STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255141	A. BUILDING _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICAYUNE REHABILITATION AND HEALTHCARE CENTER	1620 READ ROAD PICAYUNE, MS 39466

(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 at the facility from 08/28/2023 through 08/31/2023. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F558, F578 and F656. The facility had a census of 107 and 120 was licensed for beds.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and facility policy review the facility failed to ensure a call light was accessible to a resident in her room for one (1) of 25 sampled residents. Resident #47 Findings include: A record review of the facility's policy "Answering the Call Light", revised September 2022, revealed " The purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines ... 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor ..."	F 558	Preparation and submission of the plan of correction by Picayune Rehabilitation and Healthcare Center does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirement of state and federal law. 1. On 8/28/23 Resident #47 call light was placed within reach by certified nurse's aide #1 (CNA). On 8/28/23 the Director of Nursing (DON) assessed Resident # 47 for any abnormalities with	9/30/23

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

Electronically Signed | 09/14/2023

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F 558	Continued From page 1 On 08/28/2023 at 10:58 AM, during an observation, Certified Nurse Aide #3 (CNA) pushed Resident #47, who was sitting in a shower chair, into her room and explained to the resident that she would go get her CNA and they would be right back. CNA #3 instructed Resident #47 to not try to get up and she left the room. Resident #47 was covered with a shower blanket while sitting in the shower chair near the bed. The call light was on the resident's bed but was out of reach for the resident and the resident was unable to move the shower chair to be able to access the call light. After three (3) minutes, CNA #1 entered the resident's room and explained to Resident #47 that she was going to assist her because her assigned CNA was occupied. On 08/29/23 at 03:23 PM, during an interview with Resident # 47, she explained that every time she received a shower, the CNA pushed her back to her room and left her on the shower chair for several minutes until her aide was able to transfer her off the shower chair. She confirmed that because she was covered up with the shower blanket, she could not reach the call light and that sometimes she was in the room by herself. On 08/30/23 at 02:00 PM, during an interview with CNA #2, she explained she was the CNA assigned to Resident #47 on 08/28/2023. She confirmed Resident #47 received a shower from the shower aid. She stated the process is that the shower aide completed the showers for the residents and once the shower was completed, the shower aid assisted the residents back to their room and notified the CNA assigned to the resident that the resident was back in their room.	F 558	no negative findings. Beginning on 8/28/23 an in-service was initiated with all staff on the call light policy along with Resident Rights by the Staff Development Coordinator (SDC). 2. The facility determined that each of the 107 residents has the potential to be affected. 3. On 8/28/23 an in-service was initiated by the Staff Development Coordinator with all staff on the call light policy and Resident Rights. On 09/01/23 observation rounds were completed on all resident rooms by the DON to check placement of call lights and ensure call lights were within reach. No issues were identified. 4. Beginning 9/5/23 the Director of Nursing or Assistant Director of Nursing will conduct observations rounds on ten resident room weekly for four (4) weeks and then monthly for three (3) months and quarterly thereafter to ensure the call light policy and procedures are being followed and call lights remain within reach of residents. A report will be submitted to the Quality Assurance Performance Improvement on 9/29/23 for review and recommendations then and monthly for three (3) months. The Director of Nursing is responsible for monitoring and compliance.	

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F 558	Continued From page 2	F 558		

She confirmed the shower aid left residents in their room on the shower chair, covered with a blanket after each shower most of the time, and that sometimes it would take a few minutes for the assigned CNA to assist the resident if she was busy with another resident.

On 08/30/23 at 02:20 PM, during an interview with CNA #3, she explained she was the shower aid and worked Monday through Friday and every other Saturday. She confirmed that on 08/28/2023, when Resident #47's shower was completed, the resident was left in her room on the shower chair, covered with two shower blankets with no staff present, and the call light was not within the resident's reach. She confirmed that because the resident was wrapped with the shower blankets, Resident #47 could not access the call light that was located on her bed.

On 08/31/23 at 10:53 AM, during an interview the Director of Nursing (DON), he explained that he expected the staff to always have a resident's call light within reach and not to leave a resident unattended on a shower chair.

