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M 000	Initial Comments The State Agency (SA) conducted an recertification survey at the facility from 08/21/23 through 08/24/23. During the survey, the SA determined the facility was not in compliance with the Minimum Standards for Institutions for the Aged or Infirm, state licensure requirements and cited M500, M610, M625, and M650. The facility census was 98 and the facility held a license for 120 beds.	M 000		
M 500	45.17.2 Residents' Rights Residents' Rights. The residents' rights policies and procedures ensure that each resident admitted to the facility: 1. is fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission and during stay, of these rights and is given a statement of the facility's rules and regulations and an explanation of the resident's responsibility to obey all reasonable regulations of the facility and to respect the personal rights and private property of other residents; 2. is fully informed, and is given a written statement prior to or at time of admission and during stay, of services available in the facility, and of related charges including any charges for services covered by the facility's basic per diem rate; 3. is assured of adequate and appropriate medical care, is fully informed by a physician or nurse practitioner/physician assistant of his medical conditions unless medically contraindicated (as documented by a physician or nurse practitioner/physician assistant in his	M 500		10/5/23

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M 500	Continued From page 1 medical record), is afforded the opportunity to participate in the planning of his medical treatment, to not be limited in his/her choice of a pharmacy or pharmacist provider in accordance with state law, as referenced in House Bill 1439, which states that the facility shall not limit a resident ' s choice of pharmacy or pharmacy provider if that provider meets the same standards of dispensing guidelines required of long term care facilities, to refuse to participate in experimental research, and to refuse medication and treatment after fully informed of and understanding the consequences of such action; 4. is transferred or discharged only for medical reasons, or for his welfare or that of other residents, or for nonpayment for his stay (except as prohibited by sources of third-party payment), and is given a two weeks advance notice in writing to ensure orderly transfer or discharge. A copy of this notice is maintained in his medical record; 5. is encouraged and assisted, throughout his period of stay, to exercise his rights as a resident and as a citizen, and to this end may voice grievances, has a right of action for damages or other relief for deprivations or infringements of his right to adequate and proper treatment and care established by an applicable statute, rule, regulation or contract, and to recommend changes in policies and services to facility staff and/or to outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal; 6. may manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the	M 500		

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M 500	Continued From page 2 facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law; 7. is free from mental and physical abuse; 8. is free from restraint except by order of a physician or nurse practitioner/physician assistant, or unless it is determined that the resident is a threat to himself or to others. Physical and chemical restraints shall be used for medical conditions that warrant the use of a restraint. Restraint is not to be used for discipline or staff convenience. The facility must have policies and procedures addressing the use and monitoring of restraint. A physician order for restraint must be countersigned within 24 hours of the emergency application of the restraint; 9. is assured security in storing personal possessions and confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in the case of his transfer to another health care institution, or as required by law of third-party payment contract; 10. is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; 11. is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care; 12. may associate and communicate privately with persons of his choice, may join with other residents or individuals within or outside of the facility to work for improvements in resident care, and send and receive his personal mail	M 500		

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M 500	Continued From page 3 unopened, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 13. may meet with, and participate in activities of, social, religious and community groups at his discretion, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 14. may retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, unless medically contraindicated (as documented by his physician or nurse practitioner/physician assistant in his medical record); 15. if married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician or nurse practitioner/physician assistant in the medical record); and 16. is assured of exercising his civil and religious liberties including the right to independent personal decisions and knowledge of available choice. The facility shall encourage and assist in the fullest exercise of these rights. This Statute is not met as evidenced by: Level II Based on staff and resident interview, record review and facility policy review the facility failed to assist a resident with his right to vote for one (1) of five (5) residents reviewed for voting rights. Resident #31	M 500	A. For resident #31 his address was changed to the facility address so that he could participate in the voting process with all elections. Arrangements will be made to transport him to the pole or have an absentee ballot sent to the facility. An	

