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	27BN	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUMPHREYS CO NURSING CENTER	500 CCC ROAD BELZONI, MS 39038

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M 000	Initial Comments The State Agency (SA) conducted an annual recertification survey at the facility from 8/29/23 through 8/31/23. During the survey, the SA determined the facility was not in compliance with the Minimum Standards of Operation for Institutions for the Aged or Infirm, state licensure requirements and deficiencies were cited at M500, M610,and M815. The facility held a license for 60 beds at the time of the survey, and the facility census was 53.	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	M 500		10/4/23

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M 500	Continued From page 1 nurse practitioner/physician assistant in his 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	M 500		

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M 500	Continued From page 2	M 500		

transactions made on his behalf should the 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,

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M 500	Continued From page 3 and send and receive his personal mail 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 resident interviews, staff interviews, record review, and facility policy review, the	M 500	1. Resident #33's jacket was replaced on August 31, 2023 by the facility. Social Services interviewed all interviewable residents on 9/11/2023 regarding not knocking on doors before entering	

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M 500	Continued From page 4 facility failed to initiate and resolve grievances from the residents in the monthly Resident Council meetings for two (2) of eight (8) residents attending. Resident #19 and Resident #33. Findings include: Review of the facility policy titled, "Grievance - Residents," with a revision date of 4/22, revealed, "All residents are to be encouraged and assisted (if necessary) in filing grievances to include those with respect to care and treatment, the behavior of staff and other resident's and other concerns regarding their facility stay, in the event that they have a need to make a concern known. The following outlines the process: ... The Social Worker or Social Service Designee has been appointed by the Administrator to work with the Resident Council ... to receive grievances ... by residents ... These grievances shall be directed to the appropriate Department Head and/or Administrator for investigation and follow-up according to the following procedure: Upon receipt of a grievance/complaint the staff receiving the complaint will initiate the Grievance/Complaint Form ... An investigation led by the Administrator based on the allegations will be set forth... The Administrator and his/her designees will conduct an impartial investigation of the allegations and will discuss the findings and recommendations within five (5) workdays of receiving the complaint, with the complainant... If the resident and/or resident representative are not satisfied with the decision of the investigation, they may take their concerns to the Regional Supervisor. All staff members will acknowledge the Resident Rights Violation Policy/Procedure. " An interview during a Resident Council Meeting on 8/30/23 at 02:45 PM with Resident #19	M 500	resident rooms. 2. 53 out of 53 residents have the potential to be affected by this deficient practice. 3. An in-service was begun on September 8, 2023 by the Administrator with facility staff on the following policies: Resident Council policy with revision date 11/17; Grievances – Resident policy with revision date 04/22; Resident Rights policy with revision date 11/17; & Psychological Needs/Concerns of the Elderly Policy with revision date 01/12. In-service will continue until all facility staff are in-serviced. A Quality Assurance meeting was held on September 15, 2023 with the following members present: Administrator, Director of Nursing, Medical Director, Nurse Case Manager, Assessment Nurse, Social Worker, Activities Director, Therapy Director, Licensed Practical Nurse, & Certified Nursing Assistant. The Resident Council policy with revision date 11/17, Grievances – Resident policy with revision date 04/22, Resident Rights policy with revision date 11/17, & Psychological Needs/Concerns of Elderly Policy with revision date 01/12 was discussed & no changes to the policy were recommended by the committee. 4. The Administrator will monitor the Resident Council meeting process & Grievance policy compliance weekly for 6 weeks and then monthly for 4 months or until compliance is achieved. Social Services Director will interview 11 interviewable residents a week till all interviewable residents have been interviewed in a month for 4 months. Any grievances or concerns will be discussed in Daily stand up and then in the monthly	