On 08/31/23 at 11:00 AM, during an interview with the Administrator, she explained she expected the staff to not leave a resident unattended on a shower chair and to always have call lights within reach.

A record review of the "Admission Record" revealed the facility admitted Resident #47 on 12/14/2021 with diagnoses that included Chronic Diastolic (Congestive) Heart Failure, Paroxysmal Atrial Fibrillation, and Muscle Weakness.

A record review of the Quarterly Minimum Data

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F 558	Continued From page 3 Set (MDS) with an Assessment Reference Date (ARD) of 08/03/23, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated she was cognitively intact. Further review of the MDS revealed she required assistance from staff with transferring and bathing.	F 558		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive	F 578		9/30/23

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F 578	Continued From page 4 information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to document in the medical record discussions regarding a resident's decision to accept or decline assistance with formulating an Advanced Directive (AD) for five (5) of 25 resident records reviewed. Resident #6, Resident #34, Resident #90, Resident #93, and Resident #96. Findings include: Review of the facility's policy, "Advance Directives", revised 09/2022, revealed, " The resident has the right to formulate an advance directive ...If the Resident does not have an Advance Directive 1. If the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. a. The resident or representative is given the option to accept or decline assistance ...b. Nursing staff will document in the medical record the offer to assist and the residents decision to accept or decline assistance ..." A review of the medical record for Resident #6,	F 578	1. On 9/5/23 Resident #6, resident #34, resident # 90, resident # 93, and resident #96 and/or Resident Representatives were contacted and offered assistance by the Director of Nursing with the decision making in formulating the Advance Directive, the acceptance or declination were documented in the residents' medical records. 2. The facility determined that each of the 107 residents has the potential to be affected. 3. On 8/31/23 The facility policy for Advance Directives were reviewed and revised according to state and federal regulations by the Corporate Chief Operating Officer to include the offer to assist the Resident or resident representative in the establishment of the Advance Directives along with the documentation to include the option to accept or decline the assistance. On September 5, 2023, An Ad HOC Quality Assurance Performance Improvement (QAPI) meeting was held to review and adopt the policy changes for Advance	

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F 578	Continued From page 5 Resident #34, Resident #90, Resident #93, and Resident #96 revealed there was no documentation indicating the resident's decision to accept or decline assistance with formulating an AD. On 08/29/23 at 09:15 AM, during an interview with the Director of Nursing (DON), he stated that the facility discussed ADs with the resident and family upon admission and completed the Baseline Care plan based upon those discussions. He explained that the facility offers to assist with formulating an AD if the resident does not have one, however, he confirmed that the facility does not document those discussions in the medical record as per the facility policy. He stated that nursing staff should document in the medical record the offer to assist and the decision the resident makes to accept or decline assistance. On 08/31/2023 at 11:50 AM, in an interview with the Administrator, she confirmed the required documentation regarding assistance with formulating ADs were absent in the medical records of the residents. Record review of the "Admission Record" revealed the facility admitted Resident #6 on 6/24/2017 with diagnoses that included Osteomyelitis. Record review of the "Admission Record" revealed Resident #34 was admitted to the facility on 2/5/2020 with diagnoses that included Unspecified Dementia. Record review of the "Admission Record" revealed Resident #90 was admitted to the facility	F 578	Directives with the Medical Director and the Interdisciplinary team. The facility implemented the following system, as discussed in Ad HOC Quality Assurance Performance Improvement (QAPI) to ensure ongoing compliance on September 5, 2023. On 9/5/23 the Staff Development Coordinator initiated in-services with the licensed nursing staff and the interdisciplinary team on the Advance Directive Policies. 4. Beginning 9/5/23 the Director of Nursing and or Socail Services Director will reoffer assistance with the formulation of the Advance Directives and document response to assistance in the residents' medical records for ten (10) existing residents weekly for three (3) months until all existing residents were reoffered assistance. Beginning 9/5/23 The Director of Nursing and or the Assistant Director of nursing will audit three (3) new resident admissions to ensure assistance was offered in the formulation of the Advance Directors along with the response to the assistance to all new admissions weekly for four(4) weeks and then monthly for three(3) months and quarterly thereafter to ensure the Advance Directive policy and procedures are being followed and documented. A report will be submitted to the Quality Assurance Performance Improvement on 9/29/23 for review and recommendations then and monthly for three (3) months. The Director of Nursing is responsible for monitoring and compliance.	