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M 500	Continued From page 4 Findings Include: Review of the facility policy titled, "Resident Rights" with no revision date revealed that each resident had, "... A. The right to civil and religious liberties ..." Review of the facility policy titled, "Voting Policy" revealed "It is a policy of this facility that all residents reserve the right to vote in local, State and Federal elections...If a resident desires to go to the local precinct to vote, transportation arrangements will be made if ...and Social Services will be responsible for arranging voting by absentee ballot for any resident who so desires." During the Resident Council meeting on 8/22/23 at 2:00 PM, Resident #31 revealed he has lived at the facility for two years and no one has ever spoke to him about voting, but he would like to. An interview on 8/22/23 at 3:15 PM with Social Services revealed that all residents are asked about voting on admission and if they need assistance. A record review with Social Services revealed that Resident #31 did not have a social history assessment completed when he was admitted and the question about needing or wanting assistance with voting was not addressed with the resident. She stated voting assistance should have been addressed with the resident so he could go vote or vote absentee if he wanted to. An interview on 8/23/23 at 3:45 PM, with the Administrator confirmed that residents should be offered transportation to go vote or assisted with absentee voting. This should be addressed with them around election times.	M 500	audit was conducted on 9/15/2023 on 5 cognitive residents to determine if they are aware of their voting rights. B. Any resident of the facility that has the cognitive ability to vote could be affected by this alleged deficient practice. C. An in service was conducted on 9/14/2023 by the Staff Development Coordinator with all licensed staff and Social Service Department on the voting process and the residents right to vote. A list of these residents from 9/15/2023 will be maintained by the Social Service Department to ensure they are provided the opportunity to vote. A notification of the residents right to vote was placed in all admission packets beginning on 9/18/2023 to inform all resident of their right to vote. The Social Service Assistant will conduct an audit of 5 different cognitive residents weekly for 4 weeks, 2 times a week for 2 weeks, 1 times a week for 2 weeks and monthly beginning the week of 9/11/2023 to determine if they are aware of their right to vote. D. The Social Service Director will monitor the audit weekly on 9/18/2023 to validate that the residents are aware of their right to vote. The Social Service Director will report to the Quality Assurance/Performance Improvement Committee on October 5, 2023 then monthly for 2 months and quarterly the results of the audit to ensure that consistent substantial compliance has been meet.	

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M 500	Continued From page 5 Record review of Resident #31's "Face Sheet" revealed the resident was admitted to the facility on 8/31/21 with medical diagnoses that included Unspecified Peripheral Vascular Disease. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/27/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident is cognitively intact.	M 500		
M 610	45.21.2 Activities of daily living Activities of daily living. Each resident shall receive assistance as needed with activities of daily living to maintain the highest practicable well being. These shall include, but not be limited to: 1. Bath, dressing and grooming; 2. Transfer and ambulate; 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observation, staff and resident interview, record review and facility policy review the facility failed to provide incontinent care every two hours and as needed for a resident dependent on staff for Activities of Daily Living (ADL) for one (1) of 98 residents reviewed. Resident #86 Findings include:	M 610	A. For resident #86 he assessed by nurse supervisor on 8/23/2023 for any redness/skin breakdown related to this alleged deficient practice. Resident #86 was interviewed by the Director of Nurses on 9/7/2023 and he stated that the time frames they are coming into his room has improved at this time. Resident #86 was also instructed that when he feels the need for incontinent care to use his call light for assistance.	10/5/23

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M 610	Continued From page 6 Review of the facility policy titled, "Activity of Daily Living Policy" with a revision date of 01/2013 revealed "Policy Statement: Based on previous evaluations and current data, the nursing staff, in conjunction with Attending Physician, Consultant Pharmacist, therapy staff, and others, will seek to identify the level of care a resident requires for ADL's..." An interview on 08/21/23 08:26 AM, with Resident #86 revealed the staff does not always come and change him when he needs it. He stated that he stays in the bed most of the time and sleeps a lot because that is what he prefers. He stated that the staff does not come to change him every two hours and he wished they would come check on him more often than they do. An interview on 8/22//23 at 9:00 AM, with Resident #86 revealed that his brief was changed around 7:15 AM this morning. An observation on 8/22/23 at 10:30 AM, revealed Certified Nurse Assistant (CNA) #3 and CNA #5 performed incontinent care on Resident #86. An interview on 8/22/23 at 10:45 AM, with Resident #86 confirmed he had incontinent care around 7:15 AM and again around 10:30 AM. An interview on 8/22/23 at 1:45 PM, with CNA #3 revealed that it is hard to get incontinent care completed especially on day shift. She stated they try to make as many rounds and do as much incontinent care that needs to be done before the breakfast trays come out, but once the trays come out, they must pass trays and then help feed those residents that need fed. She stated that if a resident uses their call lights and need	M 610	B. The facility has determined that all dependent residents have the ability to be affected by this alleged deficient practice. C. An in-service was conducted by staff development nurse on 9/14/2023 with all licensed staff addressing the importance of providing activity of daily living care to dependent residents, care should be provided following facility protocol/resident individual care plan. Assistant director of nursing or Unit Manager will conduct an interview/observation audit of five residents weekly for four weeks to ensure that facility protocol/resident care plan are being followed for resident activity of daily living care beginning the week of 9/11/2023 then every other week for 2 weeks, then monthly. D. The director of nursing/administrator will review the audits weekly beginning 9/18/2023, then every other week times 2 weeks, then monthly for any activity of daily care not being provided according to facility protocol/resident care plan. The results of the audit will be reported to the quality assurance/performance improvement committee on 10/05/2023, then monthly for 2 months, then quarterly until such time consistent substantial compliance has been met.	