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M 500	Continued From page 5 revealed, she had voiced complaints in the previous resident council meetings. She revealed they had not been resolved to her liking, because some staff still enter her room without knocking. She noted that a sign had been placed on the door to alert staff to knock before entering her room and they ignore the sign. She noted it was a personal choice of hers to have staff knock before entering her room and she wanted them all to do so. She revealed she had been constantly told by the nursing facility that this is her home, so if someone was going to enter her home, they need to knock and allow her the choice to tell them they can enter. She shared that she feels they just talk about problems in resident council, and nobody does anything about the problems. An interview on 8/30/23 at 02:56 PM, with the Resident #33 revealed he has been missing a jacket for six (6) months, that it had not been replaced, and no one had talked with him about it. He noted he told the Activity Coordinator in a resident council meeting. An interview on 8/30/23 at 3:47 PM, with the Activities Coordinator confirmed she does not complete a grievance form for complaints from the resident council meeting and just tells other staff what was said in the meeting. She noted she had no knowledge that complaints in the resident council meetings had to be written up as a grievance and had not done so before. The Activities Coordinator confirmed some of the residents were still bringing up staff entering their room without knocking while having a discussion in Resident Council, but she had already told the staff about that from another meeting. She revealed Resident #33's jacket had been missing for only four (4) months. The Activities	M 500	Quality Assurance Meeting. The resident interviews, weekly resident councils, and monitoring by the Administrator will begin the week of September 11, 2023. Any deviation from said processes and policies will be reported to the monthly Quality Assurance meeting beginning on October 3, 2023 and then monthly for 4 months. Any deviations will be corrected immediately and staff responsible for the deviations will be disciplined accordingly up to and including termination.	

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M 500	Continued From page 6 Coordinator revealed other options could have been offered to Resident #33 to replace his missing jacket sooner but confirmed they had not. She revealed the Administrator was aware of the staff complaints and the missing jacket also. An interview on 8/30/23 at 04:40 PM with the Grievance Officer, revealed she did not have knowledge of any complaints from Resident Council, had not been informed of any complaints by the Activities Coordinator, and there were no grievances filed for complaints from the Resident Council meetings. She confirmed the complaints from the Resident Council meetings should have been provided to her, as the Grievance Officer, to file an official grievance on behalf of the resident, to be followed through the grievance process, and resolved timely for the resident. She confirmed resident rights are not being honored from Resident Council for the grievance process. An interview on 8/30/23 at 04:45 PM, with the Administrator revealed he did not think complaints from Resident Council were considered a grievance. The Administrator confirmed he was aware of the complaints related to staff not knocking on resident's doors before entering and also confirmed he was aware of the missing jacket for Resident #33. He also confirmed there were no grievance forms completed for any complaints from the Resident Council meetings, that all resident complaints should have an official grievance filed and to ensure the grievance process is followed properly. The Administrator confirmed that the nursing facility was not honoring the residents' rights to file a grievance, that the grievances from Resident Council were unresolved. Record review of the Resident Council meeting	M 500		

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M 500	Continued From page 7 minutes revealed "2/28/2023... STAFF REPORTS: Grievances... Nursing: On going with no knock with some CNAs (certified nurse aides) when entering room." Record review of the Resident Council meeting minutes dated 4/26/23 revealed, " ...STAFF REPORTS (Grievances & Recommendations) Nursing: Knocking before entering bathroom..." Record review of the Face Sheet for Resident #19 revealed an admission date of 9/01/21. Record review of Section C of the Yearly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 08/17/2023, for Resident #19, revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #19 is cognitively intact. Record review of the Face Sheet for Resident #33 revealed an admission date of 4/18/17. Record review of Section C of the Quarterly MDS Assessment, with an ARD of 08/08/2023, for Resident #33, revealed a BIMS score of 11, indicating Resident #33 is moderately cognitively impaired.	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;	M 610		10/4/23

