STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255125	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chadwick Nursing and Rehabilitation Center LLC	1900 Chadwick Drive Jackson, MS 39204

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 43283 Based on observations, interviews, record review, and facility policy review, the facility failed to honor resident's rights to have a choice of having bedrails for assistance with turning and bed mobility for two (2) of 19 sampled residents. Resident #54 and #78 Findings include: A record review of the facility's policy titled, Resident [NAME] of Rights, dated 01/23 revealed, Each resident has a right to a dignified existence, self-determination, and communication wish and access to persons and services inside and outside the facility in a manner and in an environment that promotes maintenance or enhancement of (his or her) quality of life, regardless of diagnosis, severity of condition or payment source and to exercise those rights as a citizen of the United States without interference, coercion including those rights specified herein . Resident #54 On 06/02/24 at 12:38 PM, during an interview with Resident #54, he revealed he wanted rails on his bed, but was told by the facility staff that he could not have rails due to the state's regulations. On 06/05/24 at 9:39 AM, during an interview with Resident #54, he explained he wanted his bed rails to assist him with turning and the rails give him some of his independence with moving around in the bed. Record review of Resident #54's Face Sheet revealed the facility admitted the resident on 9/14/22, with diagnoses that included Type 2 Diabetes Mellitus, Anemia, and Myalgia (muscle pain). Record review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/15/24, Resident #54 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #78 (continued on next page)

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.

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/02/24 at 1:50 PM, during an observation and interview with Resident #78, the resident was observed sitting up in his wheelchair. During the initial visit with Resident #78, the resident became loud and began cursing, saying what you can do is give me back my bedrails. He explained he was told the state is the ones who are responsible for taking away the bedrails. The resident reported he used the bedrails to help assist with turning and he wanted his bedrails back. Resident #78 explained the staff came in one day and just took his bedrails away. He further reported that he had asked and asked for them back, however, staff kept telling him the State will not allow him to have his bedrails. On 06/04/24 at 10:00 AM, during an interview with Certified Nurse Aide (CNA) #3, she stated the management team removed all bedrails, maybe over a month ago, but she is not exactly sure how long ago. Management told staff and residents, the State would not allow residents to have bedrails due to state guidelines. She also reported that management commented that the facility is a restraint free facility. She explained Resident #78 has been very mad and upset since his bedrails were removed and complains about not having the bedrails every day. On 06/04/24 at 10:32 AM, during an interview with Maintenance Director, he revealed the bedrails were taken off of all of the resident's beds in phases, which began the last week in April 2024 and ended 5/23/24. He explained the residents' bedrails were dismantled by order of the Administrator because they are a restraint free facility. On 06/04/24 at 5:00 PM, during an interview with the Administrator and the Director of Nurses (DON), both confirmed all resident's bedrails were removed from residents' beds. They stated the explanation given to residents and staff was that it was a state regulation. They confirmed that bedrails were not offered, and the need was not assessed per resident's choices or request. The Administrator and the DON acknowledged that this was a resident's rights issue, and the facility wishes to honor resident's rights and choices per each individual resident. They stated they plan to take the necessary steps to correct their previous action and evaluate each resident individually and restore bedrails, as appropriate, following the appropriate guidelines. On 06/05/24 at 10:20 AM, during an observation and interview of resident #78, the resident's bed still did not have any bedrails. Resident #78 remained upset about not having bedrails and voiced he wants them back. On 06/05/24 at 4:30 PM, the Administrator revealed the facility does not currently have a bedrail policy, only a restraint policy. Record review of Resident #78's Face Sheet revealed the facility admitted resident on 11/22/21, with diagnoses that included Hemiplegia Following Cerebral Infarction Affecting Left Nondominant Side. Record review of Resident #78's Quarterly MDS with an ARD of 04/10/24, revealed BIMS Score of 09, which indicated moderate cognitive impairment. Section GG revealed Resident #78 required partial/moderate assistance with rolling left to right.