STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 Agency (SA) conducted an annual recertification at the facility from 8/29/23 through 8/31/23. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F565, F584 ,F656, F684,and F812. The facility held a license for 60 beds, with a census of 53.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every	F 565		10/4/23

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

Electronically Signed | 09/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 565	Continued From page 1 request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, record review, and facility policy review, the 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	F 565	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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 565	Continued From page 2 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 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.	F 565	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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 565	Continued From page 3	F 565		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 565	Continued From page 4	F 565		

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 565	Continued From page 5 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.	F 565		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		10/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 584	Continued From page 6 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and facility policy review the facility failed to repair a wheelchair armrest for one (1) of 36 resident's wheelchairs observed. Resident # 35. Findings include: A record review of the facility policy, titled "Employee Responsibility for Maintenance of Equipment", with a revision date of 10/09, revealed, "Policy: It is the policy of this facility to maintain all equipment in good working order..." On 8/29/23 at 11:30 AM, an observation of Resident #35's wheelchair revealed that the padding to the right armrest was exposing hard plastic and the top of two (2) screws were exposed. Resident #35 was resting his arms on the arm rest. He denied having any injuries related to (r/t) arm rests and stated he did not know how long they had been that way. During an interview with Certified Nursing Assistant (CNA) #1 on 8/30/23 at 1:00 PM, she stated that if resident equipment was noted to be broken or malfunctioning, she would not use it on	F 584	1. On August 30, 2023, the Administrator replaced the broken arm rest pad on Resident #35□s wheelchair. 2. 41 of 53 residents have the potential to be affected by this deficient practice. 3. An in-service was begun on 9/11/2023 by the Administrator with facility staff on the following policies: Equipment & Supplies Policy with revision date 11/17. In-service included that staff were to log any wheelchair or equipment issues in the Maintenance Repair Log AD-133. 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 Equipment & Supplies policy with revision date 11/17 was discussed & no changes to the policy were recommended by the committee. 4. The Administrator will monitor wheelchair repairs completed that are logged on Maintenance Repair Log	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 584	Continued From page 7 a resident and she would notify the maintenance man verbally and write it in the CNA "jot" book. During an interview with Licensed Practical Nurse (LPN) #1 on 8/30/23 at 1:10 PM, she stated if a resident's bed or wheelchair was broken, they would take the resident out of it and notify the maintenance man. She stated if they found broken equipment on the weekend and the maintenance man was not available, she would swap out the equipment with equipment that was not broken and communicate with the maintenance man. During an interview on 8/30/23 at 2:00 PM, with LPN #3 she stated that they do not have any type of maintenance log and usually just call the maintenance man. During an interview on 8/30/23 at 3:45 PM, with CNA #2 she stated that she had not noted any issues with Resident #35's wheelchair when she transferred him back to bed but verified that now she saw that the padding to the right armrest was missing and needed to be replaced. During an interview and observation on 8/30/23 at 4:35 PM, with the Administrator confirmed the padding from Resident #35's right wheelchair arm rest was missing causing hard plastic and the top of 2 screws to be exposed. He verified that the facility did not have any type of maintenance log. The Administrator stated that the padding needed to be replaced because the arm rest could cause injury to the resident. A record review of Resident #35's Face Sheet revealed he was admitted to the facility on 4/21/23 with diagnoses that include Unspecified	F 584	AD-133 weekly for 6 weeks and then monthly for 4 months or until the compliance is achieved. Also, Administrator will do a weekly check on all wheelchairs in the building for 6 weeks and then will move to monthly checks for 4 months. Both of these monitoring activities 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 584	Continued From page 8 Dementia, Unspecified Severity, without behavioral disturbance and anxiety. A record review of Resident #35's Quarterly Minimum Data Set Assessment (MDS), with an Assessment Reference Date (ARD) of 7/31/23, revealed a Brief Interview for Mental Status (BIMS) score of five (5), indicating that he is severely cognitively impaired.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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 (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.	F 656		10/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 656	Continued From page 9 (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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, record review and facility policy review the facility failed to implement a care plan safe for safe smoking for Resident #23 and turning and repositioning for Resident #40 for (2) two of 16 care plans reviewed. Findings include: A record review of the facility policy titled "Care Plan Process", with a revision date of 08/17, revealed, "The facility staff shall follow the care plan..." Resident #23 A record review of Resident #23's care plan revealed with a Problem Onset date of: 4/21/2023, "Resident uses tobacco cigarettes...	F 656	1. The care plan regarding smoking for Resident #23 was updated on 8/30/2023 by the Assessment Nurse. The care plan regarding turning & repositioning for Resident #40 was updated on 8/30/2023 by the Assessment Nurse. 2. All 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: Care Plan Process policy with revision date 08/17 and will continue until all nursing staff have been 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 656	Continued From page 10 Approaches: Resident needs a smoking apron." On 8/30/23 at 2:00 PM an observation of Resident #23 in the smoking area smoking a cigarette; he was not wearing a smoking apron. During an interview with Licensed Practical Nurse #2 (LPN), who was supervising the residents' smoke break on 8/30/23 at 4:30 PM, stated that none of the residents wore smoking aprons. She stated they were all supervised. During an interview with Resident #23 on 8/30/23 at 4:10 PM, he stated that he has never worn an apron while smoking. During an interview on 8/30/23 at 4:18 PM, with the Director of Nursing (DON), she agreed that the smoking care plan was not being followed and this could put the resident at risk for injury. A record review of Resident # 23's Face Sheet revealed that he was admitted to the facility on 4/21/23 with diagnoses that include Schizophrenia, Hallucinations, Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. A record review of Resident #23's Quarterly Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 7/25/23 revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating that he is cognitively intact. Resident #40 Record review of the ADL (activities of daily living)	F 656	Worker, Activities Director, Therapy Director, Licensed Practical Nurse, & Certified Nursing Assistant. The Care Plan Process 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 Care Plan compliance with smoking and turning/repositioning of residents 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. The Director of Nursing will check 2 residents weekly for smoking for 6 weeks and then 2 residents monthly for 4 months beginning 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 656	Continued From page 11	F 656		