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M 610	Continued From page 8 3. Good nutrition, personal and oral hygiene; and 4. Toileting. This Statute is not met as evidenced by: Level II Based on observations, staff interviews, facility policy review, and record review, the facility failed to turn and reposition a resident every two (2) hours, who was unable to turn and position themselves, as evidenced by observation of the resident not being turned and positioned according to the instructions in the facility policy, the comprehensive care plan and the Certified Nursing Assistant's (CNA) Kiosk guidance for one (1) of three (3) residents investigated for positioning. Resident #40. Findings include: Review of the facility policy titled, "Prevention and Treatment of Skin Issues," with a latest review date of 08/21, revealed "Policy: It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures ... B. Turning and Repositioning Program ... An effective turning and repositioning program can help reduce the risk of developing a pressure ulcer. ... it is important to individualize each resident's turning and repositioning schedule for time and surfaces. A turn schedule should be posted for residents on a Turning and Repositioning Program and for those residents that are immobile or need assistance with mobility." An observation on 8/30/23 at 8:30 AM revealed	M 610	1. A body audit was performed on September 11, 2023 on Resident #40 by the Assessment Nurse which revealed no skin issues. 2. 38 of 53 residents have the potential to be affected by this deficient practice. 3. An in-service was begun on September 8, 2023 by the Director of Nursing with Nursing staff on the following policies: Prevention and Treatment of Skin Issues policy with revision date 02/17 and will continue until all nursing staff are in-serviced. A Quality Assurance meeting was held on September 15, 2023 with the following members present: Administrator, Director of Nursing, Medical Director, Nurse Case Manager, Assessment Nurse, Social Worker, Activities Director, Therapy Director, Licensed Practical Nurse, & Certified Nursing Assistant. The Prevention and Treatment of Skin Issues policy with revision date of 08/17 was discussed & no changes to the policy were recommended by the committee. 4. The Director of Nursing will monitor Resident Turning & Repositioning weekly for 6 weeks and then monthly for 4 months or until compliance is achieved beginning the week of September 11, 2023. The Director of Nursing will check 7 residents weekly for turning & repositioning for 6 weeks and then 7 residents monthly for 4 months beginning the week of September 11, 2023. Any	

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M 610	Continued From page 9 Resident #40 was on his back and his posted turn clock indicated he should have been positioned on his left side at 7:00 AM. An observation on 8/30/23 at 10:30 AM revealed Resident #40 was on his back and his posted turn clock indicated he should have been positioned on his right side at 9:00 AM. An observation and interview on 8/30/23 at 2:00 PM with the CNA #3 revealed, Resident #40 was positioned on his back. CNA #3 confirmed Resident #40 had not been moved by her since 10:30 AM. She revealed she left him on his back at 10:30 AM after she gave him his bed bath and confirmed the turn clock indicated he should have been positioned on his right side at 10:30 AM. She revealed she was aware that residents that cannot turn themselves have to turned and repositioned every 2 hours to avoid bedsores and being in pain from lying in one position too long. An interview on 8/31/23 at 10:30 AM with the Director of Nursing (DON), revealed she was not aware that the CNAs were not turning and repositioning Resident #40 every 2 hours. She confirmed they should have turned and repositioned Resident #40 every 2 hours to avoid the possibility of illness or injury. The DON noted the turn clocks are posted in the resident rooms as a guide to ensure the residents are turned and positioned properly and the nurses and CNAs are responsible to ensure the residents are in the proper position according to the turn clock. Record review of the Face Sheet for Resident #40 revealed an admission date of 12/21/17 and diagnoses of Other Lack of Coordination, Alzheimer's Disease, and Muscle Weakness (Generalized).	M 610	deviation from said processes and policies will be reported to the monthly Quality Assurance meeting beginning on October 3, 2023 and then monthly for 4 months. Any deviations will be corrected immediately and staff responsible for the deviations will be disciplined accordingly up to and including termination.	