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M 610	Continued From page 7	M 610		

changing then we go ahead and do the care then, otherwise after we pick up breakfast trays then we start the daily baths and perform incontinent care as much as we can. She revealed there are two CNAs on Resident #86's hall and that one of them takes lunch from 10:45 AM-11:15 AM and then the other takes lunch from 11:15 AM-11:45 AM. She stated by the time they both get back from lunch, then the lunch trays are coming out and we have to pass the trays, help feed and then pick up the trays. She revealed that they try to do incontinent care at least one time before lunch, then after lunch and check with them again before we leave at 3:00 PM.

An observation on 8/22/23 at 2:00 PM, revealed that CNA #3 and CNA #5 performed incontinent care on Resident #86.

An interview on 8/22/23 at 3:00 PM, with Resident #86 revealed the staff had come and changed him once since lunch.

An interview on 8/22/23 at 4:15 PM, with the Administrator and the Director of Nurses (DON) confirmed that Resident #86 needed to be checked and provided incontinent care every 2 hours if needed. The Administrator stated that they must do better at that.

An interview on 8/23/23 at 8:00 AM, with Registered Nurse (RN) #2 confirmed that Resident #86 needed prompt incontinent care. She revealed that means that anytime he calls for help the staff need to get to him as quick as possible to prevent skin breakdown and he also needs to just be checked on every 2 hours to see if he needs incontinent care because he sleeps a good bit.

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M 610	Continued From page 8 Record review of Resident #86s "Face Sheet" revealed he was admitted to the facility on 4/6/22 with medical diagnoses that included Cerebral Infarction, unspecified and Need for assistance with personal care. Record review of Resident # 86's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/13/23 revealed in Section C a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident is cognitively intact and in Section G that the resident needed extensive assistance with toilet use and personal hygiene.	M 610		
M 625	45.21.5 Range of motion Range of motion. Residents with limited range of motion shall receive treatment and services to increase range of motion or prevent further decline in range of motion. This Statute is not met as evidenced by: Level II	M 625	A. For resident #91 an assessment was done on 8/23/2023 by the occupational therapist for decline in range of motion of right upper extremity with no decline found. Resident #91's right upper extremity splint was placed on resident on 8/23/2023 to prevent any decline in range of motion. Licensed practical nurse #1 was given a written warning on 8/25/203 regarding applying and removing resident's right upper extremity splint according to physician's orders/individual care plan. B. The facility has determined all residents that use orthopedic splinting devices have	10/5/23

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M 625	Continued From page 9	M 625	the potential to be affected by the alleged deficient practice. C. An in-service was given on 9/14/2023 by the staff development nurse to educate all licensed staff on the policy and procedure for proper use of orthopedic splinting devices. Assistant director or unit manager will conduct an audit of five residents requiring orthopedic splinting devices weekly for four weeks beginning the week of 9/11/2023, then every other week for 2 weeks, then monthly to ensure proper placement and removal of orthopedic splinting devices. D. The director of nursing/administrator will review weekly audits beginning 9/18/2023 weekly for 4 weeks, then every other week for 2 weeks, then monthly to validate the accuracy of the audits. The results of the audit will be reported to the quality assurance/performance improvement committee on 10/05/2023 then monthly for 2 months, then quarterly until such time consistent substantial compliance has been met.	
M 650	45.21.10 Hydration Hydration. Each resident shall be provided sufficient fluid intake to maintain proper hydration and health. This Statute is not met as evidenced by: Level II Based on observation, resident and staff interview, record review, and facility policy the	M 650	A. For resident #25 the physician order was corrected 9/15/2023 to break down the amount of fluids to be given at each meal time and with each medication	10/5/23