Care Plan for Resident #40 revealed " ... Problem Onset: 12/21/2017, "RESIDENT IS DEPENDENT WITH ADLS S/T LIMITED MOBILITY, CONFUSION, DECREASED ATTENTION FROM VASCULAR DEMENTIA, ALZHEIMER'S DISEASE, AND MUSCLE WEAKNESS. ... TURN AND REPOSITION RESIDENT EVERY 2 (TWO) HOURS ... TO PROVIDE COMFORT, BODY ALIGNMENT AND REDUCE PRESSURE ROTATING BACK/LEFT AND RIGHT..."

On 8/30/23 at 8:30 AM, an observation revealed Resident #40 was positioned on his back.

On 8/30/23 at 10:30 AM, an observation revealed Resident #40 was positioned on his back.

During an observation and interview on 8/30/23 at 2:00 PM, with the Certified Nurse Aide (CNA) #3, confirmed 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. She revealed she was aware of the plan of care task on the kiosk for Resident #40 to be turned every 2 hours.

During 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 been following the plan of care to turn and reposition Resident #40 every 2 hours to avoid the possibility of illness or injury.

Record review of the Face Sheet for Resident #40 revealed an admission date of 12/21/17 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 656	Continued From page 12 diagnoses of Other Lack of Coordination, Alzheimer's Disease, Unspecified, Vascular Dementia, Unspecified Severity, with Behavioral Disturbance, Dysphagia, Unspecified, Unspecified Lack of Coordination, and Muscle Weakness (Generalized). Record review of Section C of the Quarterly Minimum Data Set (MDS), 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 of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date of 7/12/2023, for Resident #40, revealed he required total assistance of two (2) staff for bed mobility/turning side to side.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: 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	F 684	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.	10/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 684	Continued From page 13 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 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	F 684	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 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
	255259	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

(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 684	Continued From page 14 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). 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.	F 684		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		10/4/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 812	Continued From page 15 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, 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 areas are cleaned after each use, or, on a routine basis ...5. A cleaning schedule is established by	F 812	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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 812	Continued From page 16 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 black sticky build-up approximately 14 inches	F 812	revision date 05/18; Sanitation Checklist policy with revision date 05/18; Sanitary Conditions of the Food Service Department policy with revision date 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 812	Continued From page 17 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	F 812	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
	255259	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

(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 812	Continued From page 18	F 812		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255259	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

(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 812	Continued From page 19	F 812		

the dietary staff had not been informed they 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.