STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255349	A. BUILDING _____ B. WING _____	C 08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEARL RIVER CO NURSING HOME	**305 WEST MOODY STREET POPLARVILLE, MS 39470**

(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 survey and Complaint Investigation (CI), MS #22458 and MS #21986, at the facility from 8/21/23 through 8/24/23. The SA investigated MS #21986 related to dietary and there were no citations related to the complaint. MS #22458 was investigated related to an injury of unknown origin and F656 and F689 was cited related to the complaint. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and also cited F695. The facility was licensed for 120 beds and had a census of 98 at the time of the survey.	F 000		
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	F 656		10/2/23

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

Electronically Signed | 09/08/2023

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

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F 656	Continued From page 1 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §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 interview, record reviews, and facility's policy review the facility failed to ensure the comprehensive care plan interventions were implemented when a resident was transferred with a mechanical lift without the assistance of two (2) staff members for one (1) of 23 sampled residents. Resident #6 Findings include: Review of the facility's policy, "Care Plans, Comprehensive Person -Centered", revised	F 656	This Plan of Correction is submitted under Federal and State Regulations and status applicable to Long Term Care Providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings and conclusions are accurate, that the scope and severity regarding any of the deficiencies are cited correctly. Rather, it	

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F 656	Continued From page 2 December 2016, revealed, " ...A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is ... implemented for each resident ..." Record review of the Comprehensive Care plan, dated 7/6/23, revealed ... "Category: Seizures ... Intervention ...Total Assist X 2 for transfers with use of Hoyer Lift (mechanical lift) ..." On 8/24/23 at 09:00 AM, an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) revealed CNA #1 and CNA #2 had been terminated from the facility for not following the facility policy which required two persons when transferring a resident with a mechanical lift. The DON stated that they re-interviewed both employees and found that CNA #1 had transferred Resident #6 to the shower stretcher without the appropriate number of staff and CNA #2 had transferred Resident #6 from the shower stretcher to her bed without the required number of staff. On 8/24/23 at 11:00 AM, in an interview with Certified Nurse Aide (CNA) #1, she confirmed she transferred Resident #6 to the shower stretcher with a mechanical lift and did not have another staff member to assist. She stated that she had been trained in her CNA class to always have two people when transferring a resident with a mechanical lift. On 8/24/23 at 11:15 AM, with CNA #2, she confirmed she transferred Resident #6 from the shower stretcher to the bed without another staff member assisting. She stated that had been trained to have two staff members when using the	F 656	is submitted as confirmation of our ongoing effort to comply with all State and Federal regulatory requirements. 1) Certified Nurses Assistant #1 and Certified Nurses Assistant #2 were both terminated from employment from the facility for not following the plan of care of transferring Resident #6 on 08/22/23. Resident #6 requires two persons when transferring with a mechanical lift. The careplan was reviewed and revised by the Minimal Data Set Nurse to have 2 person assist in showers instead of 1 person assist. This review and revision was performed on 08/24/2023 2) The facility recognizes that all residents requiring transfers with a mechanical lift had the potential to be affected by this alleged deficient practice. 3) Education was provided to staff for following the plan of care. This education started on 08/17/2023 and continued to completion on 08/21/2023. The education was provided by the Assistant Director of Nurses (ADON). All Nurses and Certified Nurses Aides were provided education, beginning on 09/11/2023 and ongoing to the completion date of 09/13/2023, in regards to transferring with following the plan of care in regards to transfers. The education was provided by the Assistant Director of Nurses (ADON). 4) The results of the monitoring will be	

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F 656	Continued From page 3 mechanical lift. On 08/24/23 at 11:52 AM, during an interview with Registered Nurse (RN)#4, she explained that the purpose of the care plan was for facility staff to understand and know what to do for residents to meet the residents' needs. She stated that all resident care plans are located on the residents' chart at the nurse's station and on the computer. RN #4 reported that she expected the staff to follow the resident's care plan. Record review of the "Face Sheet" revealed the facility admitted Resident # 6 on 9/05/07 and she had diagnoses including Paraplegia, Multiple Sclerosis, and Osteoporosis. Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/23/23 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated Resident # 6 was cognitively intact. Further review revealed Resident #6 was dependent upon facility staff for transferring and required two persons to assist with the transfers.	F 656	brought to the Quality Assurance Performance Improvement (QAPI) Committee by the Quality Assurance Coordinator monthly for at least 3 months. If any revisions in the plan of corrections are needed, the revisions will be developed and approved by the Quality Assurance Improvement Committee to ensure the plan of correction is achieved and sustained. Charge Nurses will monitor two transfers daily for the first 30 days. Ongoing, the Charge Nurse will monitor two transfers weekly for the next 60 days. These monitoring checks will ensure that the plan of care is being followed. These monitoring checks will begin 09/11/2023. These monitoring sheets will be given to the Director of Nurses upon completion for compliance on, and the Director of Nurses will give to the Quality Assurance Coordinator starting on 09/29/2023 and continue for at least monthly for 90 days.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		10/2/23