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M 610	Continued From page 10 Record review of Section C of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 7/12/2023, for Resident #40, revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating Resident #40 is severely cognitively impaired. Record review of Section G revealed that the resident was totally dependent upon 2 staff members for bed mobility.	M 610		
M 815	45.29.1 Safe Food Handling Procedures Safe Food Handling Procedures. Food shall be prepared, held, and served according to current Mississippi State Department of Health Food Code Regulations. This Statute is not met as evidenced by: Level II Widespread Based on observation, staff interview, and facility policy review, the facility failed to maintain a clean kitchen area used to provide nutrition for 53 of 53 residents in the nursing facility. Findings include: Review of the facility policy titled, "CLEANING SCHEDULE," with a revised date of 05/18, revealed "POLICY: The Director of Food and Nutrition Services shall establish a cleaning schedule for the food service department to ensure that food is stored and prepared under sanitary conditions. PROCEDURE: 1. "All ... work	M 815	1. On August 29, 2023, the kitchen was cleaned by dietary staff and inspected by Dietary Manager & Registered Dietitian. Form-382, Daily Cleaning Sanitizing Schedule, was implemented with dietary staff starting on August 29, 2023. Dietary staff were in-serviced on Kitchen Cleaning & Sanitizing by the Registered Dietitian on 8/29/2023. 2. 53 out of 53 residents have the potential to be affected by this deficient practice. 3. An in-service was begun on September 8, 2023 by the Administrator with dietary staff on the following policies: Cleaning and Sanitizing Equipment policy with revision date 05/18; Sanitation Checklist policy with revision date 05/18; Sanitary Conditions of the Food Service Department policy with revision date	10/4/23

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M 815	Continued From page 11 areas are cleaned after each use, or, on a routine basis ...5. A cleaning schedule is established by the Director of Food and Nutrition Services ... 6. The cleaning schedule lists the following: a. The cleaning tasks to be performed b. The person or position responsible for each task c. The time frame for performing the task d. Date completed 7). The cleaning schedule is posted in the food service department ...9. Documentation of completion of the task is noted on the posted schedule. 10. The Director of Food and Nutrition Services checks routinely to see that the task is completed according to standards. 11. Retain completed cleaning schedule for thirty days." An observation on 8/29/23 at 10:23 AM, revealed the stove to have a thick shiny black buildup on the center grates and burners. The left side of the stove was observed to have streaks of yellow buildup that extended down to the floor. The bottom of the inside of the stove's oven was observed to have a shiny, black, crumb-looking build up and the inside of the oven door's glass window had a black and yellow build-up. A continued observation revealed the silver division guard of the griddle, attached to the right side of the stove top, had a thick shiny black/crusty appearing build-up on both sides, that appeared to cover approximately 95% of its surface on both sides. The entire cooking surface of the griddle was observed to have a thick yellow and black build-up on it. The floor to the left side of the stove revealed a thick black build-up that measured approximately 18 inches in diameter. The floor to the right of the stove had thick black build-up that measured approximately 24 inches in diameter; and both floor areas of build-up were observed to completely cover the visibility of the floor tiles underneath. The floor in the dry goods storage room was observed to have a trail of	M 815	05/18. Dietary Manager implemented Daily Cleaning Sanitizing Schedule, DT-383; Weekly Cleaning Schedule, DT-383; & Periodic Cleaning Schedule, DT-384; all with revision date of 10/12 and will continue until all dietary staff will be in-serviced.. A Quality Assurance meeting was held on September 15, 2023 with the following members present: Administrator, Director of Nursing, Medical Director, Nurse Case Manager, Assessment Nurse, Social Worker, Activities Director, Therapy Director, Licensed Practical Nurse, & Certified Nursing Assistant. The Cleaning and Sanitizing Equipment policy; Sanitation Checklist policy; Sanitary Conditions of the Food Service Department policy; all with revision date of 05/18 was discussed & no changes to the policy were recommended by the committee. 4. The Dietary Manager will monitor kitchen cleaning & sanitization weekly for 6 weeks and then monthly for 4 months beginning the week of September 11, 2023. The Dietary Manager will check and document the monitoring twice a week weekly and then twice a month monthly. Any deviation from said processes and policies will be reported to the monthly Quality Assurance meeting beginning on October 3, 2023 and then monthly for 4 months. Any deviations will be corrected immediately and staff responsible for the deviations will be disciplined accordingly up to and including termination.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27BN	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUMPHREYS CO NURSING CENTER	500 CCC ROAD BELZONI, MS 39038