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 43283 Based on observation, staff and resident interviews, record review, and facility policy review, the facility failed to ensure timely incontinent care was provided for one (1) of two (2) residents observed for incontinent care. Resident #48 Findings include: Record review of the facility's policy titled, Resident [NAME] of Rights dated 01/23 revealed, Each resident has a right to a dignified existence . On 06/02/24 at 12:50 PM, an observation and interview revealed Resident #48's call light was on. At that time, a Certified Nurse Aide (CNA) entered the resident's room and turned off the light and exited the room. When the resident's room was entered, there was a strong unpleasant odor noted. Resident #48 reported she had told the CNA she needed to be changed. The resident stated the CNA turned the light off and said she would come back. The resident complained that it takes a long time for staff to answer her light, and when they do, they turn off the light and then it takes forever for them to come back to provide the care that had been requested. The resident then added that this happens on all shifts, at different times. On 06/02/24 at 1:10 PM, during an interview with Resident #48, she reported she is still waiting for someone to come clean her up. At 1:16 PM on 06/02/24, an observation revealed Resident #48's call light was again going off. The Director of Nursing (DON) entered the resident's room and came back out of Resident #48's room. On 06/02/24 at 1:22 PM, during an observation and interview revealed Resident #48's call light continued to go off. At this time, Licensed Practical Nurse (LPN) #2, entered the resident's room and came back out of the room. LPN #2 explained the resident was waiting on her CNA to come change her. LPN #2 explained the CNA was working her way to the resident, as there is one (1) CNA on the resident's hall with 12 residents. On 06/02/24 at 1:30 PM, during an interview with CNA #3, she explained it was not her that came out of resident's room earlier, but she will go and check on the resident. After CNA#3 came back from Resident #48's room, she explained the resident needed to be changed, so she will go ahead and change the resident. At 1:50 PM on 06/02/24, an observation revealed CNA #3 returned to the room of Resident #48 with supplies to provide incontinent care. While incontinent care was provided, an observation revealed the resident's incontinent brief was soiled and saturated with urine. On 06/03/24 at 3:12 PM, during an interview and observation of Resident #48, she was sitting in her wheelchair, wearing a gown and tee shirt. The resident reported she was waiting to get cleaned up. There was a strong smell of urine noted in the resident's room and in the hall outside the resident's room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 3:25 PM on 06/03/24, during an interview with CNA #4, she explained she uses the pocket care guides for knowledge of individual resident care. She stated she has worked with Resident #48 previously, and the resident can stand and pivot and is incontinent of bowel and bladder. CNA #4 acknowledged Resident #48 does have periods of confusion, but she can make her needs known. At 3:35 PM on 06/03/24, during an observation of incontinent care provided for Resident #48, the resident's brief was saturated with urine. The resident's wheelchair was also wet. CNA #4 confirmed urine had leaked from the resident's brief onto the wheelchair seat. On 06/04/24 at 1:00 PM, during an interview with the DON, she explained she expects all residents to be changed in a timely manner, by any staff member who can provide the care, including nurses. On 06/05/24 at 4:00 PM, during an interview with the Administrator, she explained she expects all nursing staff to provide care for residents and for no resident to wait long periods of time for care. Record review of the Face Sheet of Resident #48 revealed the facility admitted resident on 04/17/18. The resident's diagnoses included Cerebral Infraction (stroke), Type 2 Diabetes Mellitus and Hypertensive Heart Disease. Record review of Resident #48's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/22/24, revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. Section GG revealed resident required substantial/maximal assistance with toileting and personal hygiene. Section H revealed Resident #48 is always incontinent of bowel and bladder.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41680 Based on observation, interviews, record reviews, and facility policy review, the facility failed to ensure oxygen was delivered in a manner to prevent potential complications as evidenced by not following physician orders or facility policies related to oxygen therapy when a resident's oxygen tubing was not dated and there was no humidification provided for one (1) of 19 sampled residents. Resident #52 Findings Include: Record review of the facility's policy titled, Oxygen Therapy, reviewed 1/15, revealed, Oxygen is administered to promote adequate oxygenation and provide relief of symptoms of respiratory distress . Equipment: . 2. Humidifier, if needed . Procedure: .8. Change tubing weekly. 9. Date tube when changed (weekly). On 6/02/24 at 1:02 PM, an observation and interview with Resident #52 revealed Resident #52 was sitting on her bed with oxygen flowing at 2 liters per nasal cannula. The oxygen tubing did not have a date on it, nor was there a humidifier bottle attached to the delivery system. Resident #52 stated she has been hospitalized two times due to shortness of breath. On 06/02/24 at 1:08 PM, in an interview with Licensed Practical Nurse (LPN) #1, she confirmed that there was no date on the oxygen tubing and there was no humidifier bottle attached to the oxygen. LPN #2 stated oxygen tubing should be changed and dated weekly. She stated if not, it could lead to an infection issue. LPN #1 explained that a humidifier should be attached, as it provides moisture and helps prevent the resident's nostrils from getting dry. On 06/04/24 at 3:46 PM, in an interview with the Director of Nurses (DON) she stated Resident #52 should have had a humidifier bottle attached to the oxygen delivery system. She stated the humidifier is used to prevent help keep the resident's nasal area moist. The DON stated the reason for changing tubing and dating it lets staff know when it was first applied. The DON stated The tubing is changed weekly to decrease the possibility of bacteria growing within the tubing. The DON explained that she expects staff to change a resident's oxygen tubing and to keep a humidifier on the oxygen. Record review of the Physician Orders for Resident #52 for the month of June 2024, revealed an order dated 5/6/24 Oxygen at 2 L/min (two/Liters/minute) per nasal bi-prong (cannula) continuously . An additional order dated 5/6/24 revealed Change Oxygen tubing weekly on Friday: Date and initial . Record review of Resident #52 Face Sheet revealed an admitted [DATE] with diagnoses that included Shortness of Breath and Acute respiratory failure with hypoxia. Review of Resident #52's Annual Minimum Data Set (MDS), with Assessment Reference Date (ARD) 5/13/24, revealed a Brief Interview for Mental Status score of 14, which indicated the resident was cognitively intact. Section O was coded for oxygen.