nursing". The facility notified the Medical Doctor and obtained an order to have a portable X-ray performed. Review of the Narrative of Investigation revealed "...Based on security footage and witness statement, It is possible that the fracture may have come about through contact with an object and it occurred sometime during the day shift and the first hour of the second shift. No abuse was suspected". On 5/15/19 at 4:05 PM, during an interview with Registered Nurse (RN) #1, Minimum Data Set (MDS) Coordinator, stated that she had no training in MDS. She started in November of 2018. The Nurse Consultant and a MDS nurse from a sister facility have helped her. The previous MDS nurse was here for two and one half (2 1/2) days and gave her verbal instructions. RN #1 stated, she had been reading the Resident Assessment Instrument (RAI) Manual and doing the best she could. She stated, she saw fracture in Item JI900 on the MDS, and thought that was where it should go. She stated, that the fracture of the fifth (5th) digit of Resident #3's left hand was not caused by a fall; therefore, it should not have been coded in that item number. On 5/15/19 at 4:30 PM, an interview with the Director of Nursing (DON), revealed, she stated ,that the fracture of the 5th digit of the left hand was not the result of a fall. It was an injury of unknown origin. It should not have been coded on the MDS as a fall with major injury. She stated, the facility's policy for accuracy of	F 641	was educated by Nurse Consultant on ensuring the accuracy of assessments and following the Resident Assessment Instrument Manual. On 6/12/2019, a 100% audit of the last three months Minimum Data Set assessments for all residents was conducted by the Nurse Consultant. Four coding errors was found and corrected to reflect the actual condition of the resident. Beginning June 11, 2019, the Minimum Data Set Nurse will monitor the Minimum Data Set Assessments per Minimum Data Set schedule for four months to ensure their accuracy. The Care Plan Nurse will review Minimum Data Set weekly starting June 11,2019 for twelve weeks to ensure ongoing compliance. Any adverse findings will be forwarded monthly to the Quality Assurance Committee Performance Improvement for further action by the Care Plan Nurse.	

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F 641	Continued From page 14 assessments was not followed.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under	F 645		6/19/19

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F 645	Continued From page 15 paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to accurately complete a Pre-Admission Screening (PAS) for one (1) of two (2) residents reviewed for PAS; Resident #43. Findings include:	F 645	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because	

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F 645	Continued From page 16 Review of the facility's "Admission Criteria" policy, revised December 2016, revealed, "Our facility will admit only those residents whose medical and nursing care needs can be met. ...8. Nursing and medical needs of individuals with mental disorders or intellectual disabilities will be determined by coordination with the Medicaid Pre-Admission Screening and Resident Review program (PASARR) to the extent practicable. 9. Potential resident with mental disorders or intellectual disabilities will only be admitted if the State mental health agency has determined (through the preadmission screening program) that the individual has a physical or mental condition that requires the level of services provided by the facility." Record review of the Pre Admission Screening (PAS) for Resident #43, dated 1/10/18, revealed, under section "Federal Pre-Admission Screen and Resident Review (PASRR) - For Nursing Facility Admissions, Part B - Level II Referral Criteria", the question "Person has a diagnosis of a major mental illness?" was answered "No". A Level II PASRR was not completed for Resident #43. Review of the Diagnosis/History for Resident #43, revealed, he had a diagnosis of Schizophrenia, with an onset date of 1/9/18. On 5/16/19 at 1:43 PM, an interview with the Social Services Director (SSD), revealed, she stated, "No, he did not have a Level II. I do my PAS and if a Level II is needed, they come out. I've never had to call them. I looked and did not see a level II screening. He was in another nursing home before he came here but I couldn't	F 645	is required by the provision of Federal and State law. This plan of correction constitutes the facilities credible allegation of compliance. Resident #43 no longer resides in the facility. All residents with a mental illness or intellectual disability have the potential to be affected by this deficient practice. A 100% audit was completed on 06/13/2019 by the Social Worker of all residents that have a mental illness or intellectual disability diagnosis to ensure that all Preadmission Screening/Preadmission Screening Resident Review's are accurate and include Level II's as needed. The audit revealed five Preadmission Screening/ Preadmission Screening Resident Review that was not completed. On 06/13/2019, the Social Worker completed the five Preadmission Screening/Preadmission Screening Resident Reviews. On June 11, 2019, Chief Operations Officer in serviced The Social Worker was provided in-service education on the proper completion of the Preadmission Screening/ Preadmission Screening and Resident Review related to a mental illness or intellectual disability diagnosis and the need to have a Level II completed. beginning June 11, 2019, the Social will review three medical records a week for eight weeks to observe any changes in diagnosis and the completion of Level II's.	