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M 650	Continued From page 10 facility failed to follow a physician order for a resident who was prescribed fluid restriction for one (1) of nine (9) residents on fluid restriction. Resident #25 Findings include: A review of the policy titled, "Fluid Restriction, revealed Fluids will be restricted," originated 9/04, revealed Policy: "Fluids will be restricted for residents as directed by physician's orders. The following conditions may require intervention of restricting fluids: ...end stage renal disease. Limiting fluids places the residents at high risk for dehydration."... Procedure: 1.)"Fluids will be distributed to residents placed on fluid restriction in the manner indicated below (Fluid Restriction)1200 cc (cubic centimeter) (Total nursing)360 cc (By Shift 120 cc day 120 cc eve (evening) 120 cc noc (night) Total Dietary) 840 cc (Breakfast) 360 cc (Dinner) 240 cc (Supper) 240 cc."...3.)"Nursing service will document intake and output."... An interview with Resident #25 on 8/21/23 at 2:00 PM, she revealed she was on dialysis and stated she did not know if she was on fluid restrictions and stated, "I may be since I am on dialysis, but I am unsure." An observation of the breakfast tray on 8/22/23 at 8:00 AM, revealed 360 cc of fluids on the tray. An interview with the Director of Nursing (DON) on 8/22/23 at 12:45 PM, he revealed after review of the physician's orders and medication record he confirmed Resident #25 had an order for a 1200 milliliter (ml) fluid restriction. The DON revealed the physician's order did not have the fluid amounts broken down for staff to know	M 650	administration. A flow sheet was created on 9/15/2023 and put into place for resident #25 on fluid restriction for licensed staff to document intake and output. B. The facility has determined that all residents on fluid restriction has the potential to be affected by this alleged deficient practice. C. An in-service was conducted by staff development nurse on 9/14/23 with all licensed staff on the policy of fluid restriction and intake and output documentation. All residents on fluid restriction will have a Intake and Output flow sheet put into place on 9/15/2023. The assistant director of nursing or unit manager will conduct audits of five residents on fluid restriction weekly for four weeks beginning the week of 9/11/2023, then 2 times a week for 2 weeks and then monthly to determine compliance with fluid restrictions. D. The director of nursing or administrator will review weekly audits beginning the week of 9/18/2023, then 2 times a week times 2 weeks, then monthly to validate accuracy of weekly audits. The results of the audit will be reported to the quality assurance/performance improvement committee on 10/05/2023, then monthly times 2 months and then quarterly until such time consistent substantial compliance has been met.	

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M 650	Continued From page 11 exactly how much fluids to provide the resident and confirmed that they did not have any monitoring of Intake and Output (I & O) documented. The DON confirmed the fluid restriction should have been broken down for staff to know the number of fluids to provide the resident and the I &O should be documented on the medication record. The DON indicated a potential concern from not monitoring the I & O is the resident could take in too much fluid and cause fluid overload. An interview with the Dietary Manager on 8/22/23 at 1:00 PM, she revealed the resident was on a 1200 cc fluid restriction and revealed she uses the breakdown of fluids on the fluid restriction policy to know how much fluid to provide a resident on fluid restriction each meal. The Dietary Manager revealed she was unaware of how the nursing staff communicates the amount fluids to provide to the resident. An interview with the Registered Dietician (RD) on 8/22/23 at 1:05 PM, she revealed Resident #25 is on a 1200 cc fluid restriction and her I & O should be monitored and totaled daily to ensure the resident is adhering to the fluid restriction and not consuming too much or not enough fluids. The RD revealed possible concerns from not monitoring I &O is dehydration or possible fluid overload. A interview with the Minimum Data Set (MDS) Coordinator on 8/22/23 at 1:15 PM revealed after review of the physician's orders that the physician's orders reflects the resident is on 1200 cc fluid restriction but no monitoring for I &O or break down of the fluid intake on the physicians orders and confirmed the nursing staff would not know how much fluids to provide to the resident.	M 650		

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M 650	Continued From page 12 An interview with Certified Nurse Assistant (CNA) #1 with the MDS Coordinator in presence on 8/22/23 at 1:25 PM, she revealed Resident #25 was not on any fluid restrictions to her knowledge. An interview with the MDS Coordinator on 8/22/23 at 1:30 PM, revealed the facility has looked into the I & O issues in the past but could not get it added as a special requirement for nurses to document the amount of I & O and the 24-hour totals. An interview with Licensed Practical Nurse (LPN)#1 on 08/22/23 at 2:33 PM, revealed she believed Resident # 25 was on fluid restriction, but she was unaware of the specific amount of fluid restriction. LPN #1 revealed "I just give her about a 1/2 of cup of water with each medication pass and she drinks what she wants. LPN #1 confirmed they were not monitoring I & O on the resident but confirmed they should be monitoring I & O since she is on fluid restriction. Record review of the Physician Orders for August 2023 revealed an order dated 3/10/23 "NAS (No Added Salt) Regular with 1200 cc fluids restriction." A review of the Medication Administration Record for August 2023, revealed Resident #25 had medications scheduled for 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, and 8:00 PM daily. Record review of the "Face Sheet" revealed that the facility admitted the resident on 3/10/23 with diagnoses that included Hypertensive heart and chronic kidney disease with heart failure with stage (5) five chronic kidney/ESRD (end-stage renal disease).	M 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50CH	A. BUILDING: _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOCTAW RESIDENTIAL CENTER	135 RESIDENTIAL CENTER RD CHOCTAW, MS 39350

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M 650	Continued From page 13 Record review of the MDS with an Assessment Reference Date (ARD) on 6/09/23, Section C revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 which indicated that he was cognitively intact. Section O revealed that it was coded as receiving dialysis.	M 650		