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F 689	Continued From page 4 Based on interviews, record review, and facility policy review the facility failed to ensure a resident who was transferred using a mechanical lift was transferred with appropriate supervision for one (1) of three (3) sampled residents transferred with mechanical lifts. Resident #6 Findings include: Review of the facility's policy, "Lifting Machine, Using a Portable", revised September 2017, revealed, " ...The purpose of this procedure is to help lift residents using a manual lifting device ...General Guidelines Two (2) nursing assistants are required to perform this procedure ..." An interview on 8/24/23 at 09:00 AM, with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), revealed Certified Nurse Aide (CNA) #1 and CNA #2 had been terminated from the facility for not following the facility policy which required two persons when transferring a resident with a mechanical lift. The DON stated that during an incident investigation, the CNAs were interviewed again and it was discovered that CNA #1 had transferred Resident #6 to the shower stretcher without using the required number of staff and CNA #2 had transferred Resident #6 from the shower stretcher to her bed without the appropriate number of staff. During an interview on 8/24/23 at 11:00 AM, with CNA #1, she confirmed she transferred Resident #6 to the shower stretcher with a mechanical lift and did get another staff member to assist her. CNA #1 said she showered the resident and took her to her room.	F 689	1) Certified Nurses Assistant #1 and Certified Nurses Assistant #2 were both terminated from employment from the facility for not following the plan of care of transferring Resident #6 on 08/22/2023. Resident #6 requires two persons when transferring with a mechanical lift. 2) The facility recognizes that all residents requiring transfers with a mechanical lift had the potential to be affected by this alleged deficient practice. 3) All Nurses and Certified Nurses Aides were provided education, by the Assistant Director of Nurses, beginning on 08/17/2023 and ongoing to the completion date of 08/21/2023, in regards to transferring with a mechanical lift policy, and the requirement of two persons during the transferring with a mechanical lift. Maintenance Director will be required to perform monthly functioning and mechanical checks on each lift that the facility owns beginning 08/23/2023. These checks will be documented and turned into the Quality Assurance Coordinator on 09/15/2023 and ongoing at least monthly for 90 days. 4) The results of the monitoring will be brought to the Quality Assurance Performance Improvement (QAPI) Committee by the Quality Assurance Coordinator monthly for at least 3 months. If any revisions in the plan of corrections are needed, the revisions will be	

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F 689	Continued From page 5 During an interview on 8/24/23 at 11:15 AM, with CNA #2, she confirmed she transferred Resident #6 from the shower stretcher to the bed without another staff member assisting. She stated that Resident #6 was on the shower stretcher in her room and she cut the resident's hair and transferred her back to her bed. CNA #2 explained that she was aware that the facility required two (2) staff when using a mechanical lift. Record review of the "Face Sheet" revealed the facility admitted Resident # 6 on 9/05/07 and she had diagnoses including Paraplegia, Multiple Sclerosis, and Osteoporosis. Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/23/23 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated Resident # 6 was cognitively intact. Further review revealed Resident #6 was dependent upon facility staff for transferring and required two persons to assist with the transfers.	F 689	developed and approved by the Quality Assurance Improvement Committee to ensure the plan of correction is achieved and sustained. Charge Nurses will monitor two transfers daily for the first 30 days. Ongoing, the Charge Nurse will monitor two mechanical lift transfers weekly for the next 60 days. These monitoring checks will begin on 09/11/2023. These monitoring sheets will be given to the Director of Nurses upon completion for compliance, and the Director of Nurses will give to the Quality Assurance Coordinator on 09/29/2023 and on going at least monthly for 90 days.	