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F 645	Continued From page 17 get the PAS from them so I did another one." The SSD stated, that a PAS gives the resident a score to determine long term care placement criteria into a nursing facility. She revealed, that it is important to accurately complete the PAS to be certain that the Resident does meet criteria for placement here. She confirmed, Schizophrenia is a major mental illness. She stated, "It was overlooked. I am aware that it's a major mental illness. It would be important to have a Level II because of the severity of that diagnosis. It was an oversight on my part." In an interview, on 5/16/19 at 2:03 PM, with the Director of Nursing (DON), upon review of the PAS for Resident #43, dated 1/10/19, she confirmed, there should have been a Level II completed and that the facility's policy for admission criteria was not followed in regards to the PAS.	F 645	The Minimum Data Set nurse will review each Minimum Data Set as they come due per the Resident Assessment Instrument Manual to ensure they have the proper Preadmission Screening and Resident Review in place as needed as an ongoing measure towards compliance. The Minimum Data Set Nurse will report adverse findings monthly to the Quality Assurance Performance Improvement Committee for further action. Completion date 06/19/2019	
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 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		6/19/19

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F 656	Continued From page 18 (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, record review, facility policy review, and staff interview, the facility failed to implement the comprehensive care plan addressing weight loss as evidenced by not following up on the recommendations by the Registered Dietician (RD) for one (1) of five (5) care plans reviewed; Resident #45. Findings include: Review of the facility's "Care Plans,	F 656	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because is required by the provision of Federal and State law. This plan of correction constitutes the facilities credible allegation of compliance.	

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F 656	Continued From page 19 Comprehensive Person-Centered" policy, revised December 2016, revealed, a comprehensive, person-centered plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Record review revealed, the Consultant Registered Dietician (RD) documented an assessment for Resident #45, dated 5/8/19, which revealed the staff had reported the resident was requesting Ensure plus daily with breakfast. The recommendation further documented Resident #45's current weight was 122 pounds (#) and the weight change for 33 days was -2.71%, for 91 days was 8.55% and for 110 days was -18.77%. The recommended intervention by the RD, revealed, to offer Ensure plus with breakfast daily to help promote a gradual WG (weight gain). Record review of Resident #45's comprehensive care plan, revealed, a care plan problem titled, "Weight Loss", with an onset date of 2/18/19. The goal and target date revealed, the resident will show no significant weight change through next review date, which was 7/24/19. Interventions listed for the problem of weight loss included the RD to assess and evaluate as needed (PRN), make recommendations as needed. The comprehensive care plan did not indicate RD's recommendations had been implemented. An observation, on 5/14/19 at 03:21 PM, revealed, Resident #45 appeared thin. On 5/16/19 at 8:55 AM, Resident#45 was observed in the dining room feeding self. He	F 656	Resident #45 suffered no adverse effects from this deficient practice. Resident #45 now receives Ensure Plus per Physician's orders. All residents with dietary recommendations for dietary supplements with meals are at risk for this deficient practice. A 100% audit of May and June's Dietary recommendations, written orders for these recommendations, and the care plans for these recommendations was completed 6/12/2019 by the Nurse Consultant. The results of this audit showed 100% compliance in these areas. The Director of Nursing, Assistant Director of Nursing, Care Plan Nurse, and Dietary Manager received additional education on 6/11/2019 by the Nurse Consultant on the implementation of the care plan to include providing dietary supplements per Dietary Recommendations. Starting June 11, 2019, the Assistant Director of Nursing will monitor the Dietary Recommendations daily after they are received until all are completed for three months, then ongoing to ensure all recommendations are addressed. The Dietary Manager will monitor the Dietary Recommendations monthly to ensure ongoing compliance. Adverse findings will be forwarded monthly to the Quality Assurance Performance Improvement Committee by the Dietary Manager for additional action.	

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F 656	Continued From page 20 consumed 75% of the meal with 360 cc (cubic centimeters) of liquids. There was no Ensure Plus on the resident's tray. On 5/16/19 at 3:30 PM, an interview with the Licensed Practical Nurse (LPN) #1, revealed, she is responsible for developing and updating the residents' care plans. LPN #1 confirmed, the care plan for weight loss and interventions for Resident #45 were not followed. LPN #1 revealed, the nurses should know to make sure the Dietary recommendations are being processed and followed.	F 656	Completion Date 06/19/2019	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced	F 692		6/19/19