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M 815	Continued From page 12 black sticky build-up approximately 14 inches wide that extended from the entry door to the dry goods storage room to approximately three (3) feet into the room. The crate that held the bucket of sanitizing water and towels, on the left side of the 3-compartment sink and the crates that held the jugs of sanitizer on the right side of the 3-compartment sink, were observed to be covered, on top edges, with a large collection of crumb-looking particles and a shiny residue. The second shelf of the prep table surface that stored the containers of rice, meal, flour, and sugar, had a buildup of crumb-looking particles and a puffy white residue. The continued observation also revealed a large floor fan that had a build-up of loose particles located on the inside of its front cover. The fan was observed to be tilted upwards and blowing towards the prep table located in front of the handwashing station. The edges of the floor near the walls in the entire kitchen area were observed to have a buildup of crumb-looking particles all around it, approximately 5 (five) inches wide. An interview on 8/29/23 at 10:45 AM with Dietary Aide # 1 revealed she was not aware of a cleaning schedule and did not sign off on one to show she had cleaned the kitchen. During an observation and interview on 8/29/23 at 10:55 AM with the Dietary Manager (DM), she confirmed there was a thick shiny black buildup on the center grates and on the center burners of the stove; the left side of the stove had streaks of yellow buildup that extended down to the floor confirmed the edge of the bottom of the inside of the stove's oven had a shiny, black, crumble-looking build-up on the inside of the oven door's glass window had a black and yellow build-up. The DM also confirmed the silver	M 815		

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M 815	Continued From page 13 division guard between the griddle, attached to the right side of the stove top, had a thick shiny black/crusty appearing buildup on both sides of the silver division guard that appeared to cover approximately 95% of its surface, and confirmed the entire cooking surface of the griddle had a thick yellow and black buildup on it, the floor to the left side of the stove had a thick black build-up that measured approximately 18 inches in diameter, confirmed the area to the right side of the stove had a thick black buildup that measured approximately 24 inches in diameter. A continued observation with the DM, she confirmed the floor in the dry goods storage room had a trail of black sticky buildup approximately 14 inches wide that extended from the entry door to the dry goods storage room to approximately three (3) feet into the dry storage room. The black crate that held the bucket of sanitizing water and towels, on the left side of the 3-compartment sink and the two (2) black crates that held the jugs of sanitizer on the right side of the 3-compartment sink were covered with a large collection of crumb-looking particles and a shiny residue. She then confirmed the surface of the second shelf of the prep table, located in front of the stove that stored the containers of rice, meal, flour, and sugar, had a buildup of crumb-looking particles and puffy white residue. confirmed the large floor fan had a build-up of loose particles located on the inside of its front cover, and confirmed the fan was tilted upwards, blowing towards the prep table located in front of the handwashing station. The Dietary Manager further confirmed the edges of the floor near the walls, in the entire kitchen area, had a build of crumb-looking particles all around it, approximately 5 inches wide, and confirmed there was not a cleaning schedule for the dietary staff. The Dietary Manager revealed the dietary staff had not been informed they	M 815		

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M 815	Continued From page 14 needed to sign a cleaning schedule. The Dietary Manager attempted to find a filed copy of the last cleaning schedule for the kitchen, but revealed she was not able to locate any previously completed cleaning schedules. The Dietary Manager confirmed she should have maintained a dietary staff cleaning schedule to maintain a sanitary food preparation environment to avoid the possibility of illness for all the nursing facility residents and to avoid the possibility of a fire on the stove top and in the oven. An interview on 8/29/23 at 3:00 PM, with the Administrator confirmed there was not a cleaning schedule for the dietary staff. He confirmed there should be a dietary cleaning schedule, with assigned task, completed for each area of the kitchen to avoid the possibility of illness for all the residents and that the buildup on the stove top and in the oven posed a risk for fire. Record review of the Inservice Training for the Dietary Department, titled, dated 5/3/2023, revealed "TITLE AND DETAILED CONTENT OF INSERVICE: ... 2. Cleaning the kitchen." The record review revealed Dietary Aide #1, Dietary Aide #3, and the Dietary Manager attended this in-service.	M 815		