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48181 Based on observation, staff and resident interview and record review, the facility failed to have sufficient nursing staff to meet the needs of residents as evidenced by failure to answer call lights and provide incontinent care in a timely manner for three (3) of 19 sampled residents, with the potential to affect all residents residing in the facility. (Residents #48, #87 and #23) Findings Include: Resident # 48 On 06/02/24 at 12:50 PM, an observation and interview of Resident #48, revealed a Certified Nurse Aide (CNA) entered the resident's room and turned off the resident's call light and exited the room. When the resident's room was entered, there was a strong unpleasant odor. Resident #48 stated the CNA turned off her call light and said that she would be back. The resident complained that this is something that happens frequently and it takes a long time for them to return to provide the requested care. The resident was unable to provide information regarding shifts and timing of the occurrences, adding that this happens on all shifts, at different times. On 06/02/24 at 1:16 PM, an observation revealed Resident 48's call light had been turned back on. At this time, the Director of Nurses (DON) entered the resident's room and came back out. During an observation and interview on 6/2/24 at 1:22 PM, revealed Licensed Practical Nurse (LPN) #2 entered the room of Resident #48 and came back out. LPN #2 stated that the resident was waiting on her CNA to come change her and explained the CNA was working her way to the resident's room, as she was the only CNA on the hall with 12 residents. During an observation at 1:50 PM on 06/02/24, revealed CNA #3 entered the resident's room and provided incontinent care. While observing the care, it was noted that the resident's incontinent brief was soiled and saturated with urine. On 06/03/24 at 3:15 PM, another observation of Resident #48 revealed that she was sitting up in her wheelchair waiting on assistance from staff. At this time, there was a strong smell or urine noted in the resident's room and in the hall outside the resident's room. On 06/03/24 at 3:35 PM, during an observation of incontinent care provided to Resident #48 revealed the resident's brief was saturated with urine. CNA #4 confirmed that the brief had leaked onto the wheelchair seat. Record review of the Face Sheet for Resident #48 revealed the facility admitted the resident on 04/17/18. The resident's diagnoses included Cerebral Infarction (Stroke), Type 2 Diabetes Mellitus and Hypertensive Heart Disease. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the Quarterly Minimum Data Set (MDS), for Resident #48, with an Assessment Reference Date (ARD) of 04/22/24, revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. Resident #87 On 06/02/24 at 1:15 PM, in an interview with Resident #87, she complained of having to wait long period of time for staff to answer her call lights. Resident #87 reported this happens all the time. Resident #87 explained, the staff will answer the call light, and say they will tell someone, but will never come back and you will have to ring again, and someone will answer the light and say the CNA is on break and when she comes back, they will let her know. Resident #87 stated this happens during every shift, at all times of the shift. She stated she has even asked the nurses for assistance but has been told to wait for her CNA. A record review of the Face Sheet for Resident #87 revealed the facility admitted the resident on 09/13/24. The resident's diagnoses included Metabolic encephalopathy, Acute Kidney failure, and Hypertensive Heart Disease. A record review of the Quarterly MDS, for Resident #87, with an ARD of 03/11/24, revealed a BIMS score of 15, which indicated the resident was cognitively intact. Resident #23 On 06/02/24 at 2:13 PM, during an observation and interview with Resident #23, the resident revealed the facility is often short of staff and the wait time can be long when the call light is activated. The resident stated as recently as a week ago, there have been times when he has used his call light on the 11:00 PM to 7:00 AM shift and no one responded. On 06/02/24 at 2:30 PM, in an interview CNA #2 revealed at times the facility is short staffed. CNA #2 explained there have been days when there was only one CNA to cover an entire hall and the nurses will not assist the CNA's when they are short staffed. On 06/04/24 at 1:00 PM, during an interview with the DON, she explained she expects all residents to be changed in a timely manner, by any staff member who can provide the care, including nurses. On 06/05/24 at 4:00, during an interview with the Administrator, she explained she expects all nursing staff to provide care for residents and for no resident to wait long periods of time for care. Record review of the Face Sheet revealed the Resident #23 was admitted to the facility on [DATE] with diagnoses that included End Stage Renal Disease and Type 2 Diabetes Mellitus. Record review of Resident #23's Annual MDS, with an ARD of 4/2/24 revealed the resident had a BIMS score of 15, which indicated the resident was cognitively intact.