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F 692	Continued From page 21 by: Based on observation, record review, staff interview, and facility policy review, the facility failed to follow up on dietary recommendations for one (1) of five (5) residents reviewed for nutrition; Resident #45. Findings include: Review of the facility's "Weight Assessment and Intervention" policy, revised September 2008, revealed, the multidisciplinary team will strive to prevent, monitor and intervene for undesirable weight loss for residents. Record review revealed, the Registered Dietician (RD) documented an assessment for Resident #45, dated 5/8/19, which indicated the staff had reported the resident was requesting Ensure Plus daily with breakfast. The RD's assessment documented, Resident #45's current weight was 122# (pounds), and the weight change for 33 days was -2.71%, for 91 days was 8.55%, and for 110 days was -18.77%. The recommended intervention, by the RD, revealed to offer Ensure Plus with breakfast daily to help promote a gradual WG (weight gain). Record review of Resident #45's documented weights, revealed, on 1/14/19 his weight was 150.20#, on 5/4/19 was 122#, and on 5/14/19 was 114#. Resident #45 showed a 6.56% weight loss from 5/4/19 to 5/14/19 (10 days). On 5/14/19 at 3:21 PM, an observation of Resident #45 revealed, he appeared thin. On 5/16/19 at 8:55 AM, Resident #45 was	F 692	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because is required by the provision of Federal and State law. This plan of correction constitutes the facilities credible allegation of compliance. Resident #45 suffered no adverse effects from this deficient practice. Resident #45 now receives Ensure Plus per Physician's order as of 05/22/2019. All residents who received dietary recommendations have the potential to be affected by this deficient practice. A 100% audit of all dietary recommendations for May and June 2019 by Nurse Consultant to ensure all dietary recommendations were completed in a timely manner. The results of the audit revealed that all of the dietary recommendations were completed timely. On 06/11/2019, Dietary Manager, Assistant Director of Nursing, and Director of Nursing were educated by Nurse Consultant of the facility's protocol for dietary recommendations. Dietary Recommendations will be monitored beginning 6/11/2019 by the Assistant Director of Nursing daily after they are received until all are completed for three months and then ongoing to ensure	

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F 692	Continued From page 22 observed sitting at a table, in the dining room feeding himself. He consumed 75% of his meal with 360 cubic centimeter (cc) of liquids. Resident #45 stated, he was full, got plenty to eat, and does not want anything else. Resident #45 stated, he had a Pepsi to drink when he gets to his room. On 5/16/19 at 9:30 AM, an interview with the Dietary Manager, revealed, she passes on the Dietary recommendations to the Assistant Director of Nursing (ADON). On 5/16/19 at 10:04 AM, an interview with the ADON, revealed, she does not get the recommendations from the Dietician, the Director of Nursing (DON) does. On 5/16/19 at 10:05 AM, an interview with the DON, revealed, she had not seen the dietary recommendation written on 5/8/19 at 11:09 AM, which revealed the staff reported Resident #45 had been asking for Ensure Plus with breakfast and that she recommended an order be written for this. The DON revealed, she did not know how the recommendation got on the chart, or if the physician had been notified of the recommendation. The DON confirmed, the recommendation was in Resident #45's chart, but she did not know if it had ever been communicated to Resident #45's Physician; and the recommendation in the chart was flagged to be signed by the Physician, but no signature was noted and no order had been written for Ensure . The DON revealed, the process for dietary recommendations has been that the Dietician will hand them out to the DON, ADON or a nurse, then the staff member that received the recommendation, writes the order for the	F 692	compliance. Dietary Manager will monitor the completion of dietary recommendations monthly. Adverse findings will be forwarded monthly to the Quality Assurance Performance Improvement Committee by the Dietary Manager for further action. Completion Date 06/19/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255217	A. BUILDING _____ B. WING _____	05/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER HEIGHTS HEALTHCARE CENTER	402 ARNOLD AVENUE GREENVILLE, MS 38701

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F 692	Continued From page 23 recommendation and places the order on the chart. They fax the recommendation to the physician and implement the order after they have received confirmation from the physician. The DON revealed, the facility does not have a procedure to log and monitor implementation of the dietary recommendations.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255217	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/20/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER HEIGHTS HEALTHCARE CENTER	**402 ARNOLD AVENUE** **GREENVILLE, MS 38701**

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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 | 06/17/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255217	A. BUILDING _____ B. WING _____	05/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER HEIGHTS HEALTHCARE CENTER	402 ARNOLD AVENUE GREENVILLE, MS 38701

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E 000	Initial Comments * EMERGENCY PREPAREDNESS * Survey conducted on 5/20/19 reveals 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

Electronically Signed | 06/17/2019

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.