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F 578	Continued From page 6 on 10/25/2022 with diagnoses that included Cognitive communication deficit and muscle weakness. Record review of the "Admission Record" revealed Resident #93 was admitted to the facility on 12/2/2022 with diagnoses that included End Stage Renal Disease. Record review of the "Admission Record" revealed Resident #96 was admitted to the facility on 4/5/2023 with diagnoses that included Cerebral Infarction and Adult failure to thrive.	F 578		
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	F 656		9/30/23

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F 656	Continued From page 7 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 observations, resident and staff interviews, record reviews, and the facility policy review the facility failed to implement a care plan to ensure the call light was within reach for (1) of 25 sampled residents. Resident #47 Findings include: A review of the facility's policy, "Care Plans, Comprehensive Person-Centered" with a reviewed date of January 2023, revealed " A comprehensive, person-centered care plan ... to meet the resident's physical, psychosocial and functional needs is ...implemented for each resident ..."	F 656	1. On 8/28/23 Resident #47 call light was placed within reach by certified nurse's aide #1 (CNA). Beginning on 8/28/23 an in-service was initiated with all staff on following the plan of care regarding the call light policy by the Staff Development Coordinator (SDC). 2. The facility determined that each of the 107 residents has the potential to be affected. 3. On 8/28/23 an in-service was initiated by the Staff Development Coordinator on following the person-centered comprehensive care plans with all staff. On 09/01/23 observation rounds were	

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F 656	Continued From page 8 A record review of the Comprehensive Care Plan, undated, revealed "Focus: I am at risk for falls ...Interventions/Tasks ...Be sure my call light is within reach..." During an observation on 08/28/2023 at 10:58 AM, Certified Nurse Aide #3 (CNA) pushed Resident #47, who was sitting in a shower chair, into her room. The call light was on the resident's bed but was out of reach for the resident and the resident was unable to move the shower chair to be able to access the call light. After three (3) minutes, CNA #1 entered the resident's room and explained to Resident #47 that she was going to assist her because her assigned CNA was occupied. In an interview with CNA #3 on 08/30/2023 at 02:20 PM, she confirmed that on 08/28/2023, when Resident #47's shower was completed, the resident was left in her room on the shower chair, covered with two shower blankets with no staff present, and the call light was not within the resident's reach. She confirmed that because the resident was wrapped with the shower blankets, Resident #47 could not access the call light that was located on her bed. On 08/31/2023 at 10:53 AM, during an interview the Director of Nursing (DON), he explained that he expected staff to always follow a resident's care plan and that all care plans can be viewed on the CNA's Kardex. On 08/31/2023 at 11:10 AM, during an interview with Registered Nurse (RN) #1/Care Plan Nurse, she explained the purpose of the care plan was for staff to know how to care for the residents.	F 656	completed on all resident rooms by the DON to check placement of call lights and to verify the resident care plans were being followed. No issues were identified. 4. Beginning 9/5/23 the Director of Nursing and or the Assistant Director of Nursing will conduct observations rounds on ten resident room weekly for four (4) weeks and then monthly for three (3) months and quarterly thereafter to ensure the person-centered care plans are being followed and call lights remain within reach of residents. A report will be submitted to the Quality Assurance Performance Improvement on 9/29/23 for review and recommendations then and monthly for three (3) months. The Director of Nursing is responsible for monitoring and compliance.	

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F 656	Continued From page 9 She stated that all residents' care plans are available on the computer and on the Kardex for the CNA to assess. She expressed that as the care plan nurse, she expected facility staff to follow the care plan for resident care. A record review of the "Admission Record" revealed the facility admitted Resident #47 on 12/14/2021 with diagnoses including Chronic Diastolic (Congestive) Heart Failure, Paroxysmal Atrial Fibrillation, and Muscle Weakness.	F 656		